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HIV/AIDS Risk Reduction Intervention for Women who have Experienced Intimate Partner Violence

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Abstract

A growing body of literature highlights the association between women who have experienced intimate partner abuse (IPA) and their heightened risk for HIV/AIDS (human immune deficiency syndrome/ acquired immune deficiency syndrome) infection. Finding HIV risk reduction strategies that are contextually relevant for this population is an important public policy priority. This qualitative study researched women who have experienced intimate partner abuse in order to develop a HIV/AIDS risk reduction intervention unique to their circumstances. This pilot study explored the critical components of such an intervention among a racially/ethnically stratified (African-American, Mexican-American and Anglo) sample of women (n=43) who have experienced IPA. Focus groups were conducted and transcribed, and a content analysis was used to identify major themes. In all five focus groups, participants viewed the research as interesting, good, beneficial, and/or important based on their perceptions of risk for infection. Respondents felt that they knew of ways to protect themselves from infection in non-abusive relationships; however, acknowledged the difficulties of doing so given the context of their abusive relationships. Examining the racial/ethnic differences across focus groups showed that the language used by women is quite variable. The ways in which survivors define rape, sexual abuse, and their own experiences are all unique; however, their actual experiences have many similarities. Discussed at length are the topics participants shared as critical in informing the design of an intervention and the relevance of the findings to social work clinical practice is explained.

Keywords

HIV/ AIDS risk assessment; HIV/AIDS prevention; Intimate Partner Abuse

INTRODUCTION

HIV risk-reduction strategies that are contextually relevant to women who have experienced intimate partner violence are an important public policy priority. In the United States, women's lifetime prevalence of experiencing IPA is between 1 in 5 and 1 in 3, meaning that over 12 million women will be physically assaulted by a partner or ex-partner during their lifetime (Raj, Santana, LaMarche, Amaro, Cranston & Silverman, 2006). Of all women who experience IPA, 40%-45% are forced to have sex by their intimate partners (Campbell & Soeken, 1999). Forced sex and other coercive sexual behaviors such as verbal sexual degradation and refusal to wear a condom are related to increased risk for STDs, including HIV/AIDS (Eby, Campbell, Sullivan and Davidson, 1995). As research suggests, physical and sexual violence towards women increases the likelihood of HIV transmission (El-

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Bassel, Gilbert, Krishman, Schilling, Gaeta, Purpura and Witte, 1998; Wingood, DiClemente, & Raj, 2000). In social work clinical practice when working with clients who have a history of physical or sexual violence, it is essential that clinical social workers be aware of their clients' HIV, at-risk status. The following sections provide an overview of the prevalence of HIV among women, a discussion of the intersection between intimate partner abuse (IPA) and heightened risk for infection and the impact of culture, particularly race and ethnicity on women's experience of abuse and HIV risk.

Women and HIV

In 2005, women accounted for 26% of new HIV/AIDS diagnoses. Of these new diagnoses, 80% occurred through high-risk heterosexual contact, a percentage that has increased nearly 20% in two years. Notably, HIV was the number one cause of death for African American women between the ages of 25 and 34. The rate of HIV/AIDS diagnoses for Hispanic woman was approximately 6 times the rate for Anglo women, while the rate of diagnoses for African American women was about 24 times that of Anglo women (Centers for Disease Control and Prevention, 2007). The high incidence of women becoming infected with HIV by male partners through unprotected anal and vaginal sex has given researchers and health policy makers a reason to turn their attention to factors such as intimate partner violence as an influence on a women's heightened risk for infection.

Intimate Partner Abuse and Risk for HIV

Research on the intersection of IPA and HIV indicates that partner violence is associated with increased risk for HIV infection (Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow, 2004; El-Bassel, Gilbert, Wu, Go, & Hill, 2005; Gielen, McDonnell, & O'Campo, 2002). Research among men who are perpetrators suggests that abusive male partners pose a greater risk of HIV infection to women than their non-abusive counterparts (Raj et al., 2006). Men with a history of intimate partner violence are much more likely to report risk taking activities such as unprotected sexual intercourse and sexual infidelity (El-Bassel, Fontdevila, Gilbert, Voisin, Richmond & Pitchell, 2001; Raj et al., 2006). There is also an association between perpetrations and forcing unprotected sexual intercourse (Raj et al., 2006). Together, these findings suggest that women are at risk because of their partners' behaviors more so than their own.

