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Impact of sexual trauma on HIV care engagement: Perspectives of female patients with trauma histories in Cape Town, South Africa

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Abstract

South African women have disproportionately high rates of both sexual trauma and HIV. To understand how sexual trauma impacts HIV care engagement, we conducted in-depth qualitative interviews with 15 HIV-infected women with sexual trauma histories, recruited from a public clinic in Cape Town. Interviews explored trauma narratives, coping behaviors and care engagement, and transcripts were analyzed using a constant comparison method. Participants reported multiple and complex traumas across their lifetimes. Sexual trauma hindered HIV care engagement, especially immediately following HIV diagnosis, and there were indications that sexual trauma may interfere with future care engagement, via traumatic stress symptoms including avoidance. Disclosure of sexual trauma was limited; no women had disclosed to an HIV provider. Routine screening for sexual trauma in HIV care settings may help to identify individuals at risk of poor care engagement. Efficacious treatments are needed to address the psychological and behavioral sequelae of trauma.

Keywords

South Africa; HIV; Sexual violence; Traumatic stress; Adherence

Introduction

South Africa bears the largest HIV burden of any country in the world, with about 6.4 million people living with HIV and 370,000 new infections annually (1). Women make up a

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Compliance with Ethical Standards:

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Ethical approval: The study was approved by the ethical review boards at Duke University and the University of Cape Town. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent: Informed consent was obtained from all individual participants included in the study.

disproportionate number of those infected, and women aged 15-49 are 1.6 times more likely than men in the same age group to be infected with HIV (23.2% prevalence among women vs. 14.5% prevalence among men) (2). South African women also experience interpersonal traumas at high rates. It is estimated that one-quarter to one-half of South African women have experienced a lifetime history of physical or sexual assault from a male partner (3-5), and in one study, one in ten experienced sexual assault from a non-partner (5). Because interpersonal violence is often co-occurring (4, 6) and may have a cumulative and interactive effect (7), it can be difficult to determine the independent effects of sexual violence. Experiences of interpersonal violence, and sexual trauma in particular, often result in traumatic stress symptoms, which affect cognitive, behavioral, and emotional functioning (8-10). Traumatic stress is often comorbid with other mental health disorders, such as depression, anxiety disorder, and substance use (11), adversely affecting overall quality of life.

The fact that South African women report high rates of both sexual trauma and HIV is not coincidental. Sexual trauma and HIV infection share common risk factors, including poverty, substance use and gender inequality (12). Moreover, women who experience sexual abuse in childhood are at increased risk for exposure to intimate partner violence in adulthood (5), a known risk factor for HIV infection (13). Sexual trauma further contributes to HIV infection biologically, through genito-anal injuries that facilitate transmission of the virus (14), as well as socio-contextually, as violence makes it challenging to negotiate HIV risk reduction practices such as abstinence or condom use (15). Beyond the traumatic event itself, a history of trauma can over time lead to diminished sense of control over one's body, reduced self-esteem, self-destructiveness, and maladaptive coping behaviors, including substance use, all of which can compromise a woman's ability to protect herself from HIV (16-18). Although South Africa has a strong legal framework on sexual assault (19), only a small fraction of assault cases get reported to the criminal justice system (20), and the public health care setting, where survivors often present, lacks the training and resources to meet the complex psycho-social needs of survivors (21).

Without proper treatment, living with both HIV and the traumatic stress that results from sexual abuse can have long-lasting, deleterious effects on HIV outcomes. A comprehensive review of the literature found that having a history of trauma was consistently associated with worse HIV-related clinical outcomes and faster progression to AIDS (22), and a cohort study in the United States found that HIV-infected individuals with lifetime trauma were twice as likely to die over a three-year follow up period (23). While there is evidence that traumatic experiences may have direct physiological effects on immune functioning in individuals living with HIV (24), it is more likely that the impact of trauma on clinical outcomes is explained by poor care engagement over the HIV care and treatment continuum. While limited, evidence suggests that experiencing sexual trauma or interpersonal violence may interfere with an HIV-infected woman's ability to adhere to her medication and be retained in care over time (25, 26). There are several potential explanations for why this interference may occur. First, trauma may influence care engagement by delaying acceptance of one's HIV diagnosis and limiting motivation for self-care. Second, avoidant behaviors may be a key mechanism of this effect; if women are actively avoiding reminders of their trauma, and if HIV care and medication is a reminder, then proper engagement may

likely suffer (27). Third, it is plausible that having both an HIV diagnosis and a history of sexual trauma can compound personal shame and stigma, creating additional barriers to accessing medical care (28).

