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Child Abuse in Young, HIV-Positive Women: Linkages to Risk

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Abstract

In this article we explore the lives of young women living with HIV who experienced physical and/or sexual abuse in childhood. Using a modified version of the Life Story Interview, 40 women recruited from HIV clinics in three different states participated in a qualitative interview. Interviews covered abuse experiences, cognitive and emotional consequences of abuse, coping strategies, and sexual behavior and relationships. Overall, these young women had complex abuse histories, often experiencing more than one type of abuse in the context of other difficult life events. Avoidance and substance use were frequently utilized as coping strategies for abuse-related distress. Young women reported sexual and relationship concerns, including avoidance of sex, sexual dysfunction, sex as a trigger for abuse memories, and difficulty establishing intimacy and trust. Relationships between abuse-related reactions and sexual risk behavior, as well as recommendations for interventions, are discussed.

Keywords

abuse; physical; abuse; sexual; coping and adaptation; HIV/AIDS; risk; women's issues; young women

The Centers for Disease Control and Prevention estimates that half of all new HIV infections in the United States are found in adolescents and young adults, primarily through sexual transmission (Centers for Disease Control and Prevention, 2008). Furthermore, engagement in risk behaviors such as increased number of partners, lack of condom use, and substance use are found at high rates in HIV-positive adolescents. Engagement in sexual risk behavior after HIV diagnosis is prevalent (Kalichman, 2000; Wenger, Kusseling, Beck, & Shapiro, 1994), even among HIV-infected adolescents engaged in primary care (Murphy et al., 2001). Violence and abuse are increasingly recognized as factors important to the acquisition and transmission of HIV (Hein, Dell, Futterman, Rotheram-Borus, & Shaffer, 1995; Moreno, 2007). Rates of sexual and physical abuse are estimated at 25% in the general population (Polusny & Follette, 1995); however, rates in HIV-positive samples are even greater. In studies of HIV-infected women, reported sexual assault ranges from 43% (Zierler, Witbeck, & Mayer, 1996) to 68% (Kalichman, Sikkema, DiFonzo, Luke, & Austin, 2002; Kimerling, Armistead, & Forehand, 1999). In women and adolescents with HIV, 50% have reported the experience of childhood physical or sexual abuse (Pao et al., 2000; Simoni & Ng, 2000).

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The psychological, interpersonal, and health sequelae of child abuse in women are varied and well documented. Perhaps the most prevalent psychological diagnosis after traumatic experiences such as child abuse is posttraumatic stress disorder (PTSD). Estimates of abuse-related lifetime PTSD range from 48% to 85% percent (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997), and some continue to manifest symptoms of PTSD long after the abuse occurs. In HIV-positive samples, rates of PTSD have been estimated at 30% to 50% (Israelski et al., 2007; Martinez, Israelski, Walker, & Koopman, 2002; Safren, Gershuny, & Hendriksen, 2003). However, childhood abuse, both sexual and physical, can also result in a myriad of other outcomes, beyond a PTSD diagnosis, that influence individual and interpersonal trajectories. Abuse reactions included changes in cognitions related to trust, intimacy, control, esteem, and safety (Resick & Schnicke, 1993; Tarakeshwar et al., 2005). Also documented are difficulties in affect regulation, anger expression, negotiation of interpersonal relationships, as well as potential disruption to identity formation such as low self-esteem, poor sexual adjustment, and risk for revictimization (Cloitre, Scarvalone, & Difede, 1997; Erdmans & Black, 2008; Follette, Polusny, Bechtle, & Naugle, 1996; Fullilove, Fullilove, Smith, & Winkler, 1993; Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007; Wilson and Widom, 2008).

In addition to these outcomes, multiple studies have provided evidence that abuse experiences are associated with engagement in sexual and other risk behaviors (El-Bassel, Gilbert, Rajah, Foleno, & Frye, 2000; Myers et al., 2006; National Institute of Mental Health Multisite HIV Prevention Trial Group [NIMH MHPTG], 2001; Wilson and Widom, 2008). For example, in the Women's Interagency HIV Study, a history of child sexual abuse was associated with HIV risk behaviors, including lifetime history of drug use; being with a partner at risk for HIV; having more than 10 lifetime male partners; trading sex for money, drugs, or shelter; and being forced to have sex with an HIV-positive partner (Cohen et al., 2000). In a sample of 3,346 at-risk women, childhood sexual abuse was associated with HIV risk behaviors, including more unprotected sex, more partners, and more sexual activity coupled with substance use (NIMH MHPTG, 2001). A recent prospective study demonstrated a link between documented sexual abuse, physical abuse, and neglect with prostitution (Wilson & Widom, 2008).

Mental health symptoms generally, and posttrauma symptoms in particular, are associated with risk behavior, and have been proposed as mediators of sexual risk behavior after abuse (Miller, 1999). A longitudinal study of adolescents showed that mental health symptoms (including PTSD symptoms) experienced during adolescence were associated with HIV risk behaviors during adolescence, and increases in mental health symptoms corresponded to increased engagement in risk behavior in young adulthood (Stiffman, Dore, Earls, & Cunningham, 1992). Mental health symptoms have been shown to have associations with sexual risk behavior through increased fearfulness of condom-use negotiation, less control in relationships, less efficacy in negotiating condom use, and norms that do not support "healthy sexual relationships" (DiClemente, Marinilli, Singh, & Bellino, 2001). In one study of HIV-infected women, a history of child sexual abuse was associated with psychological difficulties, problems with intimate relationships, and sexuality. Maladaptive coping strategies to deal with abuse-related emotions, including substance use, were reported by these young women (Tarakeshwar et al., 2005). Substance use might function in some cases as a strategy for coping or self-medicating symptoms (Chartier et al., 2009; Stewart, 1996).