An Intersection: Culture, Intimate Partner Violence, and HIV Risk

Research indicates that African American women and Latinas experience disproportionately high rates of both HIV and IPA (Raj, Silverman, & Amaro, 2004). While African American women report similar rates of abuse compared to their White counterparts (Ramos, Carolson & McNutt, 2004, Bauer, Rodriguez, & Perez-Stable, 2000), the rate of intimate partner violence related to homicide among African American women is double that of White women (Lee, Thompson, and Mechanic, 2002). Additionally, African American women suffer more severe injuries from their intimates and have weapons used against them more frequently (Lee, Thompson & Mechanic, 2002). Whyte (2006) found that African American women recognized their risk for HIV and worried for their personal sexual safety. In a study involving Hispanic women, Raj et al., (2004) found that "abused women were significantly more likely than those not abused in the past three months to report high STD/HIV perception…, gender-based risks including sexual control by male partners…, and male partner risk including male infidelity" (p.519).

As indicated in the above mentioned discussion, current literature examines the effect of culture on women's experience of abuse and HIV risk, especially among racial and ethnic minority groups. For the purposes of this study, culture is defined as "a set of characteristics that includes the 'beliefs, practices, values, norms and behaviors that are shared by members

of a group,'" (Kasturirangan, Sandhya, & Riger, 2004, p. 319). Some of these cultural differences that may play an important role in women's perceptions and experiences of intimate partner violence (Ramos, Carlson, & McNutt, 2004) may contribute to different attitudes, beliefs, and knowledge levels in regards to HIV awareness and prevention. Understanding these differences is central to supporting women who have experienced violence in reducing their risk for HIV/AIDS infection.

While individualist cultures emphasize independence and personal achievement (Kasturirangan et al., 2004), collective cultures generally "emphasize obedience to and harmony within the group," (Yoshioka & Choi, 2005, p.514). Many communities of color, including African American and Latino communities, tend to value the collective over the individual. In collective cultures, group members are likely to work together to solve problems, save face with others, and preserve a relationship in the event of conflict, even if doing so poses a risk of personal cost (Yoshioka & Choi, 2005).This perspective offers greater insight to why the Western model (which encourages a woman to leave the relationship and live autonomously) may be culturally unacceptable to women or societies with collectivist worldviews.

A second cultural framework imperative to this discussion is that of male honor. Often, the cultural context of machismo and marianismo prevent Latinas from leaving abusive relationships. Doing so would bring shame to themselves and their families. Fear of social consequences, economic problems, limited job skills, and a depleted sense of self-esteem are also barriers to leaving abusive relationships that result from machismo/marianismo (Moreno 2007).

Latinas who are immigrants to the United States face a unique set problems. First of all, non-citizen immigrant women are at increased risk for intimate partner violence because of their lack of legal rights (Raj & Silverman, 2002). Moreover, deportation is a constant threat for women who are undocumented (Moreno, 2007, Raj & Silverman, 2002). This is significant when considering that, in abusive relationships, 72% of citizen and legal-permanent-resident spouses do not file immigration papers on their wives (Raj and Silverman 2002). Latinas who are immigrants may have little knowledge of the services available, may be unaware of laws that could protect them, and may be intimidated to approach the legal system, especially if they fear deportation (Raj & Silverman, 2002). The scholarship is clear: women who have experienced intimate partner violence need contextually and culturally relevant, multi-faceted interventions that reduce their risk for HIV/AIDS infection. This qualitative study researches women who have experienced intimate partner abuse to develop a HIV/AIDS risk-reduction intervention relevant to the uniqueness of their circumstances.

