Coerced Childhood Sexual Episodes and Adult HIV Prevention

Jay P. Paul, PhD

In their pursuit of the key factors that influence HIV risk behaviors, HIV prevention researchers have focused increasing attention on the effects of childhood sexual abuse. Many studies have shown a strong relationship between childhood sexual abuse and HIV sexual risk behavior in adulthood both for women and men. This article briefly reviews this literature (omitting specific reference to many seminal studies due to space limitations). It goes on to provide frontline prevention workers—particularly those in settings where in-depth, long-term interventions are impractical—with potential ways to respond to childhood abuse.

Childhood Sexual Abuse and Its Effects

While the link between abuse and risk is clear, it has been harder for researchers to describe this relationship in more detail: to demonstrate the ways in which coercive childhood sexual experiences may shape adult sexual behavior. Among the research challenges are: the diversity in types and intensity of experiences classified as “childhood sexual abuse,” the confounding of the effects of these experiences by other adverse developmental factors, and the individuality of the ways each person cognitively processes and comes to understand his or her victimization experience.

Given these conditions, it is not surprising that no single set of symptoms or syndromes is universal to all sexually abused children; instead, there is a broad range of reactions to childhood sexual abuse. Some people show incredible resilience, surviving these experiences relatively unscathed. Others may express far more extensive symptomatology. Although a 1993 review of 45 studies of abused children found no specific pattern of symptoms in a majority of these samples, the review did find higher rates of post-traumatic stress disorder (PTSD) and sexualized behavior among sexually abused versus non-abused children.

An examination of the reported effects of childhood sexual abuse highlights potential intervening variables that may increase HIV risk. Studies have found higher rates of depression and self-destructive behaviors or attitudes in adults, increased use of alcohol and other drugs, dissociative symptoms (compartmentalizing aspects of one’s conscious experience, going “outside of one’s body”), difficulties with sexual functioning and intimacy, as well as greater numbers of sexual partners, more frequent sexual activity, and less attention to risk.

Several proposed models may explain these effects. The most well known, the “traumagenic model,” posits four key dynamics that lead to negative outcomes: powerlessness, betrayal, traumatic sexualization, and stigmatization. “Powerlessness” refers to a child’s experience of being in a threatening situation in which his or her desires and self-efficacy are repeatedly overruled and frustrated. With severe abuse, this dynamic can produce PTSD-like symptoms, including recurrent and intrusive re-experiencing of the trauma, dissociation/psychic numbing, anxiety/stress, and hypervigilance. It is also associated with various acting-out behaviors. Abuse-related powerlessness may be generalized to other situations as “learned helplessness.”

The second dynamic, “betrayal” refers to the violation of a child’s implicit expectation that his or her well-being is important to adults. This can lead to persistent feelings of mistrust, extreme dependency, depression, anger, and hostility. “Traumatic sexualization” refers to a child’s inappropriate sexual socialization, which may lead to maladaptive patterns of sexual behavior and distorted or inappropriate beliefs about sexuality. Finally, the
It is not time to throw up your hands and shout, but I find myself poised, perhaps without justification, for a Eureka moment. Recent research—notable for the uniformity of its findings—increasingly supports hypotheses posed a decade ago that childhood sexual abuse may be a fundamental factor determining HIV risk among a wide variety of people. These studies conclude that survivors of abuse are significantly more likely than those without a history of abuse to participate in unprotected sex.

We have known for years that conditions ranging from low self-esteem to substance use seem to increase risk taking. Now—that is, over the past few years—researchers have identified at least one factor that may underlie these conditions. Further, it appears that among population groups such as people with HIV and gay men, rates of childhood sexual abuse are significantly higher than within the “general population.” These developments suggest that there is the potential for interventions to be more targeted—and therefore more effective—than ever before. These interventions are also likely to be relevant to a large number of people at risk. Finally, as Mary Curry and James Bristol report in this issue of FOCUS, there is reason to suspect that childhood sexual abuse may also impair health-seeking behaviors, which are necessary to sustain adherence to medication regimens and overall health care.