Much of the prior research has focused attention on child sexual abuse. Several researchers have suggested that cumulative trauma or multiple forms of trauma are perhaps more salient markers of adjustment than single incidents of abuse or abuse of a single type (Hedtke et al., 2008; Saunders, 2003). Therefore, in our study, we expanded the question to include women who had experienced sexual and/or physical abuse, and attempted to contextualize abuse experiences within the larger scope of exposure to other types of potentially traumatic events.

Evidence across quantitative and qualitative studies suggests that women with past abuse histories, including both physical and sexual abuse, can experience negative sequelae across a range of domains that increase risk for HIV acquisition and ongoing sexual risk behavior after diagnosis. To better understand the sequelae of complex histories of abuse, as well as to elucidate further the relationship between abuse and risk behaviors, we explore emotional, cognitive, and behavioral reactions to abuse; coping strategies; HIV risk behavior; and the intersection of these factors on intimate relationships.

Method

A naturalistic approach was selected to study the impact of sexual and physical abuse on the life trajectories of HIV-infected young women (Denzin & Lincoln, 1994). Although the extant literature demonstrates the potential negative influence of abuse and trauma on sexual risk behavior, the multiple manifestations of the effect of abuse on psychological well-being and social interaction over the course of adolescent development is less well documented. An inductive investigation was warranted, both to give voice to victims of childhood abuse and to increase our depth of understanding, by allowing participants to contextualize events and subsequent experiences in their own words. Following the method of the Life Story Interview (Lieblich, Tuval-Maschiach, & Zilber, 1998), participants were asked to narrate their lived experience through audiorecorded, one-on-one, in-depth interviews. Through this developmental perspective participants were allowed to anchor their narrative to their identified important life events or “chapters.” The use of this method was chosen to enhance our understanding of abuse over the course of adolescent development rather than for the purpose of creating specific typologies based on the structure of the narrative (Stamm et al., 2008). In addition to these narratives, descriptive demographic data were collected as well as a quantitative measure of PTSD to characterize the study sample and provide a complementary method for understanding the effects of trauma symptoms on current functioning. Saturation was determined by consensus of the primary interviewer and authors who reviewed transcripts as interviews were completed.

Participants

Forty HIV-infected women, ranging in age from 18 to 24 years, who reported sexual or physical abuse prior to age 18, were recruited for this study through Adolescent Trial Network (ATN) sites in New York City, Miami, and Philadelphia. Inclusion criteria included sexual activity (defined as vaginal or anal sex with a male) within the previous 4 months. Recent sexual activity was an inclusion criterion because we wanted to explore intimate relationships in this study. Inclusion criteria also included HIV acquisition through heterosexual intercourse or intravenous drug use after the age of 9 years. Recruitment was stratified to include a sample of current substance users, such that 23 of 40 (57.5%) participants reported greater than minimal use of alcohol, marijuana, or other illicit drugs in the previous 4 months. This strategy ensured that we had enough participants to explore the role of substance use in these women’s lives. A total of 84 women were approached for the study; 8 women were not interested or were lost to care (i.e., did not return to the clinic and could not be contacted) prior to screening. A total of 76 women completed the screen. Of these screened women, 34 were ineligible based on study entry requirements and 2 declined to participate.

Procedure

Nurse coordinators at each site approached potential participants during a clinic visit, described the study, and obtained written informed consent for screening for eligibility. Questions were asked regarding sexual activity and substance use within the previous 4 months, and occurrence of sexual and/or physical abuse prior to age 18. Women meeting inclusion criteria were invited to participate and gave further written informed consent and permission to have interviews

audiotaped. Interviews were scheduled within 60 days, and conducted by one of three trained interviewers.

Interviews began with a semistructured interview reviewing abuse events, age and frequency of abuse, PTSD symptoms, and sexual behaviors. Then a 1- to 2-hour interview, based on the Life Story Interview, was conducted. The primary interviewer was a trained adolescent medicine physician who was not affiliated with the clinics. Several interviews were conducted by a clinical psychologist, and a doctoral-level graduate student in public health proficient in qualitative research methods, neither of whom were professionally affiliated with the clinics. All interviews were transcribed word for word, and the original recordings were destroyed. All interviews were reviewed by three of the authors as they were received. Participants were compensated for time, transportation, and child care, according to site-local customs. Approval for study protocol was given by each participating site's institutional review board.

Measures

Abuse—Participants were assessed for abuse histories prior to the age of 18. A modified version of a standardized traumatic event assessment method (Dansky, Saladin, Brady, Kilpatrick, & Resnick, 1995) utilized in the National Survey of Adolescents (Kilpatrick et al., 2000) was used in this study. Abuse was defined by a positive response to a contextually orienting screening question followed by endorsement of at least one behaviorally specific description of an event of physical or sexual abuse occurring prior to age 18. Examples of specific items included: “Has a boy or man ever put his penis inside your vagina or rear end or inside your mouth when you didn’t want them to?” and, “In your lifetime, has anyone, including family members or friends, ever attacked you with a gun, knife or some other weapon, regardless of whether you ever reported it or not?”