METHODS

In order to develop a HIV/AIDS risk reduction intervention, this pilot study explored the following research questions within focus groups among a racially/ethnically stratified (African-American, Mexican-American and Anglo) sample of women (n=43) who have experienced IPA:

- What are the influences of sexual abuse or rape on risk for HIV infection?
- What are the beliefs and practices concerning HIV/AIDS prevention knowledge among women who have experienced IPA?
- Are there ethnic/racial differences in knowledge, beliefs, and practices concerning HIV/AIDS prevention?

- What information can inform the design of a culturally and contextually grounded HIV/AIDS risk reduction intervention for women who have experienced IPA?

Setting & Sample

Before implementing the research project, the researchers convened a group of community collaborators, including HIV/AIDS service providers, IPV practitioners, and consumers to determine their priority concerns related to the targeted population. During this rich dialogue, the research objectives guiding the research study were collectively established and Institutional Review Board approval was then obtained. Data collection was conducted on the premises of a domestic violence shelter that provides a wide spectrum of services to survivors of violence. A convenience sample including African American women (n=10), Mexican American women (monolingual [n=15], bi-lingual [n=10]), and Anglo women (n=8) participated in the racially/ethnically stratified focus groups (see Table 1). The sample consisted of forty-three women who were currently living at the shelter or the transitional living facility next to the shelter. The average age of the participants was 34.36 (SD=8.47), 12 (27.9%) had a high school diploma, and 3(6.9%) had a college degree. As to martial status, most of them are either single (n=14; 32.6%) or divorced (n=13; 30.2%). A large majority of women (n=34; 79%) reported having children (average of 2.38 children). One fourth of the participants (n=11; 25.6%) have no income, and about half (n=22; 51.2%) have monthly income less than $1000.

Due to the stigma and sensitivity of the topics, there were between 8 and 15 women in each focus group. Purposive sampling was used to identify participants who met the following criteria: women who 1.) were over the age of eighteen and 2.) had experienced rape/sexual abuse or had unwillingly had sex with partners within relationships. Recruitment included two strategies: either participants were identified by the shelter staff, or participants who were interested by posted flyers contacted the principal investigator directly. All participants were provided an overview of the study, a guarantee of confidentiality, and a $25.00 grocery store gift certificate at the end of the focus group as an incentive to participate. Declining to participate in the study did not affect services received from the shelter.

Data Analysis

Grounded theory served as the theoretical framework for analyzing the data. Content analysis was used to reduce the data from large amounts of text from the focus group transcripts into a few, mutually exclusive categories. A selection of themes, grouping data around a central issue or occurrence, served as the basic units of analysis (Webber, 1990). Focus group data were coded and analyzed using three coders focusing upon primary themes. In order to validate the interpretations of the data, a summary of the themes was discussed among raters, and themes were also discussed among the community advisory board. Traditional standards for reliability and validity do not apply to qualitative studies, since other strategies are available (Padgett, 1998, p. 95). Triangulation strategies included a post-group questionnaire to confirm themes identified in focus groups, debriefing sessions among facilitators, inter-rater comparisons, community advisory board feedback, relevant note-taking by moderators, and a review of transcripts by investigators.

RESULTS

Based upon the analysis, the following descriptive themes were identified. In the following section, the common themes across all focus groups are described and explored, using the women's own narratives to exemplify them. In order to simply and clearly express the content of the women's statements, stuttering (repeated words or incomplete words) and stalling phrases (such as "umm" or "you know") have been omitted and indicated by "…".

The end of the results section reports major racial/ethnic differences in the way forced sex and sexual abuse were defined and viewed. Below is a visual representation of the themes discussed in the focus groups.

Influences of Sexual Abuse or Rape on Risk for HIV infection

Importance of Research: Perceived Risk—In all five focus groups, participants viewed the research as interesting, good, beneficial, and/or important. They indicated various reasons why they viewed this project positively, giving special attention to how important it is based on the nature of their abusive relationships.

Some participants indicated that it was important because it helped increase knowledge:

> "I think this study is good because for one, you learn about the AIDS."

> "I think it'll be beneficial to women who have been in domestic violence because the more we know about it and what really goes on the more we can prevent [it]."