More nuanced insight is needed into the extent to which sexual trauma interacts with HIV in women's lives, including how sexual trauma may interfere with HIV care engagement, especially in sub-Saharan Africa, which bears the largest burden of HIV infection. This study aimed to fill these gaps in knowledge by qualitatively documenting the experiences of HIV-infected women with histories of sexual trauma in one clinic in Cape Town, South Africa. Qualitative findings can help to clarify the HIV care needs of HIV-infected women with sexual trauma histories and inform locally relevant interventions in this setting, particularly as trauma-informed treatments have not been systematically integrated into HIV care services in most low-resource settings.

Methods

Setting

The study was situated in the township of Phillipi, approximately 15 miles (24 kilometers) from the Cape Town Central Business District. Community resources and local infrastructure are limited in Phillipi, and socioeconomic indicators point to high rates of poverty and hardship. According to the most recent available census data (29), only 32% of residents had completed a high school education, 38% were unemployed, and 78% reported an annual household income below 3,200 South African rand (US \$278, based on exchange rates during the study period).

Recruitment and study procedures were conducted in a single government health care facility in Phillipi. The facility follows over 2,500 HIV-infected patients in its adult HIV clinic. Patients receive HIV clinical services, including antiretroviral therapy (ART), free of charge as per national protocol. At the time of the study, patients could initiate ART when they met any one of the following criteria: CD4 count <500 cells/mm³; WHO clinical stage 3 or 4; pregnant or breastfeeding; and/or tuberculosis diagnosis (30).

Sample and recruitment

Clinic patients were eligible to participate in the study if they were female, enrolled in HIV care at the study clinic (regardless of ART initiation), and reported a history of sexual abuse at any point during their lifetime (childhood or adulthood). A variety of strategies were employed to identify eligible participants, including referrals of HIV-infected women from providers following medical appointments as well as broadly introducing the research study to individuals in the HIV clinic waiting room. Potential participants were told that the study was for HIV-infected women, and were asked about traumatic experiences only when following up privately with a research staff member (NC), who screened the women for eligibility. The inclusion criterion of sexual trauma history was assessed in a semi-structured manner that inquired about experiences of sexual abuse or assault at any point in her life and by any type of perpetrator. The interviewer asked about, for example, “times that you've been forced to do sexual things that you didn't want to do” and “times you were coerced to

take part in sexual acts you did not agree with.” If the woman met eligibility criteria and was interested in enrolling, then she was scheduled to return to participate in the in-depth interview. All study participants were enrolled between October 2014 and March 2015.

Procedures

Enrolled participants took part in a one-time, semi-structured in-depth interview. All interviews were conducted by a South African researcher (NC) who had prior experience with qualitative research. Interviews were conducted in Xhosa in a private room in the study clinic, and lasted between 90 minutes to two hours. Interview questions followed a semi-structured guide that included open-ended probes on HIV and sexual trauma histories, coping behaviors, contextual issues, and reflection on the discussion (Table 1). The interviewer was trained prior to data collection on how to follow the open-ended guide and probe on salient themes throughout the interviews, and received ongoing supervision. She also received training and supervision by a clinical psychologist on how to respond sensitively to participants who spoke about past or current traumatic events, and strategies for minimizing distress during the interview. All women were provided with a list of community resources. For individuals with severe distress or suicidal ideation, a clinical psychologist provided a clinical assessment and facilitated direct referrals to safety and/or mental health services, as necessary.

Participants were compensated 100 Rand (\$8.70, based on exchange rates during the study period) for their time and related travel costs. All participants provided written informed consent to participate in the study. Study procedures were approved by the institutional review boards at the University of Cape Town and Duke University.

