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Depression and social support among women living with the substance abuse, violence and HIV/AIDS syndemic: A qualitative exploration

Samantha L. Illangasekare, Ph.D., M.P.H.,

Johns Hopkins Bloomberg School of Public Health, Department of Population, Family, and Reproductive Health, 615 N. Wolfe Street E4140, Baltimore, MD, 20205; tel: 410-502-3284

Jessica G. Burke, Ph.D., M.H.S.,

University of Pittsburgh Graduate School of Public Health, Department of Behavioral and Community Health Sciences, 218 Parran Hall, Pittsburgh, PA 15261; tel: 412-624-3610

Geetanjali Chander, M.D., M.P.H., and

Department of Medicine, Division of General Internal Medicine, Johns Hopkins Medical Institutions, 1830 E. Monument St, Rm 8060, Baltimore, MD 21287; tel: 443-287-2030

Andrea C. Gielen, Sc.D, Sc.M

Johns Hopkins Bloomberg School of Public Health, Department of Health, Behavior, and Society, 624 N. Broadway Room 554, Baltimore, MD 21205; tel: 410-955-2397

Samantha L. Illangasekare: sillanga@jhsph.edu; Jessica G. Burke: jgburke@pitt.edu; Geetanjali Chander: gchande1@jhmi.edu; Andrea C. Gielen: agielen@jhsph.edu

Abstract

Intimate partner violence, HIV/AIDS and substance use are described as the SAVA “syndemic” among low-income urban women because of their intersecting and synergistic presence in these women's lives. Depressive symptoms are significantly associated with these SAVA factors and while social support is potentially protective for depression, little is understood about its impact on depression associated with the SAVA syndemic. This paper investigates how women living with SAVA experience and describe depressive symptoms, and examines how the types of social support they access impact their experiences of SAVA and depressive symptoms. Qualitative in-depth interviews were conducted with 24 HIV-positive low-income urban women who experienced IPV and used cocaine or heroin in their lifetime. Interviews were analyzed based on study aims, principles of thematic content analysis, and grounded theory. Women identified multiple SAVA factors as catalysts for depression and noted their synergistic effect on depressive symptoms, which were both a trigger for and result of drug use. Women accessed varying sources of social support to address their SAVA factors and associated symptoms of depression, relying on

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Correspondence to: Samantha L. Illangasekare, sillanga@jhsph.edu.

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informal sources for instrumental support related to IPV and formal sources for support related to HIV, drug use, and depression. These findings have important implications for health providers who serve SAVA-affected women, and suggest that comprehensively addressing all SAVA factors (and IPV in particular) and improving their access to quality social support at critical times is essential in order to improve their mental health.

Keywords

intimate partner violence; HIV/AIDS; substance abuse; syndemic; depressive symptoms

Introduction and Background

The synergistic and clustering epidemics of intimate partner violence (IPV), HIV/AIDS, and substance use among urban women in the US are collectively described as the SAVA (substance abuse, violence and AIDS) “syndemic” (Gielen et al., 2007; Meyer, Springer, & Altice, 2011; Senn, Carey, & Venable, 2010). The concept emphasizes that health issues influenced by broader social factors do not occur in isolation, but rather intersect and mutually-enhance their negative impacts on health outcomes (Romero-Daza, Weeks, & Singer, 2003; Singer, 1994). Research indicates that minority women living in low-income, urban communities are especially vulnerable to IPV, HIV/AIDS, and substance use (Black et al., 2011; Centers for Disease Control and Prevention, 2011; Curtis-Boles & Jenkins-Monroe, 2008; Substance Abuse and Mental Health Services Administration, 2012) and that each health problem is often experienced by the same vulnerable women (Gielen et al., 2007; Illangasekare, Burke, Chander, & Gielen, 2013b; Illangasekare, Burke, McDonnell, & Gielen, 2013a).