Agencies working on the front lines of the epidemic and counselors working with brief counseling interventions rarely have the resource of time to undertake the psychotherapy necessary to resolve childhood sexual abuse. As Jay Paul outlines in his comprehensive article, however, there are a number of interventions that providers in these settings can employ to identify clients who have experienced childhood sexual abuse, educate them about the adult manifestations of abuse, provide social support, and ensure that they receive appropriate referrals. In doing so, he offers a model for at least beginning to respond to clients with other complex psychological disorders at agencies whose primary focus is not mental health.

The societal challenge of stemming childhood sexual abuse is enormous, extending far beyond HIV prevention, and more research is necessary to understand the relationship between HIV risk and abuse. Nonetheless, the existing research has moved HIV prevention one step closer to finding effective—if complicated—strategies for preventing HIV among people at highest risk for infection.

References

FOCUS April 2003

Editorial: Eureka?
Robert Marks, Editor

According to a social learning model—appropriate because childhood sexual abuse can directly shape future patterns of sexual behavior and relationships—abuse can impair the appraisal of potential risk to self and the capacity to enact behaviors necessary to reduce risk. The abuse experience can teach victims to use sexual behavior as a means of obtaining attention or relief, and to view sex as a “commodity” to be exchanged to meet other needs. HIV risk is clearly linked to the traumatic sexualization dynamic, including “hypersexualization” (involving more sexualized behavior, a greater frequency of sexual encounters, and greater number of sexual partners), and to substance abuse. Most models linking childhood sexual abuse and risk note the importance of coping strategies learned by traumatized individuals, especially consistent use of substances and other escape/avoidance strategies.

Treatment of Childhood Sexual Abuse
In general, clinical interventions that respond to traumatization involve some means of confronting and reflecting upon the traumatic experience. For example, cognitive processing therapy emphasizes in-depth exploration to access and process the emotions that have been distorted and obscured by erroneous beliefs and interpre-
Abuse can powerfully shape adult sexual behavior, interfere with the ability to accurately appraise risk, and undermine efforts to avoid sexual risk scenarios.


Abuse Interventions for HIV Programs

HIV prevention programs can implement approaches that are more suitable to their capacities. Among these are: routine client screening at the time when clients request services; client reassessment over the course of services; basic psychoeducation about childhood sexual abuse; staff support and training; referral for substance abuse treatment; and referral to other services.

Routine Client Screening. Special training is not required to ask a series of simple questions about childhood sexual experiences that might have been coercive or abusive. As with any highly sensitive topic, these questions must be preceded by sufficient rapport-building and are best introduced by preparing the client for the sensitivity of the material. As an example, this introduction was used in a four-city telephone survey of men who have sex with men in the United States: 3 “These questions are about unwanted sexual experiences. If you’ve had any such experiences, they may be difficult to discuss and I would appreciate your willingness to answer these questions. Thinking back from your childhood to the present, have you ever been forced or frightened by someone into doing something sexually that you did not want to do?”

In this study, if participants said “No” to the above question, they were asked again about these matters. Interviewers noted that “Sometimes people’s views about their experiences change over time. Did you ever have an experience when you felt at the time that you were forced or frightened into doing something sexually that you did not want to do?” This practice recognizes that some people may initially say “No” due to their hesitancy to either label certain experiences as coercive or to disclose this to someone else.

Other approaches include raising the topic by first asking about any of a variety of childhood or adolescent sexual experiences, and then establishing the age of the interviewee and his or her sexual partner. This manner of defining “sexual abuse” assumes that a sufficient age difference presupposes a power differential between the parties involved, and therefore does not require asking whether the sexual encounter was coerced. This approach appears to be less appropriate for gay and bisexual men. In one study of gay and bisexual men who reported sex between the ages of 13 and 15 with partners at least 10 years their senior, 44 percent reported that no coercion was involved. While self-report bias may account for some of this result, it is also possible that these incidents were either not experienced as threatening or had been sought out by some youth as a means of connecting—without risking peer stigma—with a male who shared their sexuality.