> "…it's good because…for some ladies out there that still don't know what AIDS is…this is a chance for people to talk about it so [they] know…how to take care of [themselves]."

Others stated that the research is important based on their perceptions of risk for infection in terms of their partner's behavior. Respondents report that their partners' physically abusive behaviors put them at personal risk for being infected:

> "I think it's very good because a lot of times you don't realize, especially if you're a battered woman, how at risk you're putting yourself just by staying with the person you're with because they obviously don't give a crap about you—whupping up on you. They don't five a crap about your safety… health-wise either."

> "You know, even if my man hasn't… forced me to have sex…him bein'…violent with me period, it raises a lot of flags."

Recognition of their partners' infidelity, sometimes with multiple partners, makes women feel particularly vulnerable to infection:

> "When you start thinking about a lot of stuff that…your significant other would come home and fight you for a reason is you never know why. And you always, sometimes you think it's because…another person."

> "I am aware that I do not sleep with anyone, but I don't know if he has slept with anyone."

> "Yeah, I was thinking that…I think that often times in an abusive relationship…I'm looking at my abusive relationship past and there was a lot of infidelity."

Respondents report that their partner's sexually abusive and sexually controlling behaviors put them at risk for infection:

> "I think it is an important study because I know that first of all my ex refused to wear protection and second of all I know that he was unfaithful all of the time… and when he came home and…especially [if he] had been drinking or whatever it wasn't an option not have sex. And so…I think it's a good study because the chances are a lot greater when the odds are out there to catch something."

> "I was forced to have sex when I didn't want to even when I was pregnant. And the thing is, I was so scared because my biggest fears was, 'okay, I'm gonna end up with something. The baby's gonna end up with somethin'…I was scared because I just…I didn't know what he was doin' out there on those streets. I knew he was

> messin' with girls. You know, I knew that he had so many other things goin' on and I didn't have any ways to protect myself."
>
> "I had a daughter that way [by rape]. I didn't want to be with him anymore. He grabbed me by my hands by force and he forced me…and I cried and kicked and ended up pregnant. I became pregnant with my daughter. It was like a rape …and later… I got an infection—it was that time he raped me. I went to the clinic and they told me that I couldn't pee because I had an infection…and I said, "But why?" …it was because of the virus…[T]hey did studies on me and such because I was pregnant…and if I wanted to abort it or not…I told them about my daughter… but it wasn't an ugly sickness. They gave me treatment…but I had the infection from him…My daughter turned out fine."
>
> "My partner would take [condoms] off while…we were sleeping together. He would take them off with the lights off and I ended up pregnant"

Their partner's drug use put focus group participants at an increase for both violence and HIV infection.

> "there was also some, you know, some drug stuff goin' on too and I think that's the case for a lot of people. In abusive relationships they have those dual issues that contribute to this disease."
>
> "I think that [drug use] was…one of the biggest issues we had. I found out he was snorting powder. And you know, he would start all this, you know, wild talk about stuff they would be out there doin' and stuff, you know? 'And then, then you… you'd sit up and tell me all this stuff and then in the end you think I want to get in a bed wit' you?' I did everything I could to make myself as unattractive as I could because I didn't want…I wanted nothing to do with him. And…it's stupid 'cause at the same time I still loved him…it was just so hard because I couldn't be myself you know…'cause I've never been a mean spirited person. I've never been mean before. And the one thing I can't ever say I was violent. And you know, this man made me hit him with a can of corn in his head, cause I didn't want to [have sex with him] and I had reached a point and my son was there. 'And you're gonna make me—?' and he was high, in front of my son! I don't think so. I thought I killed him. We got outa there."