Each aspect of the SAVA syndemic is associated with physical and mental health outcomes, including depression. The prevalence of depressive disorder among HIV-positive women is significantly higher than that of their HIV-negative counterparts (Campbell & Lewandowski, 1997; Morrison et al., 2002). Similarly, women who have experienced or live with IPV are at greater risk of reporting associated depressive symptoms and other mental health sequelae including post-traumatic stress disorder, anxiety, and suicide risk (Bonomi et al., 2006; Bradley, Schwartz, & Kaslow, 2005; Campbell & Lewandowski, 1997; Coker et al., 2002; Dienemann et al., 2000; Dutton et al., 2006; Gielen, McDonnell, O'Campo, & Burke, 2005; Johnson, Cunningham-Williams, & Cottler, 2003; Morrison et al., 2002; Ramos, Carlson, & McNutt, 2004). Women who abuse illegal substances or alcohol also experience higher rates of depression compared to women who do not and those in the general population (Chander, Himelhoch, & Moore, 2006; Chander & McCaul, 2003). Quantitative evidence exists that the syndemic effect of living with all three SAVA factors is associated with increased risk of depression among women (Gielen et al., 2005; Illangasekare et al., 2013b; Illangasekare et al., 2013a). However, no studies have investigated how the SAVA syndemic is associated with depressive symptoms among women using qualitative methods.

Given the association between the SAVA syndemic and depressive symptoms, it is critical to investigate potential protective factors and methods of intervention to reduce negative

outcomes. Social support, including emotional, informational or instrumental/financial resources provided through relationships with others, has the potential to be one such factor (Cohen, Gottlieb, & Underwood, 2000) and has been shown to be an important influence on depression and experiences of abuse (Beeble, Bybee, Sullivan, & Adams, 2009; Goodman, Dutton, Vankos, & Weinfurt, 2005; Kamimura, Parekh, & Olson, 2013; Wenzel, Tucker, Elliott, Marshall, & Williamson, 2004). Social support might be particularly important for low-income African American women because they are more likely to rely on informal support systems and less likely to access traditional mental health services as compared to white women (Bradley et al., 2005; Kanuha, 1994). However, one study has suggested that although social support is independently associated with lower depression among women, it does not buffer the negative effects of the SAVA syndemic factors on depressive symptoms (Illangasekare et al., 2013b). Examination of how women who are experiencing the syndemic also experience depression and how they use social support is necessary.

This study uses qualitative methods 1) to investigate how women who are living with the SAVA syndemic experience and describe depressive symptoms, 2) to examine the types of social support they access, and 3) to determine how this social support impacts their experiences of the SAVA syndemic and depressive symptoms.

Methods

Data Collection

Women were eligible to participate if they were 18 years of age or older, not pregnant, HIV-positive, had experienced physical or sexual IPV from a partner at any time since the age of 18, and had used cocaine or heroin at any time in their lives. Cocaine and heroin were specifically chosen for eligibility because these were most commonly investigated in previous literature on the associations between drug use, IPV and HIV risk (Braitstein et al., 2003; Gilbert, El-Bassel, Schilling, Wada, & Bennet, 2000; Illangasekare et al., 2013b). Participants were recruited from HIV primary care and community clinics serving low-income women in Baltimore through flyers and referrals from clinicians and other study coordinators. Women who called about the study were screened for eligibility over the telephone, and scheduled for an in-depth interview at a private study office near the clinic. At the time of the interview, a verbal and written study description was provided, and each participant gave informed consent before proceeding. Interviews took between one and two hours. All women were given a resource list with information for IPV, HIV and drug treatment services, and a \$30 VISA gift card for their time.

A total of 34 women were screened and 24 were eligible. One woman was ineligible because she was not HIV-positive, 5 women were ineligible because they had never used cocaine or heroin, and 4 women were ineligible because they had never experienced physical or sexual IPV. All 24 agreed to participate and were interviewed for this study. The local Institutional Review Board approved all study procedures.