Substance use—Participants were asked about the frequency and intensity of alcohol use, marijuana, and other drug use. Participants reporting either two or more occasions of having four or more drinks (binge drinking), or of alcohol use three or more times per week in the previous 4 months were classified as substance users based on alcohol use (Canagasaby & Vinson, 2005; Clark, Chung, & Martin, 2006). Substance use based on drug use was categorized as positive if there was reported marijuana use two or more times in the previous 4 months (Chung, Colby, O’Leary, Barnett, & Monti, 2003), or one-time use of another illicit drug in the previous 4 months.

Posttraumatic stress disorder assessment—PTSD symptoms were assessed with an interviewer-administered Posttraumatic Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997), based on the *DSM-IV* diagnostic criteria (American Psychiatric Association, 1994). The scale provides a severity score (17 items) and assessment of functional impairment (9 items, yes/no) in the previous month. Item anchors ranged from 0 (not at all or only 1 time) to 3 (5 or more times a week/almost always). The PDS has demonstrated high internal consistency, test-retest reliability, good sensitivity and specificity, and diagnostic agreement with the Structured Clinical Interview for DSM-IV-TR (SCID).

The Life Story Interview

A modified version of the Life Story Interview (Lieblich et al., 1998) was used to elicit the life stories of participants. We used this method of elicitation to allow participants to contextualize abuse and HIV infection within their definition of important life events. Participants were asked to identify and title different “chapters” of their lives, and to describe the defining events and details of each chapter. Interviewers were given a guide of questions and probes to facilitate the discussion and encourage elaboration on certain themes and topics as interviews

progressed. After the initial life story was elaborated, participants who did not discuss areas of interest such as abuse, coping, and sexual behavior were encouraged to elaborate on these areas. Interviewers were allowed to encourage participants to expand or elaborate to help facilitate a more natural interview and increase rapport.

Analysis

The analysis process included conventional and directed-content analysis (Hsieh & Shannon, 2005). First, each transcript was reviewed in its entirety. Codes were developed to capture concepts that were important to the research questions, and additional codes were created that emerged as significant during the data collection process and after the interviews were reviewed. Transcripts were then broken down into segments of text that could stand alone to represent an important domain, concept, or theme; labeled with the appropriate code (Bernard, 2006); and cataloged using Atlas.ti 5.0 computer software (Muhr & Friesse, 2004). One primary coder, not affiliated with the interviews or clinics, performed all the coding. A second coder reviewed the coding scheme and coded 25% of the interviews. A minimum of 80% inter-rater reliability was achieved; any discrepancies were reviewed by three authors and discussed until agreement was obtained. The segments of textual data were reviewed by code. Codes were clustered based on their representation of overlapping concepts. The relationship among codes and important themes emerging through the clustering of concepts was discussed among two of the coauthors. Important themes were synthesized for presentation. Results are presented below under the following five broad themes: complex trauma histories, abuse and risk, influence of abuse on relationships and sexuality, coping through avoidance and distancing, and coping with abuse through substance use. A description of the nature and manifestations of each theme is provided. Segments taken directly from interview transcripts are included to illustrate how the theme was expressed by participants.

Results

Complex Trauma Histories

Participants typically described their life story using chapters that loosely mirrored early, middle, and late stages of adolescence. For participants who experienced abuse prior to the age of 16, movement from one chapter to the next was often precipitated by a traumatic life event, including molestation, rape, physical abuse, or separation from their primary caregiver.

Thirty women reported sexual abuse, 32 reported physical abuse, and 22 reported both types of abuse (55%). The average PTSD score on the PDS was 20.75 (*SD* 10.18), reflecting moderate to severe levels of PTSD symptoms. Approximately 15% of the sample reported mild PTSD symptoms (<10), 37.5% reported moderate symptoms (10 to 20), 30% reported moderate to severe symptoms (21 to 35), and 15% reported severe symptoms (>35). Of nine items assessing the effect of PTSD symptoms on current functioning globally and across specific life areas, participants rated the strongest effects on sexual relationships (67.5%), followed by general satisfaction with life (57.5%), family relationships (52.5%), friend relationships (50%), and fun and leisure activities (45%).

Of the 30 participants who reported sexual abuse, the majority (19) experienced forced fondling, oral sex, and/or vaginal/anal penetration prior to reaching 12 years of age. Eleven reported an additional rape by a different perpetrator between ages 12 and 18. Although childhood sexual abuse was often inflicted by a person connected to the family—such as the stepfather, cousin, or mother's boyfriend—sexual abuse reported during middle and late adolescence was more often perpetrated by persons from outside the family, including boyfriends, boys from school, and other men in the community. Several of the women who were raped reported multiple perpetrators during the event.

The majority of physical abuse reported by participants during childhood and early adolescence was the result of violence inflicted by a primary caregiver. Descriptions of violent episodes included beatings with fists, wires, and other objects that resulted in bruises to the head, arms, and legs. Several participants also described being choked or threatened with a knife. Physical abuse described after the age of 12 was more commonly inflicted by the participant's romantic partner than a guardian or caregiver. For most women, this included being slapped, kicked, punched, and choked by their partner.