It is important to note that deficits in self-awareness and interpersonal regulation may leave individuals unaware of their emotional vulnerabilities in this area. Disclosure could lead to unanticipated emotional distress either during or subsequent to the interview process. Interviewers should pay attention to client behaviors that may indicate tension, including changes in speech such as incomplete sentences, stuttering, omissions of words, frequent gaps or pauses, and shifts in vocal register to a higher pitch, and non-verbal signals such as shallow or rapid breathing, changes in eye contact, and body tension. However, in research involving telephone interviews with an extensive series of abuse-related questions, an interview was never broken off due to respondent distress.

Client Reassessment. Programs can also train staff to be aware, throughout the course of services, of the clinical signs of childhood sexual abuse in order to target clients who did not disclose such a history in screening interviews. Staff can ask...
clients with such symptomatic patterns about early life events that might have been traumatic or especially stressful. They may describe these events as “periods of no power, humiliating events or people, or events of molestation, or abuse.”

**Basic Psychoeducation about Childhood Sexual Abuse.** While staff may not have the expertise to provide in-depth clinical care for abuse, they may be able to help clients by explaining how childhood sexual abuse can affect individuals and the options clients have should they wish to seek further help. The goal of a psychoeducation program—which should be reviewed, if not developed, by an experienced therapist—is for clients to focus on here-and-now issues, including how early abuse experiences may intrude upon current relationships. Revisiting or re-experiencing traumatic material is not part of this process.

Basic psychoeducation describes the long-term effects of childhood sexual abuse and explains abuse-associated symptoms, including PTSD. Psychoeducation may normalize client experiences, providing a context whereby clients can understand their actions or reactions in various situations, reduce their shame and self-blame, and correct their misunderstandings about behavior or relationship problems that may stem from childhood events. It can be undertaken either individually or in groups; group education allows for additional social support.

**Staff Support and Training.** Due to the affect-laden nature of childhood sexual abuse—and its relatively high prevalence in certain populations—it is important for staff addressing such issues to have access to support. It is useful to have candid discussions about the “hot-button” nature of this topic and the degree to which staff serve as “receptacles” for both their clients’ and their own feelings. Such discussions can normalize staff reactions and facilitate both peer support and staff supervision around this topic. Supervision and training of program staff can also help ensure that no staff members are overly intrusive in their interviewing style, a situation that has the potential to recreate the abuse relationship.

**Referral for Substance Abuse Treatment.** Due to higher rates of substance abuse among those with abuse histories and the persistent association of substance use with sexual risk-taking, it is beneficial to treat this symptom as soon as possible. While substance abuse may have roots in psychic numbing and the use of dissociative coping strategies to manage emotional distress, clients who abuse substances must address this issue prior to further psychological work. Substance abuse treatment agencies must be sensitive to the ways in which substance use serves such coping functions, and provide clients with basic training in alternative strategies to handle distress.

**Other Referrals.** Finally, HIV programs should develop referral lists of therapists who specialize in childhood sexual abuse. Given the sensitive nature of this issue, programs should seek expert input in developing a process to screen the abuse-related capacities of potential referral therapists.

**Conclusion**

It is imperative that HIV prevention programs address the impact of childhood sexual abuse. The evidence points to the power of abuse to shape adult risk behavior, interfering with abilities to appraise risk and undermining efforts to avoid sexual risk scenarios. Despite its clinical complexity, childhood sexual abuse can be addressed, on some level, in any program without tremendous additional staff resources or training. Future research may identify the most effective interventions for particular populations, but enough is known to guide basic program development.
The Effects of Childhood Sexual Abuse on Adherence and Health

Mary Curry, LISW and James Bristol, LISW

A great deal of research has focused on the effects of childhood sexual abuse on HIV-related risk, and much of this data support the hypothesis that there is a significant impact. Much less attention has been paid to the ways in which a history of abuse may diminish the health-seeking behaviors—for example, self-care and medication adherence—of HIV-positive people.

Clinicians at the Southwest CARE Center—a comprehensive HIV care program in Santa Fe, New Mexico—believe that, ultimately, successful HIV treatment adherence equates with successful self-care. In this sense, adherence is a broad, holistic concept, encompassing any aspect of a client’s self-care that might interfere with or enhance his or her ability to successfully partake in HIV drug therapy. Center staff hypothesize that childhood sexual abuse is common among people with HIV—particularly gay and bisexual men—and staff estimate that as many as 40 percent of the center’s HIV-positive, gay male clients will self-identify as survivors of childhood sexual abuse. Staff also hypothesize that childhood sexual abuse undermines the capacity to adhere.