In Depth Interviews

Data were obtained through semi-structured, in-depth interviews. The interview guide included open-ended questions exploring the participants' experience with drug and alcohol use, HIV infection and intimate partner violence, and the relationships among the three. Women were also asked about their experiences with depression and sadness, specifically related to their HIV status, experience with IPV and use of drugs or alcohol. Finally, women were asked about social support networks and how they use social support to address experiences with HIV, IPV and substance use. All interviews were audio-recorded and transcribed, and notes were taken during the interview.

Coding, Theme Development and Analysis

Data were prepared for analysis by reviewing field notes and audiotapes and making any clarifications or corrections in the transcripts. Final transcript documents were imported into Atlas.ti qualitative data management software. Each transcript was read multiple times by the first author and a coding scheme was developed using principles of thematic content analysis and grounded theory to organize and structure the data. Codes were initially created to reflect the study aims and then open coding was conducted to generate in vivo codes and allow additional themes to emerge from the data. The coding scheme was discussed over the course of development by all co-authors to add any emergent themes or resolve any differences in interpretation. The co-authors jointly agreed on a final coding scheme that was then applied by the first author to all transcripts.

Results

The sociodemographic characteristics of women in the sample are presented in Table 1. We first present results that address our first research objective: to investigate how women who are living with the SAVA syndemic experience and describe depressive symptoms.

Depressive Symptoms Among Women Experiencing the SAVA Syndemic

All women discussed feeling sadness or depression at some point. . The majority (n=17, 70.8%) also reported being diagnosed with depression by a medical provider and being prescribed medication for depression and/or other mental illnesses. Most women used the word “depression” when describing their emotions in relation to their drug use, HIV status or IPV, but other terms suggesting depressive symptoms included sadness, miserable, grief, and loneliness. Depressive Symptoms Result From Experience of IPV, Living with HIV and Substance Use

While all women experienced all of the SAVA syndemic factors, not all described they combination of the factors as contributing to her depression. However, each woman did discuss feelings of depression as resulting from her experiences of either IPV, HIV status, or substance use or combinations of the three. Some cited abuse as causal factors for their depressive symptoms. One participant suggested that her experience of violence was related to being a drug user, and indicated that her partner assumed she was going out with other men simply because she used drugs, thereby inciting his anger and violence towards her.

I thought [the depression] came from just the beatings, the arguments, and the abuse that he was giving me for no reason...I came to realize that it was just him that I was seeing at the time, but he didn't believe that because most people that use drugs, I guess, go out. When they go out, they go out.

– 52 year old woman

Women also discussed feeling depressed when thinking about past violence. One participant said,

Sometime, I think about it. Yeah sometimes I think about it...it don't make me feel too good. I get kind of sad. And if I'm by myself, I kind of have, like pick up a book or something and start reading, 'cause I don't want to get too deep with it. It's going to depress me again, all over again.

– 50 year old woman

Participants described depression resulting from their drug use. They discussed depressive symptoms beginning after the effect of the drugs wore off:

So I started feeling depressed and stressed out after when I'd get high, and then after the high wears off, the depression comes on. And then when I was trying to stay sober, it started like I was getting depressed also. So in either way, it would set in. Then I would start the cycle all over again.

– 50 year old woman

Women related their HIV to subsequent feelings of depression as well. The majority who linked their depressive symptoms to their HIV status said that this occurred immediately following their diagnosis:

What happened was, in 2001, when I first found out about my HIV, it was time for me to see somebody, because I went into a funk, and I went and crawled inside myself and didn't want to come out.

– 46 year old woman

A minority of women felt that thinking about their HIV-positive status led to experiencing depressive symptoms currently. However, many women felt like their HIV status no longer impacted their mood or mental health and was limited to a period of time immediately after their diagnosis. One woman who had been living with HIV for 16 years said,

So far as HIV, HIV doesn't bother me. I've dealt with it for years. So the trauma of that came in the first year, too. That's over with. It doesn't bother me, you know?