In addition to abuse experiences, participants described growing up in family environments that included being raised by a single parent, interactions with the foster care or residential care systems, early loss experiences such as exposure to the sudden and violent death of close family members, early exposure to interpersonal and community violence, economic hardship, and substance-using parents or guardians. Many women were from single-parent households, typically female led, with fathers who were infrequently present and in many cases contributed only sporadically to the economic maintenance of the family. These single-parent families were often living with or in close proximity to extended family members such as aunts and grandparents, who at times functioned as an extended caretaking system, and one that provided needed support. However, the extended caregiving system also appeared to increase the vulnerability of these young women and place them at risk for abuse. For example, some women described sexual abuse inflicted by male cousins while in the care of extended family, and physical abuse perpetrated by their grandparents or other extended family members. Other women described sexual abuse by partners of their mothers. Additionally, numerous young women were victimized while in the foster care or residential care systems.

Many young women described the death of close family members when they were young children, including a substantial portion of deaths attributed to HIV/AIDS and violence such as shooting deaths. Women also described extensive drug and alcohol use by their parents and extended families. In many cases, substance use was comorbid with other problems; for example, one participant's mother died from AIDS and was also a drug user. Some participants reported mental health problems and substance use in their maternal caregiver. These early losses and familial drug use also appeared to increase vulnerability to abuse and engagement in risk behaviors. For example, a young woman whose mother was a substance user who was removed from her home stated that she was "the only girl living with all males" and who felt "unwanted" by other family members who shuttled her among their homes, who "ran away" repeatedly, and lived in a group home as a way of addressing her feelings of familial abandonment. Another woman described increased isolation and abuse as a function of parental problems with substances in the following way:

So she [mother] was always out. Going out to drink. And when she came home, it's beating time. And that was just like the life every day. Or go to the store. I couldn't go outside. Can't have no friends. Can't use the phone. Sending me to the stores late at night. It's 3, 4 in the morning. And where she was living at, it's like dark, dark blocks. Sometimes she used to try to keep me out of school. And I would have to cry and beg and plead like, "Please let me go to school. Don't keep me here all day."

Thus, abuse events were contextualized by participants within family and living environments that were often unstable and without adequate resources. Caregiver substance use played a primary role in promoting risk. The environments promoted by caregivers with substance use and mental health problems not only increased risk for initial experiences of abuse, neglect, and exposure to other forms of violence, but appeared to "push" these young woman from the home to other risky contexts such as the street, and away from potentially stabilizing forces such as school.

Abuse and Risk

For most participants, the abuse events they described resulted in emotional distress and actions that appeared to increase their risk behaviors and heighten their environmental risk. Several women reported running away, living in group homes, or residential centers in some cases, as a way of escaping their family situation where abuse occurred. However, the new environments often functioned as contexts that appeared to increase vulnerability to risk behavior and additional abuse situations. One woman who moved to a residential home to avoid her abusive home life described how she felt after leaving her home:

[I] got out and had all this freedom. I didn't know what to do with it. I was fighting for every little thing just because I felt that I needed something to get this anger off of me. Because I had a whole lot of anger towards the world, I done joined gangs. And then I started selling drugs.

Thus, emotional reactions to abuse, coupled with contextual factors such as homelessness and high-risk environments, were associated with engagement in risk behaviors involving drugs, violence, and association with risky peers.

Many women described “going to the streets” as a reaction to abuse at home and the lack of a supportive primary caregiver. One woman, describing why she ended up on the street, said her reason for running away was “because she [mother] wasn't giving me what I needed, she shown me no attention.” Another woman linked her exposure to the street environment with drug use, saying, “I was running away. I was staying the night out. I was tricking for marijuana, so I think I was an addict from the gate.” Running the streets was viewed also as freedom, independence, and distraction from difficult life situations. For example, another participant stated, “I didn't really care about my problem at the time. The only thing I cared about was getting back on the street and do what I wanted to do.” Another said, “Besides the first seven years of my life, my first teen years was the best as far as partying, the streets, and everything. Well, back then I thought it was the best. It gave me good memories.”

Although providing freedom and release, being in the streets was also viewed by these young women as risky. As one participant said, “I probably would have been dead in the street. Because I was into the streets hard. And that's all I cared about. Was in being outside, just being outside. Anything but being indoors.” The streets added a layer of risk to the already risky home environment that some were experiencing, a theme expressed by one young woman who described physical abuse both from caregivers at home and from people she met on the streets. Being “into the street” increased exposure to risky peers. As one woman stated, “And then I just got caught up with the wrong people. Hanging out at the age of 13 and not coming home.”

Other women described running the street, including exchanging sex for a place to stay or for drugs, to survive outside their home environment. Both homelessness and running away have been linked to increased engagement in risk behaviors (Aidala, Cross, Stall, Harre, & Sumartojo, 2005; Kidder et al., 2007). As one woman said, “And I ran off, and I kept getting high. I kept prostituting, hurting myself, doing what I need to do.” Another woman stated that she left home and moved from place to place: “Yeah, screwing people, trying to eat, sleep. Homeless for a while.” Sex exchange was reported by several women, whether for survival purposes or for drug or monetary gain; thus, the streets provided access to necessary resources. Unfortunately, sex exchange in some cases led to additional experiences with violence such as rape or physical abuse. One woman described the complex interaction between sex work, violence, and drug use when she returned to the streets to work after she experienced a rape: “Probably the same night, I got right back out there. That's just how bad I was addicted to crack.” This cycle of substance use, new exposure to violence, and increased use of substances has been demonstrated in a prospective study of women, and might involve the use of

substances to self-medicate distress associated with abuse or assault, and reflect the risky environments in which illicit drug use occurs (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997).