Finally, some participants indicated that this research was good because it promoted group support and cohesion, while helping them realize that they were not alone:

> "A lot of [good counselors] just have the education that's it. But I think it would be more beneficial if there were people in there and they're like us. Sitting around like we [are] doing. Talking about like what we's talking about and what we've gone through… that's a support group."
>
> "I feel better, you know. I feel like I've released something. You know what I'm sayin? It helped me to feel like I'm not the only one…I might not be in the same situation or whatever with anybody else or they in the same one with me, but …it feels good to get up and talk…not havin' anybody judge me…just like [with] this little community group right here."
>
> "[The cycle of violence] is like a merry go round. And, you know, we as women have obviously all made a choice to jump off. So we got skinned knees and bruises and left a lot of shit behind, but it's possible…its possible to get off and get out. And I think, you know, in these groups and these sessions they're going to come up with need to point out that you're not alone. There are places. Its' going to hurt. Its

not going to be easy but you can do it. And you'll never ever, no matter what this man tells you, he is not all you have. He is not all you have."

Beliefs and Practices concerning HIV/AIDS Prevention Knowledge

No Realistic Agency to Protect Oneself: Substance use lowers inhibitions—

Respondents shared their knowledge concerning ways to protect themselves from infection with such strategies as abstaining from sexual intercourse; limiting the number of sexual partners and, therefore, limiting the likelihood of taking in another's bodily fluids; using condoms; and having themselves tested for the disease. However, there was consensus across focus groups that there did not seem to be any realistic methods available to them to protect themselves from infection.

"By God, you better get your ass up and go to the store and get you some condoms you know. Even if he doesn't want to wear them there are female condoms, you know. Even if he doesn't want to wear them there are female condoms that you can put inside yourself and if you want to you'll go with it. You'll get it. But you know, it's either yes or no. That's not saying that you're not in an abusive relationship where you can do that."

"But some of us don't have the option. Some of us are in a situation where having safe sex is not a factor"

"But if you are in a bad relationship, you knew, sometimes, you know, you're made to do things that you don't want to. Or you're not, you're not into it that night, but he doesn't care. You're his woman and you know what? You belong to him."

"If you don't have a healthy relationship, it doesn't work."

"I think it is harder when you have an abusive partner because the first thing that comes out of their mouth is why [use of condom]?"

Respondents addressed how substance use limits one's ability to negotiate safe sex or make it a priority.

"It completely lowers your inhibitions to where you are just retarded for lack of a better word. You are just out of you mind."

"Even if you go to a club, you know, you're putting yourself at risk too by going out, you know, getting drunk and the other person being drunk. You know who he's been with. You don't know who you've been with and you just, you know, say 'okay, let's go'."

Racial Differences in HIV/AIDS Knowledge, Beliefs & Practices

In all focus groups, women expressed that they were unable to make sexual decisions in the relationship, ranging from inability to negotiate condom use to forced and/or coerced sex. Three main themes were identified as follows: 1) The participants had to have sex when their partners wanted it; 2) if they did not have sex when their partners wanted it, they were at increased risk for physical and emotional abuse; and 3) even those who did not report sexual abuse, or denied it was part of the relationship, expressed that their partners' infidelity put them at risk for HIV infection. As well as similarities across focus groups, there were major racial/ethnic differences in the way forced sex and sexual abuse were defined and viewed.

- Hispanic English speakers had not quite conceived of the possibility that forced sex within a relationship equals rape; yet, they had a sense that HIV infection was a possible result of their own and their partners' infidelities.

- African Americans shared the belief that sex was a more respected area and that rape was a final straw. It was unforgivable, and they would leave any partner who devalued such a sacred part of the relationship.
- Hispanic Spanish speakers were much more open in their discussion of forced sex, physical abuse and infidelity. They told their stories in less guarded manner than the participants in the other focus groups (e.g.,"he'd punch me and hit me" and "I cried and kicked"). They also discussed that sexually transmitted infections and unplanned pregnancies occurred through forced sex.
- Anglos had much less discussion of rape and forced sex within their intimate relationships. However, they did talk about childhood molestation and gang rape, incidents that had happened in the past. They also expressed the fear that if they did not have sex with their partners, their partners would "leave and go get it somewhere else," thereby increasing their risk of becoming infected with HIV and other STD's.

Overall, studying the racial/ethnic differences across focus groups showed that the language used by women of different races and ethnicities is quite variable. The ways in which survivors define rape, sexual abuse, and their own experiences are unique; however, their actual experiences have many similarities.