– 39 year old woman

Most described one or two factors being the main causes or catalysts for any feelings of sadness or depression. One participant who experienced physical abuse noted that she experienced severe depression as a result of this IPV but did not mention depression resulting from her drug use and explicitly stated that her HIV status didn't affect her mood or mental health:

It really didn't – once it sunk in, it really didn't – I wasn't like, “Oh Lord, I'm going to die. Boo-hoo.” It didn't hit me like that. It was just like I knew I did what I did, and I got what I got out of it. So now I just have to live my life the best way I can now. And that's just how I took it, and that's how I live with it now.

– 51 year old woman

Some participants described ways in which intersecting SAVA syndemic factors contributed to depressive symptoms. One participant described being in a violent relationship with a partner who would use her HIV-positive status to stigmatize and initiate fights with her. She felt that he was only in a relationship with her because she was bringing in money to support both of their drug addictions, and this combination of factors resulted in her reduced feelings of self worth:

Then they want to fight because I ain't what they wanted. It was like living with pimps. We started off as being together, and they got used to me taking care of their habit and mine...and then when they knew I was positive, they didn't care. We didn't have normal sex. They didn't want to have unprotected sex with me anyway, so...and that kept my self-esteem down real low. They really wasn't interested in me. They was just interested in me providing, thinking about their habit, and giving them a place to live. And I'm paying the bills...and it kept me down and low. I stayed in that pattern when I got high, and that was an addiction.

– 47 year old woman

By stating that they “didn't have normal sex” this participant seemed to suggest that her partner did not engage in sexual acts that felt normal to her, but rather in sexual acts that were outside of her comfort zone and were unwanted. Her experience demonstrates the cyclical and synergistic nature of the SAVA syndemic factors in their relationship to resulting depressive symptoms.

Another participant's experience with a violent partner, drug use and HIV highlighted ways in which the integrated nature of these SAVA factors contributed to her depression. She met her partner when she was already smoking cocaine, and he exploited her addiction to keep her trapped and isolated by bringing her cocaine so she would not leave the house. She contracted HIV from this partner, and he continued to severely abuse her physically, sexually and psychologically for a year, keeping her trapped by physically locking her in his house, as well as by infecting her with HIV and feeding her addiction. She described experiencing depression, anxiety, and panic attacks as a result of these experiences with her abuser:

I mean, I never had no troubles with my behaviors or, you know, being stable in my own mind. But after that, brutal beatings and locked in closets in the dark. And getting checked to make sure they ain't no man been touching me. And knowing I haven't been anywhere, so how could somebody touch me, you know? He was just a really nasty person.

– 38 year old woman

Depressive Symptoms Are a Catalyst For an Increase In or Initiation Of Substance Use

A bidirectional relationship between depression and drug use was commonly reported. In addition to reporting that depression resulted from use of drugs or alcohol, many women described using substances in order to cope with feelings of sadness and depression;

Well, yeah, once I got addicted, I used because I didn't want to feel what I was feeling.

– 49 year old woman

Women talked about their use of drugs as medication for their feelings of sadness:

They made me feel better. Picked me up and made me feel better, the heroin and the cocaine. That gave me some energy, of course, the cocaine... It was like I was self-medicating with the drugs.

– 50 year old woman

Some women specifically identified their depression as the catalyst for their initiation into drug use:

I didn't have no self confidence in myself and I was nasty and I felt depressed, didn't want to talk to nobody. My life didn't mean nothing to me and then that's why I just took all the drugs.

– 55 year old woman

For several women, drug use and depression were part of a cycle, each fueling each other:

If I keep on focusing on how many times I'm using, it's going to put me in a depressed state and then I'm going to use that much more.

– 51 year old woman

Next, we present results that address our second research objective: to examine the types of social support accessed by women experiencing the SAVA syndemic.