Influence of Abuse on Relationships and Sexuality

Psychological, behavioral, and psychosocial reactions to abuse were multifaceted. The phenomena of overaccommodation and assimilation in response to abuse histories was evidenced in several interviews. Overaccommodation is changing beliefs to an extreme to incorporate the meaning of the abuse into existing schemas, such as, “No man can be trusted.” Assimilation, which is altering the meaning of the event to fit with prior schemas, can be seen in the expression of self-blame and guilt: “I must have done something to make this happen” (Resick & Schnicke, 1993). In these participants, cognitive reactions appeared to be heightened when family were involved with the abuse. One mother’s response was to accuse her daughter of “wanting her man” after her daughter disclosed abuse by the mother’s partner. This young woman recanted her disclosure to maintain “peace” in the household, accepting responsibility for the abuse and normalizing the fact that the abuse would be ongoing. Abuse experiences can lead to difficulty resolving the occurrence of abuse with a “just world,” where good things happen to good people and bad things happen to bad people. One woman wondered how to resolve the meaning of “mother as caregiver” with the abuse inflicted on her, asking her mother:

“Am I really your child. Did you adopt me from somewhere?” And she was like, “Why would you ask me?” I said, “Because all the things that you did to me in my life, you just wasn’t supposed to do to me, you know, unless I wasn’t your real child.”

Self-blame, a form of assimilation, was also mentioned as a reaction to abuse. As one participant said, “I was sixteen. I thought it was my fault. I was lost.” These cognitive reactions affect individual adjustment, but also have the potential to affect the quality and negotiation of intimate relationships.

Consistent with the concept of overaccommodation associated with abuse, many women described difficulty trusting people in general, and sexual partners specifically. Trust and intimacy have been identified as important to negotiations of safer sex practices in intimate relationships, and might also be related to other facets of sexual risk behavior such as partner selection and number of partners (El-Bassel et al., 1998; Gilbert, El-Bassel, Schilling, & Friedman, 1997; O’Leary & Jemmott, 1995). Many women reported that not trusting others was a coping mechanism that kept them safe. One woman described this distancing as follows:

Because I’ll put a boundary because I tell myself being that I’ve been hurt before in my life, I’m not going to get hurt no more. So I just put like a little boundary in to stop people from getting close. ... I feel, if you don’t get close, I can’t get hurt.

Trust played an important role in relationships for these women, linking the effects of their abuse to sexuality and intimacy.

Traumatic sexualization has been described as a consequence of abuse, and includes shaping of the individual’s sexuality through the developmentally inappropriate exposure to sexual relations with an adult. In theory, abuse victims can become “oversexualized” and seek out sexual relationships as a means of attaining love and affection or material goods, or alternately, abuse victims can become sexually withdrawn and avoidant (Finkelhor & Browne, 1985; Wyatt et al., 2002). In these narratives, cognitive reactions related to power, control, and self-esteem appeared to be linked to increased engagement in risk behavior, whether through a greater number of partners or through relationships with riskier partners.

Engagement in sex has been posited as a way of remedying the impaired sense of power and control stemming from abuse. Several women provided descriptions of their younger selves as “boy crazy,” and described a strong desire for sex. As one woman stated of her abuse, “Actually it made me like addicted to sex kind of. And that was always my weakness because any kind of emotion or something, I’m going to want to sexually [be] with him.” Some women identified engaging in sex for both material reward and the feeling of power associated with sex. For example, a woman who had experienced long-term sexual abuse by her mother’s partner said,

I don’t know how it happened, but it was like I got used to it. I would look forward to it in some kind of way, like I knew that if I went, and I did it, I knew I could get those hundred-dollar shoes that all my friends had.

She then generalized her sexual and emotional experience with her abuser to other men:

At that time, I was starting to really get into guys because I thought, you know, I was always like, well, if I do this and that, they’re going to give me this and that. It was like I couldn’t go without it. I knew that if I did it that I was going to get the things I wanted to get. So I was just sleeping with everybody and all that.

Another woman identified her poor self-esteem as a link to HIV acquisition through engagement with a risky partner:

But I think a lot of stuff drove me to get this. You know, it was not having that male figure around, not having somebody telling you that you’re beautiful. Just all that hurtfulness and disrespectfulness and everybody put together done drove me to actually listen to what this man had to say, and that’s how I got it.

Women also described using sex to cope with abuse-related distress, and to feel better. One woman linked her need for relief to an increased number of partners and HIV acquisition:

I kind of think that that contributed to me kind of because it made me so wanting for sex, where I constantly was out there looking for it because that looked like my only way to relieve some of the things that was going on. So that’s where I got it [HIV], I guess.

Some women described feelings of emotional numbing, described as the inability to experience positive feelings or enjoyment, in association with sex and intimacy. One participant described this as follows:

I didn’t care about nothing. I would have sex with a lot of people, and that’s not me. But my feelings was just numb from all the stuff that happened to me in 13 years. I started having sex more, and, I don’t know why. More and with different people. I couldn’t have a monogamous relationship.