Components of a HIV/AIDS Risk-Reduction Intervention

Participants offered sound feedback on the topics they felt would be critical in informing the design of a culturally and contextually grounded HIV/AIDS risk-reduction intervention. Broadcasting information widely to the general population about domestic violence, how to prevent it, and where to go for help permeated the dialogue within the focus group sessions. Free, convenient testing and access to shelters and health care, with child care and transportation support was recommended. Learning about domestic violence, self-esteem, and life skills to increase efficacy, in addition, personal capacity building, communication, negotiating skills, educational and employment attainment were prominently mentioned themes.

DISCUSSION

The most salient point for women in IPA situations is that they know the ideals for protecting themselves but are required to operate in non-ideal situations. They (for the most part) have not been able to negotiate safe sex, they cannot trust their partners, and they have little to no control over their sexual choices. As indicated by Dunkle et al. (2004), women are becoming directly infected with HIV by their abusive partners. Some of the women clearly noted that the only way to protect oneself is to leave the relationship. The CDC (2003) as well as others (Cabral, Pulley, Artz, Johnson, & Stephens, 1999; Potts, 1994) have called for the development and wide dissemination of effective female-controlled prevention methods, stating that "more options are urgently needed for women who are unwilling or unable to negotiate condom use with a male partner" (p.2). It is our understanding that this is the first qualitative study designed to develop an HIV/AIDS risk reduction intervention specifically for women who have experienced IPA. This study bridges the gap in the existing literature by identifying the information necessary to design a culturally, contextually grounded multi-faceted HIV/AIDS risk-reduction intervention that attends to personal capacity building and life skills with the intent of diminishing a woman's risk for infection.

In clinical practice when working with clients who have a history of physical or sexual violence, it is essential that clinical social workers be aware of their clients' HIV, at-risk

status. Crises intervention and solution focused models are standard therapeutic models for working with trauma survivors. These models emphasize clients' immediate needs—safety, basic resources, and mental and physical health. The findings from the focus groups suggest that sexual health and sexual safety planning are also immediate needs. Therefore, a more holistic view of health, one in which sexual health is as important as physical and mental health, is called for.

Three important techniques a practitioner can use to encourage sexual safety include: explore, educate, and empower. First, it is important to explore the client's attitudes, beliefs, and experiences regarding her HIV prevention practices and sexual history. Is this something to which a client can relate? If it is, is she ready to discuss it? What barriers does she or has she faced practicing safe sex? Feminist theory asserts the importance of client-centered and client-led practice. Thus, a client must not feel pressured to disclose if she is not ready. Creating a safe space and building a strong rapport must occur for the client to feel comfortable talking about sex and sexual abuse with a therapist. It is also important to be mindful of the guilt, shame, and social taboo in regards to talking about sex. Given that there is a great deal of stigma associated with sexually transmitted diseases may be a barrier to broaching this topic, it is important to normalize the client's experiences: many abusive partners engage in risk-taking behaviors, such as illicit drug use and risky sex outside of their primary relationships. Being at risk for sexually transmitted diseases is not something she alone has experienced.

A second component for sexual safety planning is education. One of the roles of a social worker is to provide the information and resources necessary for a client to make informed decisions about her health—including her sexual health. It is reasonable to argue that focusing on some elements of health (e.g. substance abuse) but not others (e.g. sexual safety) is unethical: it prevents holistic healing and threatens the client's agency to make her own decisions. Discussing the different, not so obvious types of sexual abuse and expounding on both personal and partner risk behaviors presents options so a client can be informed to make her own decisions about her sexual health. Thus, while it is important to meet the client where she is, a directive approach to therapy utilized to educate and provide resources is appropriate.

Empowerment is the third and central principle for sexual safety planning. The results from this research indicate that empowerment is more pivotal to a woman's ability to protect herself than education. Most women know the basics of safe sex. Yet, they face many barriers to practicing it. They often lack the self-confidence, motivation, and hope necessary to take control of their sexual decisions, as it may not have been an option in their past relationships. In addition, sexual health may not be an immediate priority in a crisis situation. It is important for a client to recognize HIV/AIDS and other STD's as major health threats; it is empowering for her to posses the tools, skills, and resources necessary to own her sexual health. Helping a client creatively plan methods for protecting herself and have the agency to do so is a valuable part of the client-practitioner relationship and should be a primary focus of goal setting and attainment. A case-scenario illustrating these clinical practices is provided below.