The experience of one client illustrates the complexity of this issue. “Nathan,” an HIV-positive gay man, survived childhood sexual abuse with the scars of depression, substance abuse, and borderline personality disorder. He had difficulty sustaining his HIV medication regimen, eventually becoming resistant to all possible drug combinations. He died from complications of HIV.

This article hypothesizes about the dynamics that might lead to such a scenario.

Adverse Childhood Experiences

Studies have found that significant proportions of gay men have experienced childhood sexual abuse. One national sample estimated that 21 percent of gay men are sexual abuse survivors, higher than prevalence estimates for the general male population, which were two to four times lower than these rates. A Boston study found that 35 percent of 327 gay and bisexual men reported childhood sexual abuse.

Further, research has identified a significant impact of childhood sexual abuse on high-risk sexual behavior. For example, the Boston study also reported that men sexually abused as children may experience depression, low self-esteem, sexual promiscuity, interpersonal difficulty, and substance abuse. Additional studies have correlated childhood sexual abuse directly to specific risk behaviors such as unprotected anal intercourse. (See “Coerced Childhood Sexual Episodes and Adult HIV Prevention,” page 1, in this issue of FOCUS.)

The evidence that childhood sexual abuse increases the likelihood of decisions that lead to HIV risk behavior suggests there may be a similar relationship between abuse and the decisions that lead to inadequate adherence with HIV medication regimens. Further, recent research outside the realm of HIV has focused on the ways in which “adverse childhood experiences,” including childhood sexual abuse, might damage many aspects of a healthy adulthood. This research correlates adult health risk with exposure to childhood emotional, physical, or sexual abuse, and household dysfunction.

One investigation found a strong, cumulative correlation between adverse childhood experiences and an increase in adult health risk behavior and disease, including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.


Contacts

Mary Curry, LISW, Southwest CARE Center, 649 Harkle Road, Suite E, Santa Fe, New Mexico 87505, 505-989-8200, mpcurry@southwestcare.org (e-mail).

Jay P. Paul, PhD, UCSF Center for AIDS Prevention Studies, 74 New Montgomery Street, San Francisco CA 94105, 415-597-9201, jpaul@psg.ucsf.edu (e-mail).

See also references cited in articles in this issue.
disease. Adverse childhood experiences can also lead to behaviors that may be used consciously or unconsciously as coping devices. The study also found that these behaviors—such as smoking, alcohol or drug use, overeating, or sexual activity—are the linking mechanism between adverse childhood experiences and health risks. It is plausible that adverse childhood experiences that lead to illness may also induce harmful coping mechanisms that can lead to denial of physical symptoms and avoidance of health care.

Sexual Abuse and Health Seeking

The major challenge for many people with HIV is seeking health care and sustaining it in the face of complex antiviral regimens and severe side effects. Studies of HIV treatment behavior have found that psychological dysfunction—specifically depression and substance abuse—may be key factors in undermining the ability to adhere to these regimens. The potential symptoms and effects of childhood sexual abuse include one or more of the following: anxiety, panic attacks, drug and alcohol abuse, phobias, depression, grief, anhedonia, emotional disconnectedness, secrecy, and anger. Any combination of these would complicate a person’s ability to practice good self-care. Many of these symptoms and effects unfold, interact, and wreak havoc with health-seeking behaviors.

For example, in order to cope with childhood sexual abuse, excessive drug and alcohol use can lead to disregard for the self, self-isolation, emotional disconnectedness, and disconnection from others. This can undermine the self-esteem and motivation needed for health-seeking behaviors and the cognitive capacity needed to manage appointments, medication regimens, and healthy behaviors. Substance use and other sexual abuse-related coping mechanisms such as dissociation can further affect memory: forgetfulness is one of the central reasons clients miss medications. This effect is particularly problematic, since levels of adherence need to be sustained at 95 percent, which means no more than one missed dose per week. If adherence falls to less than 80 percent, there is a 50 percent likelihood of developing HIV medication resistance.

