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Why we need to think about trauma in HIV services

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Overview of session

- Define trauma
- Think about the many ways in which trauma is relevant to PLWHIV
- Think about why it is important that HIV services have an understanding of the impact of trauma
- How can services help people affected by trauma

Disclaimer – take care of yourselves
What is trauma?

- Diagnostic and Statistical Manual of Mental Disorders – 5th Edition (DSM-5; 2013)

**CRITERION A**

- *The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (direct indirect)*

Trauma = Fear + Helplessness

Can a potentially life threatening illness count as a traumatic event?
What is trauma?

- **CRITERION B: Re-experiencing**
  - Intrusive thoughts, Nightmares, Flashbacks, Emotional distress and/or Physical reactivity after exposure to traumatic reminders

- **CRITERION C: Avoidance**
  - Avoiding trauma-related reminders or trauma-related thoughts and/or feelings

- **CRITERION D: Negative thoughts and feelings**
  - Overly negative thoughts (self and world), exaggerated blame (self or others), negative affect, loss of positive affect, reduced interest, feeling isolated

- **CRITERION E: Arousal**
  - Irritability, aggression, hypervigilance (monitoring for threat) heightened startle response, sleeping and concentration difficulties
What is trauma?

Criterion F
• Symptoms last for more than 1 month.
  • (Presents similarly to Acute Stress Disorder – short term response to a traumatic event)

Criterion G
• Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H
• Symptoms are not due to medication, substance use, or other illness.

• RESILIENCE IS THE NORM
How does trauma work?

- Many complex cognitive, emotional, physiological and behavioural processes involved

- Several theoretical viewpoints – e.g.
  - Horowitz (1975, 1976)
  - Foa et al (1989) – Fear Networks

- *Cumulative aspect – ‘the kindling effect’*
Trauma and HIV

- HIV diagnosis can be traumatising
- People living with trauma may find it more difficult to manage a chronic condition (poorer health outcomes)
- People with a history of trauma are more vulnerable to HIV infection
Prevalence of Trauma in the HIV Population

- There is strong evidence that there is higher prevalence of mental health problems amongst people living with HIV compared with the general population (WHO, 2008).

- PTSD 33% more prevalent in HIV population (National Institute for mental health)

- PTSD prevalence rates – 10-74% - compared to 8% general population (Applebaum et al 2015)
Traumatic impact of HIV diagnosis

- **Shock** – highly stressful event

- **Fear of death**
  - ‘a heavy history’
  - Previous direct exposure to HIV-related death
  - Lack of up to date treatment knowledge

- **Fear of loss**
  - Health, relationships, employment, future

- **Fear of stigma, discrimination and isolation**
  - Including internalised stigma and self-directed shame

- **Fear of onward transmission** (partners, or mother to child)

- **Source of transmission** can enhance the trauma
Influence of history and context

- **Long term survivors**
  - Fear of death was very realistic
  - Multiple traumatic bereavements
  - Physical trauma of side effects of early medications
  - Rejection by society
  - Loss of significant others and survival guilt

- **Newly diagnosed people**
  - Very little information – no frame of reference
  - Less of a sense of community?

- **Asylum seekers**
  - High rates of trauma
  - Loss of family, friends and familiar base
  - Ongoing insecurity about status
Influence of history and context

- **Older age**
  - Fears about going into care
  - Concerns about managing increasing co-morbidities
  - Dementia

- **Gender and sexuality**
  - Motherhood
  - Gender-based violence
  - LGBT related issues – e.g. persecution

- **Community**
  - Social norms and expectations
  - Attitudes
  - Religious frameworks
Traumatic impact of HIV-related ill health

- Extreme ill health at time of diagnosis
  - Unknown cause
  - ICU admission
  - Cognitive impairment

- On going management of HIV – chronic stressor
  - Constant fear of people finding out
  - Non-consent disclosures
  - Stigma and discrimination
  - Fear of missing medication doses – resistance
  - Hypervigilant research – with a ‘fear filter’
**Historical Trauma**

- HIV diagnosis can exacerbate existing trauma
- HIV high prevalence in already marginalised groups (e.g. people with mental health issues, LGBT, asylum seekers)
- Historical trauma (mental health issues)
  - puts people at more risk of being infected with HIV
  - May increase risk of onward transmission
- Abuse in early life – particularly is by caregivers – can affect engagement with healthcare professionals
- Historical trauma may mean people have less helpful coping strategies after diagnosis/managing HIV
The complexities of ‘unhelpful’ coping

- **External coping**
  - Risk behaviours-sex, drugs, rock and roll
  - Historical trauma can manifest in relational issues –
    - Insecure template for relationships
    - exposure to unfulfilling relationships – chaotic, abusive
    - Distressing = familiar = safe

- Hep C, other STD’s – compound the trauma via things such further concealment – shame

- Generally not looking after health – HIV, co-morbidities, or just general wellbeing (e.g. smoking, drinking, drug use)– impact on overall health outcomes
The complexities of ‘unhelpful’ coping

- **Internal coping**
  - Rumination
    - Doesn’t solve the problem, just keeps mind on it – low mood
  - Hypervigilance
    - Constantly monitoring for threat
  - Self criticism
    - Feeds negative feelings, more unhelpful coping, further self criticism

- **Avoidance** (part of the trauma presentation)
  - Avoiding any reminders of the traumatic event, including own thoughts
  - Withdrawal
    - Isolation and not processing the trauma

- Dissociation
Trauma and Adherence

- Fear of side effects
- Chaotic lifestyle
- Medication as a trigger for overwhelming trauma memories and emotions
- Supporting a sense of denial
- Not taking ART may serve a function
  - Self punishment and/or self harm
  - Sense of control
- Worthlessness
- Hopelessness
- Lack of trust of health care professionals/system – affecting engagement
- **HOWEVER** – can also increase adherence
Vicarious Trauma/Secondary Traumatic Stress

- Dealing with a population with complex psychosocial needs – impact on healthcare professionals

- Overwhelmed
- Distressing emotional responses
- Negative thoughts about people/situations/world
- Trying to avoid certain people/situations
- Irritability/anger
- High work stress levels
- Loss of empathy
- Fear – from role pressures
- Work stress affecting sleep
- Things outside of work reminding you of work
- Periods of sick leave
- Helplessness
- Hopelessness?
What is trauma?

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What Can HIV Services Do?

- Show compassion and give space
- Delivery of up to date information
  - Make sure people have been able to take information in (dissociation)
  - Provide written info, info sources, checking in regularly
- Get to know the signs of trauma – trauma screening questionnaire?
- Signpost as necessary
- Seek consultation and/or supervision
- Be aware of power dynamics – impact of our ‘status’
- Be consistent – across the team
- Take care of ourselves and each other
- Don’t force ‘de-briefs’
Psychological first aid

- Empathy and compassion
- Listen
- Re-assure
- respond
Post Traumatic Growth

- HIV diagnosis can:
  - Help people find a community
  - Access support
  - Perspective shift – changing life choices

- The care team can:
  - Function as a ‘safe base’ for those with difficult histories
  - Help a person learn how to develop; and manage relationships
  - Help people learn to care for themselves
  - Aid an overall recovery
Thank you for listening

Questions?


References

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