Sabrina is a 24 year old client with a history of domestic violence. She has been in two abusive relationships, the last of which she left three months ago. The first month she stayed in a local domestic violence shelter. While there, she participated in brief therapy and crisis intervention sessions, focusing on basic survival needs. Now she has a stable place of residence and is seeing a clinical social worker. The social worker has experience working with trauma survivors and has already built trust and rapport with Sabrina.

Clinician: In the past we discussed personal safety planning. What if we shifted a little and talked about sexual safety planning?

Client: Sexual safety planning? I haven't heard of that.

Clinician: Well, it's a lot like safety planning. It focuses on ways you can protect yourself in a violent relationship, but it also focuses on steps you can take to protect yourself from getting hurt or abused sexually.

Client: You mean from rape?

Clinician: There are a lot of other ways women can be hurt sexually by their partners.

Client: Um, I never thought about it that way. I've never been forced to have sex. But… when your significant other is abusive and you don't know why, it's hard to trust him. He could be out there doing something with someone else.

Clinician: Is that something you can relate to?

Client: Yeah, sometimes I never knew what he was doing, and other times I could tell he was lying about where he'd been. But he'd always change his story.

Clinician: It's hard not to be able to trust someone. There's a lot of evidence that can lead to risk for getting an STD, such as HIV. Is that anything you've heard about?

Client: Well, the first time I really thought about HIV was when I was sixteen and I got pregnant. I had to take an HIV test. But it didn't really hit home until my uncle had it. Once he got it, he died fast. My mom put up a picture of him, and when I saw the picture I thought, "This is for real".

Clinician: Wow, so it really hit close to home. It sounds like it was a big eye opener.

Client: Yes, it was. It was really powerful.

Clinician: On a scale of 1-10, about how important is this topic to you?

Client: Umm, about an 8. Well, I think it's pretty important. I've been tested twice for AIDS. Both times it was when I was pregnant, and I was clean.

Clinician: That's good! It's a really good idea to get tested regularly. It's also important to realize that getting tested doesn't *prevent* you from getting HIV. What are some ways you have used to protect yourself from HIV or other STD's?

1.1 Case Example: Using a Solution Focused Model for Sexual Safety Planning

This vignette shows how all three suggested techniques are implemented as part of the clinical practice. It explores the client's history and experiences regarding partner behavior and HIV risk. It also educates her about different types of sexual abuse and her at-risk status. It is empowering in that the worker directs attention to the tangible steps the client has taken to protect herself, drawing focus to her past successes, capabilities, and strengths.

Another considerable way to foster empowerment is through the use of therapeutic support groups. The women from the focus groups expressed shared commendation regarding the benefits of gathering together to discuss issues relative to HIV prevention, sexual safety planning, domestic violence, and personal growth and autonomy. There are many benefits to this type of group intervention. It is can be less intimidating to share in a group than in individual therapy. It also is validates their feelings, thoughts, and experiences, as they see they are not alone. Overall, the participants in this sample found the focus groups in themselves to be a means of both empowerment and encouragement. They realized that they

had support systems in place and resources in reach, and they found a safe place to talk about their sexuality.

On a macro level, the focus group participants proposed wider scale alternatives in finding solutions to these overlapping phenomena including a larger community awareness approach to make the problems of HIV, IPA, and their intersection visible at a population level through campaigning, door-to-door advocating, and media advertising. Some participants even suggested that by "equipping people who are in the shelters, people like us," they could spread knowledge at the grassroots level. Second, participants echoed the importance of targeting men in research, prevention, and intervention, not just women. This parallels the findings of Raj et al. (2006) who concluded that "clinic-based interventions that integrate IPV and STD/HIV prevention among U.S. men are absent from published literature. These interventions must be developed and evaluated" (p.1877). Finally, it is essential that the most common proposed strategies become more accessible: easier testing, condom use, service availability, easier reporting, and law enforcement interaction. This means that change needs to occur on a systems level so that resources become more tangible for those who have experienced IPA.