For these women, abuse-related distress and emotional numbing seemed to serve as bridges between abuse experiences and increased numbers of sex partners, and in some cases, HIV acquisition. Cognitions related to control, power, and esteem were also associated with frequency of sexual activity, and perhaps helped young women achieve a sense of equilibrium.

In contrast to describing themselves as boy crazy or addicted to sex, other young women described low interest in sex and avoidance of sex. Sexual dysfunction has been reported as a consequence of abuse experiences (Letourneau, Resnick, Kilpatrick, Saunders, & Best, 1996; Lutfey, Link, Rosen, Wiegel, & McKinlay, 2008). Many women in this study reported a lack of sexual desire, or sexual desire that was difficult to maintain throughout the sexual encounter, and some reported inability to orgasm. Sexual difficulties led to avoidance of sex, which in turn caused conflict with partners. Fluctuations in sexual desire and the link to relationship conflict were captured in one woman’s description:

It's like sometimes I get in the mood to have sex, and sometimes I'm not. Or I'll be in the mood, and ten minutes later, I'm not. And I have had arguments and stuff with people because I fell out of the mood quick.

Similarly, one woman said, "I was horny, and then it's like as soon as we started I wasn't horny anymore and it hurt and I wanted them to stop." Fear, anxiety, and disgust were evident in some descriptions of sex with partners, including a fear of sexual arousal: "And turning anything on, he turn me off. So like I said, I don't want to do nothing." Sexual dysfunction such as lack of desire, inability to orgasm, and pain during intercourse served as barriers to enjoyable sexual relationships and as potential triggers for partner conflict.

In numerous cases, avoidance of sexual behavior appeared to be because sexual engagement served as a trigger for past memories of abuse. PTSD symptoms include avoidance of people, places, or activities that remind one of a traumatic event, and fear reactions to those cues; these young women might have had memories cued by the context of intimacy and sexuality. When asked about how abuse affected her sexuality, one woman said, "Look what I have to deal with now. That's how I feel. I've been having it in the back of my mind, in front of me. It's just stayed in my mind, period, the worst of it." Another woman said,

Because after I got raped, I just felt like I didn't want to have sex no more, even with my baby's father. We rarely had sex, rarely, rarely. I just tried it to see if it's something I could go back to, but it's not something I would want to go back to either. Because then my past will come up.

These sexual triggers led not only to avoidance of sexuality but also to avoidance of intimacy, and generalized negative feelings toward men. As one participant stated,

Even when I was with my boyfriend, we would have sex, and he would do something. And it will trigger whatever happened, and I would just push him off of me, and I would tell him, "Leave me the fuck alone." So it's still going on. That's what I have done. I don't want to be with a man.

Sexual avoidance within the context of intimate relationships can also lead to problems within the relationship and to negative partner reactions. One participant described her reluctance to engage in some types of sexual acts because of the feelings it triggered and her partner's angry response:

The boy I'm with now, he wants me to do stuff sexually that he, I guess, would normally do with other females. But because of the fact that some of the stuff he's done with other females, I have been pressured to do with other males in my past. So I don't really feel safe doing it with him, so I don't do it, and he gets mad.

These young women cited numerous examples of abuse-related sexual avoidance that led to difficulties in close relationships. Furthermore, the absence of discussion regarding discomfort with certain aspects of sexuality with partners appeared to lead to conflict. There was little evidence that these young women were comfortable discussing sexual preferences, anxieties, or fears with their sexual partners.

Notably, all of these women were sexually active as a requirement for inclusion in the study. Thus, discomfort with sex and intimacy could be an important link between abuse and risky sexual behaviors. If an individual avoids sex, is not planning on sex, or is uncomfortable talking about sex and its effects on her, she might have a difficult time planning or negotiating safe sex with partners. Additionally, she might avoid intimacy by choosing partners that she can keep at an emotional distance—which could lead to an increased number of partners or riskier, more "available" partners.

Coping Through Avoidance and Distancing

Coping styles, including strategies such as avoidance, have also been linked to poor adjustment after childhood abuse (Proulx, Koverola, Fedorowicz, & Kral, 1995; Tarakeshwar et al., 2005) and engagement in risk behavior (Batten, Aslan, Maciejewski, & Mazure, 2004). Most women reported the use of avoidance coping for dealing with emotions related to abuse. One woman described her multiple avoidance strategies:

I don't like crying or nothing like that. Stuff like that, I don't let it bother me. Like I don't think about it. I try not to think about it. I don't really talk about this stuff. I'm the type of person that keeps everything inside. I don't tell anybody.

Emotional distancing was a coping strategy that was also described frequently. For most women, emotional distancing meant social withdrawal and relying only on oneself. For example, one participant stated,

I'm the kind of person like I've been through so much I'd just rather like be by myself, stay by myself. Because when you deal with people, ain't nothing but problems, a lot of problems. So I'd rather just stay by myself.

Coping Through Substance Use

There is some evidence that engagement in health risk behaviors such as substance use can function as coping responses after abuse to manage psychological distress or pain (Stewart, 1996). Women in this study engaged in substance use both in the past and currently. Most women reported the use of substances in adolescence, to a degree that many reported concerns about safety as a result of their substance use and described their substance use as being out of control. Many women saw their substance use as a way of coping with distress associated with abuse. One woman stated of her past substance use, "Because before, when I was younger, I obviously drink all day, every day. That's how I used to stop thinking about it. I used to get drunk." Another woman reported marijuana use as a coping strategy for helping her avoid abuse memories: "I wouldn't think about it. I would be in my own little zone, and then I would smoke weed. I swear I'd spend like \$50 a day on weed. So it was like—it really just blocked everything out."