Analysis

Audio-recordings of the interviews were transcribed and simultaneously translated into English, with key identifying information (e.g., names and places) deleted from the transcripts. The textual data were then analyzed in three steps. First, individual narrative memos were written to summarize and organize the content of each transcript into its main themes and to begin to extract meaning from the data (31). Each transcript and memo pair was read by two other investigators, who provided input to ensure that the memo accurately captured key details from the original transcript. Relevant quotations were incorporated into the memos to closely reflect participants’ own words. Preparing the memos enabled the authors to begin exploring the relationships and themes in the data and proceed to the next step of analysis. Second, the memos were reviewed to identify key themes related to how sexual trauma directly or indirectly influences HIV care engagement. The memos were uploaded to a qualitative analysis software program (NVivo 10) and coded for these themes. The coded output resulted in 39 pages of single-spaced text. Third, the first author wrote analytic memos for each of the themes, using a constant comparative method to identify both similarities and differences across participants (32). Representative quotations were identified to lend evidence to each of the themes, and the corresponding memos and transcripts for each quote were revisited in order to contextualize participants’ words within their overall narratives.

Results

Description of the sample

The 15 women in the sample ranged in age from 18 to 46, with an average age of 32. Two women in the sample had been diagnosed with HIV within the past year. The remainder had been diagnosed between 3-14 years ago, with an average of about 6 years prior. All but one woman was currently on ART. Additional contextual details about the women in our sample can be found in Table 2.

Sexual trauma¹ history—The sexual trauma experiences among the women in our sample were multiple and complex (Table 2 and Figure 1). Most women (12/15) had experienced sexual trauma by more than one perpetrator over their lifetimes. Perpetrators were all male and included strangers, intimate partners, relatives, neighbors, or older boyfriends. The majority of women described penetrative vaginal intercourse by at least one perpetrator. About half of the sample (8/15) reported experiencing sexual abuse as a child (under age 18). Of the 8 women who reported sexual abuse as a child, all but one also experienced sexual trauma as an adult.

Of the 14 women who had experienced sexual trauma as an adult, 12 women described trauma perpetrated by an intimate partner and 8 women described trauma that occurred outside of an intimate partnership (6 women described both). Only two women reported experiencing what might be described as “stranger rape” – that is, an act of sexual assault by an unknown perpetrator. Of the 12 women who experienced sexual trauma in the context of intimate partnerships, half reported that they had experienced more than one sexually abusive relationship in their lifetime, and five women were involved in a sexually abusive relationship at the time of the interview. Most of the women who reported sexual trauma in the context of a partnership described the abuse as ongoing and chronic – as opposed to an isolated incident of assault – and fueled by their partner's substance use, jealousy, control, and sense of entitlement to sex in a relationship. Women typically felt that they did not have a choice but to succumb to the sexual abuse, particularly in cases where there was financial dependence or physical violence.

Although the focus of the interview was on experiences of sexual trauma, other forms of abuse in intimate partnerships were also discussed, as they often co-occurred with sexual abuse. Of the 15 study participants, 14 discussed incidences where they had been hit or beaten by an intimate partner (8 with multiple partners) (Table 2). In addition, many women spoke about emotional abuse in the form of insults, intimidation and controlling behavior.

Ongoing impacts of sexual trauma on daily functioning

Sexual trauma impacted women's daily functioning in both internal (i.e., thoughts and emotions) and external (i.e., impacts on relationships and behaviors) dimensions, as described below.

¹Note that the word “trauma” is used throughout the results to refer broadly to acts of sexual abuse or violence experienced by participants. In using this word, we are referring to trauma exposure, as opposed to implying corresponding trauma symptoms.

Internal impacts—Participants noted that their trauma experience impacted their self-concept and psychological well-being, with many reporting symptomology consistent with depression and posttraumatic stress. Participants consistently talked about feeling somehow sullied by their sexual trauma experience, and as two women put it, “less of a woman.”

Participant 11, who had been raped by a group of strangers, said that her experience impacted her self-concept: “It made me feel weak. It made me feel so unimportant. I feel useless. I feel like I’m something to be thrown away.” For a few women, feelings of shame were accompanied by self-blame and guilt, as *Participant 12* said about her sexually abusive relationship: “I start to wonder why I let it happen. Then it feels more painful.” Women reported depressive symptoms related to their abuse experience, including loss of interest and enjoyment and depressed mood, and one woman reported a suicide attempt after a trauma experience.