Women Access Numerous Types of Social Support

The women discussed using various types of social support, particularly in relationship to dealing with their HIV, substance use, experiences of IPV and depression. Two of the most common sources of support for these women were their family members and their HIV or mental health care providers. Women also discussed receiving support from their friends, partners, drug treatment programs, church communities, and their relationship with God. Women mostly relied on their sources of social support for emotional support, as exemplified by the following participant. One woman described the stress she used to have when others relied on her while she was trying to cope with her own health problems. In discussing the emotional support she finally received from her family, counselors, and sponsor, she explained how being able to rely on them lifted the burden from her shoulders that she once felt. When asked “So how does having these people in your life make you feel?” she responded:

I don't feel like that I got to carry everything on my shoulders. It [was] like a lot of big burden because I [was] always the one that everybody ran to and ran to and ran

to and I'm realizing I stayed so stressed out and wore out because I'm the type of person – I worry.

– 49 year old woman

Women also reported receiving instrumental support, such as providing a place to stay or money if needed. They could rely on family and friends for such support, and a few mentioned church members as sources of instrumental support as well. For example, one participant described how a church member took her to the hospital when she needed mental health care:

I was really, really out of it. I had no hope for the future, I had no sense of direction, I didn't have nothing, and I just didn't care, but a friend of mine, Selma, she's one of the nurses at the church I used to go to, and she works at the [hospital name redacted], and she seen what I was going through. And she took me to [hospital name redacted], and she explained to them what was going on with me.

– 46 year old woman

Finally, we present results addressing our last research objective: to determine how this social support impacts their experiences of the SAVA syndemic and depressive symptoms.

Women Received IPV-Related Support to a Limited Extent

Many participants reported disclosing their experiences of IPV to their family, friends and health care providers. For those few who were able to discuss their experiences of IPV more extensively with sources of support, this was particularly helpful in dealing with the emotional impact of the physical or sexual abuse they were experiencing. If women did receive IPV-related social support from family members, it was limited and often instrumental support only. For instance, women discussed living with family members or friends after leaving an abusive partner or having family members involved in the process of leaving:

He was still beating me up, and I just felt like shit. So I grabbed my clothes and just started walking. And I got up on [redacted] Avenue and called my dad, and he came and picked me up, and my sister was there with a baseball bat in case he was there coming at us.

–50 year old woman

Some women noted that their family or friends knew about the abuse, but that they did not discuss their feelings related to the experience or talk about the IPV in detail. Some women only chose to disclose certain aspects of their experience of IPV to their sources of support or did not discuss their experiences, and cited reasons for this lack of disclosure. First, women were concerned that they would be judged for staying with an abusive partner. Additionally, a few did not feel like their experience of IPV was a significant problem in their lives in comparison to the other issues they were coping with, so they did not feel the need to share it with people. Most commonly, women described being worried about telling their family about their partner's abuse because they were afraid that their family members would physically harm their partner:

When I was going through the things with my husband, I told my brothers, but I regret telling them, because they wanted to kill him...I didn't want my brothers going to jail to hurt this man, because he wasn't worth it, but they were at the point they were really going to hurt him...I was saying, "Well, some things I'd better keep to myself, because if my brothers know, they're going to..."

– 55 year old woman

A few women did discuss their experiences of IPV with their health care providers, particularly psychiatrists or therapists. However, when discussing their providers' responses to their disclosures of IPV, some women suggested that their providers were not completely open to this topic. For example, one woman noted that after she disclosed her experiences with IPV, her doctor expressed her dislike of her partner, but then suggested that they not discuss the partner in the clinical encounter:

She says, 'We are not going to mention [partner's name] at this function, are we?'
And I say, 'No Ma'am, we not going to talk about it'

– 46 year old African American woman

When asked how her new doctor reacted after she disclosed her IPV experience, one woman reported that he minimized the impact her IPV had on her mental health.

[He said] that I was doing better. Well, I'm seeing a new doctor, a new therapist, and the first time, when I first, I seen him one time, and he said 'Well it seems like you're doing much better' But I don't think that I am."