Other participants reported substance use as a current coping strategy for dealing with memories of abuse. For example, one participant said, "If I do think about it, I probably will want to smoke or something. I'm not even supposed to smoke 'cause I'm on probation, but maybe I would drink a little." Another woman said she smoked marijuana to cope with her emotional reactions to abuse: "So I'm still going through a depression because of shit people do to you, but I guess that's why I smoke marijuana." The use of marijuana as a coping strategy could be effective for blunting emotion, yet could also limit the development of other coping strategies and derail processing of the abuse memories. For example, one participant stated,

I got high so I wouldn't feel the pain that I was feeling. And now that I'm not high, I'm having all these emotions. I'm having the good ones and the bad ones and both of them is trying to run me out of here. The bad ones is I feel like going out there, like any little thing that make me get upset. I get upset with any little situation.

Young women utilizing substance use as a coping strategy might have been negatively reinforced for doing so when it helped to manage negative affect and keep painful memories at bay. It is conceivable that attempts to quit substances exacerbated abuse-related symptoms and result in a return to substance use. Any attempts to assist young women with reducing substance use should include attention to the utility of substance use as a coping strategy, and ensure that there are alternate coping strategies in place.

Discussion

Through this study, we documented a wide range of sequelae associated with abuse experiences. Posttrauma reactions such as PTSD symptoms, substance use, and difficulties with intimacy and sexuality were evident in many of the women we interviewed, both in their younger adolescence and their current lives, and by their own description affected their quality of life across important domains such as relationships, family, and leisure time. Theoretical models (e.g., Miller, 1999) have addressed mechanisms by which abuse and associated psychological reactions could impact sexual risk behavior before and after HIV acquisition. Propositions include that abuse is associated with sexual risk behavior through experiential avoidance (attempts to control/avoid internal experiences associated with trauma; Batten, Follette, & Aban, 2001), disrupted attachment in relationships (Kershaw et al., 2007), beliefs/expectancies that can lead to risky sexual practices, and the use of substances to “medicate” symptoms (which leads to disinhibition or impaired judgment; Stewart, 1996).

Our results are consistent with some of these proposed mediators of risk behavior, and suggest that avoidance of painful memories, difficulty with trust and intimacy, and coping strategies such as engagement in sex and substance use might be important in the link between abuse and risk behavior. Emotional responses to abuse, including PTSD symptoms such as avoidance and numbing, appear to precipitate engagement in behaviors that maintain abuse-related symptoms and in themselves constitute risk. For example, women reported that substance use was frequently utilized as a method for coping with distress associated with abuse, consistent with the findings of other researchers (Cunningham, Stiffman, Dore, & Earls, 1994; Tarakeshwar et al., 2005). For some women in our study, this substance use increased vulnerability to additional risk such as exchanging sex for drugs and sex with multiple and/or risky partners. For some women, abuse also resulted in a heightened need for engagement in sexual encounters, whether to increase a sense of power and control, obtain material goods, or as a response to emotional numbing. Intersections between mental health, substance use, and this increased engagement in sexual encounters should be further explored. The findings of this study suggest that addressing the mental health needs—including maladaptive coping strategies such as substance use—of young, HIV-positive women with abuse histories can improve quality of life and influence engagement in risk and protective behaviors.

The breadth of the effects of abuse on sexuality and intimacy were notable in these young women. Sexual dysfunction, sexual avoidance, and discomfort with intimacy were mentioned frequently, and increased need to engage in frequent sex was also noted. These findings are consistent with the concept of “traumatic sexualization” following sexual abuse (Finkelhor & Browne, 1985), where abuse influences sexual identity and behavior such that victims become either “oversexualized” or avoidant of sex. A particular focus discussed by these women was sexual avoidance, where many young women feared aspects of the sexual encounter could trigger memories, thoughts, and feelings related to their abuse experience. Because all of these women actually had recently engaged in sex, these descriptions of sexual avoidance are particularly interesting. Other studies have supported a relationship between experiential avoidance and sexual risk (Batten et al., 2004). It might be that those young women who engage in strong avoidance do not maintain intimate relationships and are at risk for problems within their relationships, such as partner violence, frequent relationship turnover, and engagement with riskier partners or decreased likelihood of negotiating condom use. Avoidance could also be related to cognitions such as trust and the ability to develop and maintain intimate relationships. One study found that avoidance coping in response to child sexual abuse was associated with fewer sexual partners (Merrill, Guimond, Thomsen, & Milner, 2003). The authors noted, however, that avoidance coping was highly correlated with “self-destructive” coping, which in turn was associated with greater numbers of sexual partners (Merrill et al., 2003). Thus, use of coping strategies and their associated behavioral sequelae can fluctuate

across time or situations, and avoidant coping could have differential associations with various sexual risk outcomes such as number of partners and condom use (Batten et al., 2003; Merrill et al., 2003). Interventions targeting coping strategies for sexual abuse victims have demonstrated reductions in risk behavior and PTSD symptoms, and should be included in the armament of sexual-risk-reduction interventions (Sikkema et al., 2007; Sikkema et al., 2008).

