POZ

Trauma and HIV

An edited excerpt of an opinion piece co-authored by Charles Stephens, founder and director of The Counter Narrative Project, and Naina Khanna, executive director of the Positive Women’s Network-USA, titled “Trauma and HIV.”

September 17, 2015 By Naina Khanna and Charles Stephens

Trauma is often thought of as an individual, interpersonal experience. But for those of us from marginalized communities, structural violence and oppression also contribute to trauma.

In recent years, federal agencies have increased attention to the links between interpersonal violence and HIV. Abuse history, for example, has been found to affect vulnerability to HIV acquisition and health outcomes after diagnosis.

However, there has been little consideration of the ways in which trauma is experienced across the lines of race, gender identity, class, sexual identity and socioeconomic status, despite the fact that the domestic U.S. HIV epidemic disproportionately affects black and Latino communities.

Better understanding the traumatic effects of racism, economic distress, heterosexism and other factors will significantly advance our efforts to achieve greater health and social equity for people living with HIV.

To begin with, what do we mean by “trauma”? It can be described as a single or series of distressing experiences, disturbing occurrences that can leave lasting emotional scars. Trauma also exists at the level of communities.

For groups that experience significant interpersonal and institutional discrimi-nation, stigma and violence inscribed in policy and practice, trauma is ever present. Thus, oppression has not only social consequences, but also psychological, emotional and physical consequences. Oppression is frequently internalized and deeply traumatic.

An understanding of trauma as structural, not simply personal, allows HIV service providers and clinicians to assume that all of their clients come with a trauma history. Thus, service providers must also recognize and be sensitive to the ways power dynamics, racism and cultural relevance in health care settings affect engagement in care. To address this, provider training and system change are necessary—beginning with an acknowledgment of the pervasiveness of trauma.

Another important step is changing the standard of care in service delivery for communities impacted by HIV. This requires a willingness to reimagine clinical settings, ensuring cultural relevance toward trauma-informed ends. In particular, understanding the traumatic effects of racism and xenophobia and instituting practices in clinical care that address those effects can greatly enhance the quality of care for communities disproportionately affected by HIV.

The creation of quality assurance measures is also necessary to evaluate how effectively service delivery and care environments are responding to trauma in the lives of their patients.

There is still substantial work ahead in understanding how trauma-informed practices that integrate an understanding of historical trauma and the impact of racism can be applied in HIV service delivery settings.

Initial steps include: ensuring representation by groups heavily impacted by HIV in organizational leadership, particularly at the board and senior management level; minimizing power dynamics between providers and patients; instituting a regular screening protocol for assessment of depression, anxiety, trauma and post-traumatic stress disorder; and integrating peer-based services and culturally relevant trauma interventions.

As we fight against inequality and health disparities, we must just as forcefully grapple with intersectionality in the lives of groups impacted by HIV. Racial justice and a commitment to anti-oppressive thinking have to ground us.