– 52 year old woman

Women More Openly Discussed HIV and Drug Use with Sources of Support

Although some women described difficulty disclosing their HIV status to their friends and family immediately after diagnosis, all women eventually told most of their sources of support. Because all women were recruited from a HIV primary care clinic, they were all frequently discussing aspects of their HIV-related health with providers, including psychiatrists and therapists. Similarly, many women were open about their drug use and many had participated in drug treatment, or in programs such as Narcotics Anonymous.

Participants reported discussing their feelings of depression with their mental health providers, and many women were prescribed medication for their depressive symptoms at one point in their lives, or currently. Women generally described these interactions with providers and their use of medication as positive and extremely helpful in addressing the depression they had experienced. However, almost no women discussed their depression with more informal social support, such as family, friends, or church members.

Conclusions and Discussion

This study of women who had experienced the SAVA syndemic over the course of their lives is the first to qualitatively examine the impact of HIV, IPV and substance use on depressive symptoms and evaluate women's use of social support in relation to these health issues.

Using in-depth interviews this research addressed three aims. First, it aimed to investigate how women who are living with the SAVA syndemic experience and describe depressive symptoms. Consistent with previous literature, women reported their HIV, IPV and drug use individually impacting subsequent experiences with depression (Campbell & Lewandowski, 1997; Chander et al., 2006; Chander & McCaul, 2003; Morrison et al., 2002). While women reported multiple SAVA factors being catalysts for their depression, many of them reported only one or two factors primarily and significantly affecting their mental health. This finding suggests that assumptions cannot be made regarding the relative impact of each SAVA factor on women's mental health; rather, impacts are variable and specific to each individual. Some women who experienced extreme physical IPV attributed their depressive symptoms to their HIV status. Others reported that their mental health was not at all impacted by experiences of abuse or HIV, but rather drug addiction.

Because women reported depressive symptoms as both a catalyst for and a result of drug use, depression appears to function as a critical factor in the intersection of HIV, IPV and substance use in women's lives. It is likely not only an outcome of the SAVA syndemic, but an important factor in perpetuating the SAVA syndemic. Some studies of SAVA have included depression as part of the syndemic in their analysis (Senn et al., 2010), but this is the first to qualitatively explore the ways in which women's experiences of the SAVA factors and depression are linked and act as risk factors for one another across their lifecourses.

Secondly, this study aimed to examine the types of social support women access. Participants reported accessing numerous sources of social support, ranging from friends and family, to providers, to religious communities. It is important to note that women did consider their mental health and medical providers as particularly influential members of their social support network, suggesting that these professionals can play a critical role in the lives of women beyond the basic care they provide. However, women seemed to rely on certain sources for specific types of social support related to varying SAVA factors. Women did rely on friends and family for support to address their IPV experiences, but this was typically instrumental support as opposed to emotional support. Research has indicated that the specific type of social support can have differential effects on depressive symptoms. For example, financial support was found to predict fewer depressive symptoms as compared to emotional or instrumental support among a population of primarily African American male and female injection drug users (Knowlton & Latkin, 2007). No studies have determined what type of support is most important in buffering the impact of IPV on depression among women. Conversely, women did not often discuss their HIV, drug use or depression with friends and family but rather relied on health care providers and treatment programs to address these health problems. Women did not appear to rely on these more formal sources of social support to address their IPV or depression specifically related to their IPV. Women did not report receiving emotional support specific to their experiences of IPV from either formal or informal sources. Our findings suggest that women do not feel encouraged and are sometimes blatantly discouraged from discussing their experiences of IPV with their sources of support.