Finally, it is possible that there are significant differences in the way specific populations respond to childhood sexual abuse. Researcher and therapist James Cassese states that for gay men, the context of traumatic events, the increased frequency of these events, and the dominant culture’s willingness to overlook or, indeed, minimize the significance of these events, complicates the ways in which gay men deal with childhood sexual abuse. Cassese suggests that becoming infected with HIV through sexual contact is itself an experience of sexual trauma. For gay male survivors of childhood sexual abuse, this re-traumatization can contribute to an ongoing cycle of abuse that challenges self-care and quality of life.

Researching Sexual Abuse and Self-Care

Research is necessary to better understand these hypotheses and to identify interventions that respond to the effects of childhood sexual abuse. What is the relationship between sexual abuse and HIV antiviral adherence? What are the cultural factors that relate to the assessment and treatment of childhood sexual abuse among HIV-positive gay and bisexual men? How can providers at front-line health care agencies adequately assess and address the needs of clients who have survived sexual abuse?

The Southwest CARE Center is researching these questions to determine the prevalence of childhood sexual abuse among its gay male client population, and to understand the relationship between childhood sexual abuse, other adverse childhood experiences, and adherence. The research will use previously validated instruments to assess depression, anxiety, childhood trauma, substance abuse, and questions specific to the circumstances of a gay male population. For example, since there is the potential for many gay men to interpret childhood sexual experiences not as abuse but as part of their overall sexual development, questions will explore childhood sexual experiences without automatically defining them as abuse.

The center’s researchers hypothesize that the study will reveal a higher prevalence of childhood sexual abuse within its gay male population, and a significant positive association between childhood sexual abuse and non-adherence to HIV antiviral drug therapies. Understanding these relationships is crucial to developing interventions to support people with HIV, since the best HIV medication regimen is only as good as a person’s ability to adhere to it.

References


Authors

Mary Curry, LISW is the Director of Social Work at Southwest CARE Center.

James Bristol, LISW is a clinical social worker at Southwest CARE Center.

Correction

The March 2003 issue omitted the following acknowledgment: “This issue of FOCUS is supported in part by a donation from Abbot Virology.” We regret this oversight.
Recent Reports

Risk among HIV-Positive Men with Past Abuse

A study of HIV-positive men living in San Francisco and New York found that a history of childhood sexual abuse greatly predicted unprotected anal sex with partners of HIV-negative or unknown serostatus. Feelings of anxiety, hostility, and suicidality often linked abuse history with sexual behavior.

Of the 456 men recruited for the study, 68 had a history of childhood sexual abuse. Of these men, 24 percent were White, 28 percent African American, 24 percent Latino, 7 percent Asian/Pacific Islander, and 18 percent of other ethnicities. The cohort of participants with no childhood sexual abuse had a similar composition. Thirty-three percent of men with a history of childhood sexual abuse (compared to 20 percent without) reported unprotected insertive anal sex, and 43 percent of men with this history (compared to 27 percent without) reported unprotected receptive anal sex in the prior 90 days.

Childhood sexual abuse was associated with recent feelings of anxiety, hostility, and suicidality, which, in turn, were correlated with acts of unprotected anal sex. While both unprotected insertive and receptive anal sex were correlated with anxiety and hostility, only unprotected receptive anal sex was associated with suicidality.

Sexual Abuse, HIV Risk, and Drinking

Sexual abuse that begins early in life and continues over time greatly increases the likelihood of adult HIV-related risk behaviors for both women and men.

Men who reported sexual abuse before age 18 (4.6 percent) were eight times more likely to engage in HIV-related risk behaviors than men who did not report sexual abuse. Men who reported physical abuse before age 18 (9.4 percent) were three times more likely to engage in HIV-related risk behavior and heavy drinking than men who did not.

Abuse and Violence among Women with HIV
Cohen M, Deamant C, Barkan S, et al. Domestic violence and childhood sexual abuse in HIV-

(Cook County Hospital, Chicago; and Seattle King County Department of Public Health.)