Women spoke about continuing to have frequent thoughts and memories of the trauma. These cognitions were often unbidden and intrusive. Triggers of these memories included being alone, seeing someone who reminded them of the perpetrator, being in a setting or context that reminded them of the trauma experience, or being exposed to images of sexual trauma in the media. Memories often led to rumination, including thoughts about why the trauma happened and whether the woman could have done anything to prevent it. Several women described an inability to sleep due to racing thoughts, and also having dreams related to the abuse, as *Participant 2* described: “I would just dream of someone wanting to sleep with me, and I would dream like fighting the person.” Most women spoke about consciously trying to avoid thoughts of the experience, by deliberately pushing unwanted thoughts away or by doing things to keep themselves busy and distracted. As *Participant 6* noted, “I just feel like keeping myself busy. I shouldn’t relax when that thought comes, because by relaxing I become emotional.”

External impacts—Participants also noted that their trauma experience had impacted their relationships with others and the way they interacted in the world. Perhaps most significantly, many perceived that their trauma history affected their ability to develop trusting relationships. *Participant 13*, who had experienced sexual abuse as both a child and an adult, described how these cumulative experiences impacted the quality of her relationships with both family and friends: “Even if I am close to you, I do not trust you. I am always suspicious.”

Disclosure of sexual trauma experiences was also very limited, ranging from telling no one to only a select few. Feelings of shame, and fears of judgment from others, contributed to restricted disclosure. Women who had been sexually traumatized outside of an intimate relationship typically feared that they would be blamed for somehow inviting the abuse. On the other hand, women who had been sexually traumatized within a relationship feared that their trauma would not be legitimized, or that they would be judged for tolerating the abusive behavior. *Participant 2*, who had experienced two sexually abusive relationships, provided insight into a common trade-off described by women: to find relief in disclosing the trauma, but risk the negative consequences that may come with disclosure:

“You become scared of telling people what happened to you, because you fear that they will judge you. You'll rather not talk about it. What's killing you inside is the fact that the more you don't talk about it, the more it haunts you.” – *Participant 2*

Role of sexual trauma in HIV acquisition and acceptance

Of the 15 women in the sample, eight linked their HIV acquisition directly to a sexual trauma experience, and three additional women thought there was a possibility that their infection could have been due to a sexually violent relationship. One woman spoke about how being diagnosed with HIV forced her to examine her relationships and sexual encounters, which brought back memories of abusive relationships:

“When you hear that you are HIV positive... you go through the memories. You regret what's regrettable. For instance, you ask ‘Had I not done this, perhaps I wouldn't be HIV positive; if I hadn't met so-and-so; or you sit and wonder who did I get it from’. That's what I went through. First of all, you wonder who you got it from. Then all the memories (of the abuse) come back.” – *Participant 12*

Participants typically described their initial diagnosis as invoking feelings of shock and fear, including thoughts of impending death (e.g., “I thought my future was dark,” *Participant 10*). However, most women spoke about how they came to accept their HIV status over time, particularly as they realized that they were not alone in living with HIV. In fact, several women spoke about how living with HIV has been easier to deal with than living with a history of sexual trauma, because trauma was seen as shrouded in greater secrecy and shame in the community as compared to one's HIV status, as these two women explained:

“The abuse I got made me feel very sad, that has been my worst experience. Contracting HIV is something that I predict would have happened either way as I grew up, or interacting with my lovers. The most difficult time of my life has been that of sexual abuse.” – *Participant 04* “HIV is easier to control and easier to talk about than sexual abuse. With HIV, at least when you take the pills, you can control HIV, and people these days talk about it. The abuse you cannot just share with anyone. And the moment you see men or see what happened to you, you start thinking about it, you could never not think about it.” – *Participant 14*

Potential impact of sexual trauma on HIV care engagement

Although at the time of the interview the majority of women reported that their HIV care engagement was good, with consistent attendance at clinic appointments and adherence to medication, the majority of women described previous challenges initiating or engaging in HIV care. Six of the women noted significant periods earlier in life when they had defaulted from care and stopped taking their ARVs due to reasons not directly related to sexual trauma. The primary reasons for defaulting were moving far from the original clinical setting and not re-establishing care, and social disruptions, including new partners and having children. Other reported challenges for care engagement included limited funds to facilitate transportation to the clinic, long waits during clinic appointments, and fears of involuntary HIV disclosure to family, friends, and neighbors. Other women spoke about how their care engagement had been directly impacted by their sexual trauma histories, or described

ongoing trauma symptoms that had the potential to disrupt HIV care engagement in the future.