Overall, studying the differences across focus groups shows that the way women of different races and ethnicities conceptualized what abuse means and the language they used to express their understanding was quite variable. Thus, it is important for future researchers and educators to clarify what they mean when using certain language, such as abuse, battering, rape, coercive sex, etc.

Thus, the implications of this study reinforce the need for developing an HIV prevention curriculum for survivors of IPA, suggesting that the provision of therapeutic groups based on psycho-educational empowerment is an important future step for practitioners providing domestic violence and sexual assault services both in private practice and agency settings. The focus group data and feedback from the community advisory board has informed the development of a six-week, two-hour-per-session curriculum that can be used to for this purpose. The curriculum will cover the following topical areas: *Module 1* will focus on Capacity Building that will cover areas such as self-perception, self-image, healthy relationships, and HIV/AIDS awareness. *Module 2* centers on Sexual Safety Planning, including issues related to power and control, early warning signs versus immediate danger, and communication and negotiation skills. *Module 3* focuses on Life Skills, including assessment of educational and employment goals, links to self-determined educational and employment goals, assessment of alcohol and drug abuse, and links to services and support. The next step of the research process entails the piloting of the intervention using a quasi-experimental/treatment and comparison groups of women who have experienced IPA.

LIMITATIONS

A few study limitations are important to note. First, the sample was not representative of women who have experienced intimate partner abuse in other parts of the U.S. Because of its non-random and small sample size (n=43), no inferences can be drawn. An increased sample size, including substantial numbers of focus group participants of this population would allow for an indication of larger variance in experience relative to the study questions. Second, collected data is reliant upon self-disclosure. Although there were measures taken in a post-group questionnaire to determine the consistency of information shared, the study results are determined by means of self-report.

CONCLUSION

This research study has provided information for the development and delivery of a HIV/AIDS risk reduction intervention for a vulnerable, underserved population. Culturally and contextually relevant tools, resources and interventions are critically needed for women who have experienced IPA. These are needed not only because of the distinct messages and images that are designed and tailored to particular groups but also because these resources will involve target populations as key consultants.

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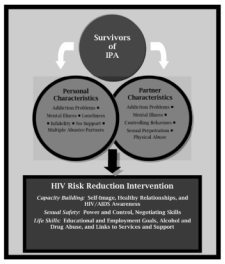

Figure 1.
HIV/AIDS Risk Reduction for IPA Survivors

Table 1

Socio-Demographic Characteristics of Participants

Socio- Demographic Characteristics	n	%
Age	1	2.33
Below and 25 years old	15	34.88
26-30 years of age	9	20.93
31-35 years of age	6	13.95
36-40 years of age	1	2.33
41-45 years of age	3	6.98
46-50 years of age	2	4.65
51 years old and above	**6**	**13.95**
Missing	**43**	**100**
Total		
Ethnic Background	8	18.60
White	9	20.93
African-American	10	23.26
Hispanic Bi-Lingual	15	34.88
Hispanic Mono-Lingual	1	2.33
Other	**43**	**100**
Total		
Level of Education	10	23.26
Less than High School	12	27.91
High School Diploma/GED	9	20.93
Some College	3	6.98
College Diploma	1	2.33
Some Graduate School	1	2.33
Graduate Degree	**7**	**16.28**
Missing	**43**	**100**
Total		
Monthly Personal Income	11	25.58
None	10	23.26
$1 to $500	12	27.91
$501 to $1,000	0	0.00
$1,001 to $1,500	3	6.98
$1,501 to $2,000	0	0.00
$2,001 to $2,500	1	2.33
Over $2,500	**6**	**13.95**
Missing	**43**	**100**
Total		
Number of Children	3	6.98
No Child	6	13.95
1 Child	14	32.56
2 Children	8	18.60
3 Children	3	6.98
4 Children	3	6.98
5 Children and More	**6**	**13.95**
Missing	**43**	**100**
Total		