Finally, this research aimed to determine how the social support women receive impacts their experiences of the SAVA syndemic and depressive symptoms. Participants reported some success in improving depressive symptoms through their interactions with providers, use of medication, and participation in treatment programs. However, they often reported that they were most vulnerable to depression immediately after HIV diagnosis and when they were actively using. During this time, they were either newly linked or not linked at all to formal social support sources, such as medical providers or drug treatment programs, which they only accessed well after their HIV diagnosis and/or while attempting to end their drug use. Therefore, any social support they were accessing, if at all, was most likely informal. Women in this study who did access informal social support reported not doing so to address their depression, but rather to address some of the other issues in their lives, such as violence or HIV. Efforts to improve and encourage women's access and use of more informal sources of social support to address depression, such as their church communities, might be critical when they are first experiencing the SAVA factors of HIV diagnosis and drug addiction. The extent to which potential sources of informal support feel prepared to help women dealing with these issues is not known, but worthy of further study. Encouraging and enabling communities to proactively offer support to women experiencing SAVA and depression could lead to successful and powerful interventions.

Because of the small sample and the recruitment strategy, the findings from this work are not necessarily generalizable to all women experiencing the SAVA syndemic. These women were recruited from a medical clinic, and therefore were likely more engaged in care, and had an older median age than the broader population of women who live with the SAVA syndemic. Future research with women recruited from different community settings could shed light on this broader population. Also, the sample was self-selected because women chose to contact the study investigators and participate in this study. However, findings contribute to the limited body of research on the SAVA syndemic among urban women, and are the first to specifically investigate the impact of the syndemic on depressive symptoms. Furthermore, this study provides critical insight into the ways women are accessing sources of social support, both formal and informal.

Implications for Practice

This study highlights the synergistic and overlapping nature of IPV, HIV infection, and drug use as the SAVA syndemic in the lives of low-income urban women. It suggests that women who experience the syndemic are affected by depression, and that depression plays an important role in the synergistic nature of HIV, IPV and substance use. These findings have implications for both community-focused intervention development and women's health practice. First, informal social support networks should be leveraged to assist women with addressing their SAVA factors and associated depressive symptoms, particularly for women who might not be connected to more formal treatment or clinical services. Increasing awareness in religious institutions and in urban communities at large about the syndemic nature of IPV, HIV and drug use, and associated mental health issues could potentially decrease stigma and encourage women to access needed support. By making these highly accessed sources of support more explicitly open to discussing and raising the issues of IPV,

HIV and drug use, women might be more encouraged to broach these topics and receive the support they need.

It is equally critical to incorporate IPV-related support services into the formal social support resources that are available to women. Because women who experience the SAVA syndemic might regularly access formal health services due to their HIV and drug use, these interactions with providers are a valuable opportunity to address concurrent IPV. While providers who see women in the context of their HIV or drug use might be more inclined to specifically address aspects of depressive symptoms related to those health issues, they should also be aware of the potential that women are also living with or have experienced IPV. In medical settings, women are more likely to feel comfortable discussing their HIV and drug use, and find that the lack of direct questioning about IPV from their clinician is significant barrier their ability to discuss IPV (Rodriguez, Sheldon, Bauer, & Perez-Stable, 2001). Some findings from this study indicate that women might not be discussing IPV with their providers because they are discouraged from doing so. Providers should be trained in trauma-informed care in order to sensitively and appropriately raise the issue of IPV in medical encounters with women who might be experiencing interrelated SAVA syndemic factors. This is particularly relevant given the Affordable Care Act requirement that screening and brief counseling for lifetime exposure to IPV be covered and recommended as a core women's preventive health benefit. By serving as a critical source of social support for women who are experiencing IPV, HIV care and substance use treatment providers could significantly improve women's safety and ameliorate the impact that the SAVA syndemic has on their mental health.

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Table 1
Demographic Characteristics and SAVA factors among HIV-positive low-income urban women who experienced IPV and used cocaine or heroin in their lifetime (n=24)

Characteristic	% (n) or (range in years)
Median Age in years	50 (34-58)
Race	
Black/African American	87.5 (21)
White	12.5 (3)
Currently experiencing IPV	12.5 (3)
Currently using cocaine or heroin	12.5 (3)
Clinical diagnosis of depression	70.8 (17)
Median length of time living with HIV diagnosis in years	14.5 (1-28)
Participated in drug treatment program	83.3 (20)