Some women described how sexual trauma experiences led to a delay in initial linkage to HIV care. Five women experienced delays of several years between the initial HIV diagnosis and enrollment in HIV care. Of these five women, three were in sexually abusive relationships at the time of diagnosis, and two had been diagnosed directly following a sexual assault by a non-partner. These women reported that they could not accept or deal with the implications of an HIV diagnosis at the time, as *Participant 11* explained: “I was too ashamed. I was too hurt.” These women only returned to HIV care later out of necessity, because of a serious illness or a pregnancy. Further, *Participant 14* spoke about how an ongoing abusive relationship had been a barrier to her remaining engaged in care: “Sometimes this person has hit you today, because they want you to sleep with them, then you are swollen and you cannot get to the clinic.” These women were highly burdened by the emotional or physical consequences of their recent or ongoing sexual trauma experiences, which resulted in delays in initiating or engaging in HIV care.

Some women also talked about how sexual trauma impacted their HIV care engagement over time, because of the cognitive association between their sexual trauma and their HIV care. Several women who were adherent at the time of the interview spoke about how taking ARVs sometimes brought up memories of their sexual trauma history. *Participant 15*, who contracted HIV from a man after she was abducted and forced to marry at the age of 15 (in Xhosa, a practice known as *ukuthwala*), said that taking her treatment reminds her of this abusive and non-consensual marriage: “I get angry, because now my life depends entirely on pills because of someone.” *Participant 7* said she had similar thoughts whenever she takes her treatment: “I always think that if that Cape Town boy hadn't raped me, I wouldn't be in this situation.” *Participant 2*, who was raped and acquired HIV at the age of 21, explained how taking treatment used to elicit feelings of shame: “Whenever I was about to take my pills I would blame myself for what happened, and I hated myself, and I saw myself as someone who is worthless in life.”

Treatment for sexual trauma within an HIV care setting

Despite the observed and potential impacts of sexual trauma on HIV care engagement and other areas of functioning, none of the women in our sample had ever disclosed their sexual trauma history to an HIV care provider. *Participant 1* said that she had never even considered the possibility of sharing her experience of sexual abuse during her conversations with the clinic's adherence counselors: “I do speak to counselors here at the clinic now and again, but I never thought about sharing this information with them.” Only one participant (*Participant 8*) reported ever receiving mental health services. Even though this participant was clearly troubled by the multiple sexual trauma experiences she had as a child and an adult, she concealed her trauma history from her mental health provider during the entire course of treatment. As she described, she has consciously tried to “block” any thoughts of the sexual trauma experience:

“I just console myself, and I tell myself to forget about it. Even though sometimes (the trauma memories) come back, I block it. Especially this year, I have been in

and out of hospital, and I have been put on anti-depressants because I have depression. So I try not to think about these kinds of things.” – *Participant 8*

Despite the reluctance to voluntarily disclose their sexual trauma experiences to others, women's responses to taking part in the qualitative interviews were universally positive. They described being able to speak to a trusted individual as lifting a burden and allowing them to feel “free”. Their reactions suggest that women would be willing to engage in trauma treatment if the setting is supportive, non-judgmental and confidential.

“If you have something in you that's packed inside of you and you don't share, that is not alright. When you speak out about something that has been bothering you, you feel a relief. And that's how I feel today.” – *Participant 6*

DISCUSSION

This study examined the experiences and perspectives of female patients in a South African HIV clinic who had histories of sexual trauma, to gain insight into the extent to which sexual trauma interacts with HIV care engagement in women's lives, and to better understand the pathways through which this interference may occur. Their narratives revealed complex sexual trauma histories; women often reported repeated experiences across their lifetimes, with sexual abuse in childhood or adolescence commonly followed by sexual victimization in adulthood, and sexual abuse often co-occurring with physical and emotional abuse from a partner. These women's experiences of trauma must be understood within a broader context of South African township communities, which are disproportionately burdened by substance use, fractured households, gender inequities, and high rates of crime and violence (33, 34). Their overlapping experiences of violence and HIV, with over half attributing their HIV infection to a sexual trauma experience, can be understood in part as a syndemic of overlapping and mutually reinforcing health ills (12). The women who participated in this study made explicit connections between the impact of sexual trauma and HIV within their personal narratives and described several mechanisms that had the potential to directly or indirectly influence their HIV care engagement or adherence, which we discuss below.