Two-thirds of a sample of women with HIV or at risk for HIV reported domestic violence in their lifetimes, and nearly one-third reported childhood sexual abuse. Sexual abuse experienced in childhood was strongly associated with a lifetime history of domestic violence and high-risk behaviors such as having multiple partners and selling or exchanging sex.

Of the 1,645 women interviewed, 1,288 were HIV-positive. The seropositive women had a mean age of 34 years. The cohort was 64 percent African American, 21 percent Latina, and 15 percent White. The sample of seronegative women was similar in age and ethnic composition. There did not appear to be an association between HIV status and childhood sexual abuse: 31 percent of the seropositive group and 27 percent of seronegative group had experienced childhood sexual abuse.

Women who had experienced childhood sexual abuse, regardless of HIV status, were two times more likely to have ever had a male partner at risk for HIV infection and 2.3 times more likely to have had more than 10 male sex partners in their lifetimes than women who had not experienced childhood sexual abuse. Childhood sexual abuse was also strongly correlated to a lifetime history of domestic violence, and placed women at greater risk for being abused in adult relationships. More than half of women who reported being forced to have sex with an HIV-positive partner in adulthood had been sexually abused as children.

Exchange of Sex and Sexual Abuse History


One-quarter of a sample of mostly African American and Hispanic men from seven U.S. metropolitan areas reported unwanted sexual activity before the age of 13. These men were nearly seven times more likely to report unwanted sexual activity since age 13, more likely to trade sex for money, food, or drugs, and more likely to inject drugs than those without a history of childhood sexual abuse.

The men in the study were part of a national HIV prevention trial for higher risk men and women. Of the 2,676 men chosen to participate, ages ranged from 18 to 70 years. Seventy-three percent were African American, 17 percent were Hispanic, and 10 percent were of other ethnicities.

Men with a history of unwanted sexual activity in childhood had an average of 32 episodes of unprotected sex with an average of six partners in the prior 90 days; men without this history had an average of 27 episodes with five sexual partners, and this difference was statistically significant. However, men who had bought, sold, or traded sex in the prior 90 days were, regardless of past sexual abuse, likely to have more unprotected sex and more sexual partners than other participants. Further, the experience of childhood sexual abuse increased the likelihood of trading sex in adulthood. Of the 25 percent who reported unwanted sexual activity during childhood, 35 percent had bought sex, 14 percent had sold sex, and 6 percent had traded sex for food or a place to stay, in the past 90 days.

A large number of men with a history of unwanted childhood activity reported unwanted sexual activity in adulthood: 34 percent reported being pressured, threatened, or physically pushed into having sex since the age of 13. Finally, men with a history of sexual abuse were more likely to report injection drug use than those without this history: 47 percent versus 38 percent.

**Next Month**

It is surprising, but nonetheless common, that we expect that just because a person provides HIV services, he or she is well prepared to talk about sex. In the May issue of *FOCUS,* Carol McCord, MSW and Stephanie A. Sanders, PhD, both at the Kinsey Institute for Research in Sex, Gender, and Reproduction at Indiana University, Bloomington, outline three strategies for raising and responding to sexual issues in HIV-related settings: creating a conducive atmosphere; recognizing the complexity of human sexuality; and assessing and enhancing provider comfort in dealing with sex-related issues.

Also in the May issue of *FOCUS,* Ed Wolf, a trainer at the UCSF AIDS Health Project, discusses the ways risk-reduction goals may, themselves, lead some counselors to focus only on the harm of sexual activity, thereby shutting down clients at a time when it is most important for them to talk about sex. He presents training activities that help prevention providers avoid this danger.
DID YOU KNOW?

You can access a FREE searchable archive of back issues of this publication online! Visit http://www.ucsf-ahp.org/HTML2/archivesearch.html.

You can also receive this and other AHP journals FREE, at the moment of publication, by becoming an e-subscriber. Visit http://ucsf-ahp.org/epubs_registration.php for more information and to register!

ABOUT UCSF AIDS HEALTH PROJECT PUBLICATIONS

The AIDS Health Project produces periodicals and books that blend research and practice to help front-line mental health and health care providers deliver the highest quality HIV-related counseling and mental health care. For more information about this program, visit http://ucsf-ahp.org/HTML2/services_providers_publications.html.