Because intimate relationships are robustly associated with quality of life, and relationships were noted by women in this study as strongly affected by abuse sequelae, interventions should also focus on ways of improving relationships for these young women and their partners (Bova & Durante, 2003). Increasing comfort with discussions of sexuality and intimacy between partners might be a useful starting point. Interventions addressing trauma-related symptoms in young women should also incorporate a focus on intimacy and sexuality, including identification of triggers for sexual avoidance, anxiety, or distress. Efficacious cognitive-behavioral interventions for PTSD that include at least some focus on sexuality, trust, and intimacy are available for abuse victims (Cloitre, Koenen, Cohen, & Han, 2002; Resick & Schnicke, 1993), and would likely be beneficial for inclusion in interventions targeting abuse in HIV-positive women; likewise, those efficacious treatments for abuse-related sequelae should include a strong focus on HIV prevention. Child sexual abuse victims have shown reduced sexual risk behavior when a focus on abuse was included in a risk-reduction intervention (Wyatt et al., 2004). Partner-focused interventions for enhancing intimacy, couples communication, and negotiation of sexual practices could be useful for those engaged in long-term relationships (El-Bassel et al., 2005).

The women in this study, although still young, had already experienced many challenges, including absent or impaired caregivers, abuse, substance use, mental health symptoms, revictimization, and HIV diagnosis. These young women began their lives in home environments that were low income, often led by single parents or alternate caregivers who themselves had problems with either substance use or mental illness or both. Alternate caregiving, when it was utilized, also appeared to increase risk for potential abuse situations. From a prevention perspective, policies and programs supporting parenting practices and safe, affordable childcare settings are imperative. If parents or caregivers work, these programs need to cover the hours when children are left unsupervised. Parental or caregiver mental illness and substance use must also be addressed for prevention of abuse. It is possible that parents with economic challenges and mental illness and substance use problems have decreased ability to monitor and care for children.

Secondary prevention efforts must also target families in which abuse has occurred. Significant vulnerability to risk behaviors such as unprotected sex and sex with riskier partners, substance use, and exposure to additional violence and abuse emerge in the period of young and middle adolescence. Our study findings suggest that some of this engagement in risk behavior could be mediated by cognitive, emotional, and behavioral responses to abuse. Additionally, increased exposure to environmental risk after abuse experiences was a concern in this study, consistent with research exploring relationships between abuse and subsequent homelessness, unstable housing, and increased engagement in risk behaviors (Coady et al., 2007). In deciding to leave unsafe home environments, young women were placed in situations that again increased exposure to risks such as homelessness, lack of economic and social resources, risky peers and sexual partners, and communities with high rates of violence and substance use. Interventions should thus focus on addressing the mental health needs of older children and younger adolescents, barriers to services (Watson, Kelly, & Vidalon, 2009), and include comprehensive approaches targeting safe home and community environments, including viable housing alternatives for homeless youth.

Methodologically, it is important to expand our study of abuse experiences to include a broader assessment of traumatic life experiences across the lifespan (Saunders, 2003). It is clear that childhood abuse does not occur in a vacuum, and must be situated within other life experiences including traumatic loss, exposure to community violence, and other experiences of interpersonal violence and neglect. Future studies must expand beyond assessment of one type of abuse, such as sexual abuse, as it might artificially show linkages to outcomes that might be better explained by exposure to multiple traumatic events and multiple types of traumatic events. These young women's lives were striking for the complexity of exposure to potentially traumatic events, and abuse experiences cannot be separated from other life events and the contexts of those events. Furthermore, this study points to the need for multilevel interventions that address several different points of vulnerability that include, but are not limited to, addressing emotional sequelae of abuse at the individual level. Comprehensive interventions will include environmental and contextual levels such as safe housing, parent mental illness and substance use, and improving skills in intimate relationships.

This study has several limitations. One limitation is the relative homogeneity of the sample. All participants were young and female, and most were Black and of lower socioeconomic status. Thus, results cannot be generalized to other HIV populations. However, because young women of color constitute one of the most at-risk groups for HIV acquisition and make up a large percentage of people with HIV and AIDS, it is an important group for study. Additionally, all of these young women reported abuse experiences, limiting our ability to understand the unique contribution of abuse to these young women's lives. Though we lacked a comparison group, the high prevalence of abuse in HIV populations makes this an important group for study. Further studies should include women who do not report abuse histories to compare their risk trajectories with those who have experienced abuse. Additionally, these young women were engaged in care, and might not be representative of persons living with HIV. They are however, important targets for intervention and are more able to receive resources and interventions because of their linkages with care. Last, these were not documented cases of abuse, but instead relied on self-report of abuse. Many studies exploring abuse rely on self-reports, one reason being that abuse is likely underreported, whether reported to child protective services or documented in other formats, such as medical charts. Until screening, detection, and intervention with child abuse improves, studies utilizing self-report remain an important adjunct to documented cases of abuse experiences.

This study brings together valuable information narrated by young women living with HIV, including how abuse has affected their past and current lives. Although these young women have been exposed to multiple types of trauma in their lives, many of them believe they have arrived at a place in their lives where they can move forward in a positive direction. There are numerous opportunities to assist these young women in enriching their life trajectories from this point forward, and to prevent or ameliorate the effects of past abuse experiences.

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