Women described the effects of their traumatic experiences on multiple spheres of their emotional wellbeing and functioning. The sequelae of sexual trauma described by participants were consistent with symptoms of posttraumatic stress disorder (PTSD), including intrusive thoughts, negative cognitions or mood, heightened arousal or reactivity, and avoidant behavior (35). Posttraumatic stress is common among individuals who have experienced sexual assault and other experiences of interpersonal violence (8-10, 36), and is also disproportionately high among individuals living with HIV (37). While studies exploring the level of health care engagement of individuals living with PTSD in Sub-Saharan Africa have not yet been conducted, studies conducted in the U.S. indicate that many individuals with PTSD may become anxious about and avoid engaging in health care (38, 39). Further, our participants reported that their trauma experiences made it difficult for them to develop trusting relationships, which has the potential to adversely impact HIV care engagement (40). Studies conducted with HIV patients in multiple settings have found that the level of trust in the patient-provider relationship is a strong predictor of ART adherence

and HIV care engagement outcomes, and future research should explore these relationships in low-resource settings (41-43).

The women in this sample displayed incredible resilience by staying engaged in HIV care despite the emotional and behavioral impacts of sexual trauma histories. Nevertheless, there were indications that sexual trauma had directly affected some participants' ability to accept their diagnosis, link to care, and stay engaged over time. A large proportion of the women we interviewed directly and indirectly attributed their HIV infection to their sexual trauma history, and some women described how being diagnosed with HIV or subsequently taking ARVs triggered memories of their sexual trauma history and reinforced feelings of shame, guilt, and low self-worth. Women also reported that they actively tried to avoid thoughts or reminders of their sexual trauma, consistent with literature describing avoidant coping behaviors as a response to traumatic stress (22). Because HIV care and treatment triggered memories of women's traumatic experiences, and women coped by deliberately avoiding such reminders, it follows that avoidant coping is a potential mechanism for poor engagement with HIV care. This finding is consistent with the literature from high-income countries, which describes that women dealing with sexual trauma histories may cope in part by avoiding engagement with health care services (44, 45). Additionally, study participants who had ongoing sexually and physically abusive relationships reported missing clinic appointments, which has been noted elsewhere (26). Taken together, these findings point to the HIV diagnosis and ART initiation periods as crucial periods for women with sexual trauma histories, who may be vulnerable to delaying care, dropping out of care, or becoming non-adherent if their engagement in HIV care or treatment triggers memories of their trauma experiences.

Importantly, several women in our study described their experiences of sexual trauma as far more distressful and shameful than their HIV status, and their feelings of shame manifested in their interactions with others. Many women reported that they had not disclosed their sexual trauma histories to their families and friends, for fear of being judged or blamed for their experiences. A published empirical review on disclosure of childhood sexual abuse in the general U.S. population noted that, across studies, almost one-third of women never disclose their traumatic experience, and many others wait several years to disclose to anyone (46). The review found that disclosure per se is not necessarily related to relief of psychological symptoms, but rather depends on the reaction and support provided in response to the disclosure. This highlights the need for women to have non-judgmental and supportive spaces where they can openly share and discuss their sexual trauma histories, and potentially further explore how those trauma histories intersect with their HIV experiences (47).

The data presented in this study point for the need for trauma-informed care in HIV primary care settings in South Africa, both to improve the psychological well-being of this patient population and to maximize the clinical outcomes of HIV treatment. In the study clinic, screening for sexual trauma was not routinely integrated into HIV care services, and no women had voluntarily disclosed their sexual trauma history to an HIV care or mental health care provider, highlighting a missed opportunity to address the impact of trauma. The low rates of voluntary self-disclosure, combined with the potential impacts of sexual trauma on

HIV care engagement, underscore the need for routine screening of sexual trauma histories, followed by appropriate referrals to trauma and mental health services (47). Effective evidence-based approaches for treating trauma are primarily cognitive-behavioral in nature and include psychoeducation, exposure techniques, cognitive processing therapy (CPT), and management of anxiety and stress through coping skills training (48-50). Very few rigorous intervention studies have provided targeted trauma treatment for HIV-infected women (51). Effective interventions have reduced traumatic stress symptoms (27, 52, 53), sexual risk behaviors (54, 55), and substance use (56), but none have thus far identified impacts on HIV care engagement. There is good reason to expect that reducing traumatic stress would increase individuals' care engagement (57), but this research has not yet been conducted. Further, women said that they gained confidence when witnessing others who were living adaptively with HIV, and that this sense of community made them feel less alone in their situation, a phenomenon that has been noted elsewhere (58). The fact that women in this study willingly spoke in great detail to the interviewer about their sexual trauma experiences, and that they universally expressed that the interview itself had a therapeutic effect, suggests that HIV-positive women may be open to participating in, and may benefit from, interventions where they could openly share their trauma experiences in a safe environment, and find solidarity with other women.

This was a qualitative study with a convenience sample of clinic-recruited HIV-infected women with a history of sexual trauma, and as such has limitations worth noting. The nature of participant recruitment may have impacted our sample and therefore our findings, in various ways. The current self-reported HIV care engagement behaviors of the sample were good overall; however, the women in our sample were diagnosed with HIV an average of 6 years earlier and 2/3 were not involved in an ongoing sexually abusive relationship at the time of the interview. Thus, the experiences reflected here may differ from those of women experiencing recent or ongoing trauma, or who have been recently diagnosed with HIV. Given high rates of poly-victimization with sexual trauma often co-occurring with physical and emotional abuse, it is not possible to completely distinguish the contribution of sexual trauma. However, it does appear that the sexual trauma experience conferred a unique sense of shame, and many women associated their sexual trauma with their HIV infection. It is possible that the women in our sample were particularly resilient, and that women whose trauma has most adversely influenced their HIV care engagement are simply no longer in the clinical setting. In addition, it is possible that we missed women who were unwilling to talk about their sexual trauma due to their deeply entrenched feelings of shame and secrecy. However, the fact that a majority of the women in our sample had told very few people about their sexual trauma experiences, and no women had received mental health treatment for their trauma, suggests that we did obtain perspectives from women who might be considered hard to reach. Despite a small sample, the qualitative narratives provided by women about their trauma experiences, the impact of the trauma on their emotional and behavioral well-being, and the intersections between trauma and HIV were richly detailed and insightful, yielding important perspectives on the role of trauma in HIV care.

Heavy coexisting burdens of HIV infection and sexual trauma exist among women in South Africa, and left untreated, women may experience ongoing adverse mental health consequences in the form of traumatic stress and depression, as well as challenges initiating

HIV care, engaging in HIV care, or disclosing their trauma experiences to HIV care providers. Limited disclosure may adversely impact HIV care providers' awareness of the unique needs of their patients with histories of sexual trauma, as well as limit their ability to provide appropriate care. Given the coexisting burdens of HIV infection and sexual trauma among women in South Africa, and the impact that trauma has on engagement in care and risk behaviors, efficacious interventions are urgently needed to address traumatic stress.

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Figure 1.
Overlap in abuse experiences in the sample (n=15)

Table 1

Content of the in-depth interview guide

<i>HIV history</i>
Experience getting diagnosed
Reactions to diagnosis
Disclosure and social support
HIV treatment experience
<i>Sexual trauma</i>
Description of trauma(s)
Impact of trauma(s) on life
Perceived overlap between HIV and sexual trauma
<i>Coping with sexual trauma</i>
Disclosure of trauma(s)
Formal services sought
Active coping behavior
Avoidant coping behaviors
<i>Social/contextual factors</i>
Relationship history
Other traumatic events
Areas of stress and impact on HIV care
<i>Reflection on discussion</i>
Experience speaking about the trauma
Willingness to talk about trauma in future

Description of the sample of female HIV-infected patients with sexual trauma histories (n=15)

Table 2

Participant ID	Age	Relationship	Education (highest grade)	Children	Employment	Time since HIV diagnosis	Childhood sexual abuse	Adult sexual abuse – Non partner	Adult sexual abuse – Partner	History of physical abuse by partner
01	42	Married	NR	3	No	4 years	Yes	Yes	^b Yes	Yes
02	31	Married	12	3	Yes	10 years	No	No	^b Yes	Yes
03	31	Married	7	2	No	14 years	No	Yes	No	Yes
04	42	Partner	1	2	Yes	<1 year	Yes	No	^b Yes	^b Yes
05	NR	Divorced; Partner	10	4	Yes	4 years	No	No	Yes	^b Yes
06	NR	Married	8	1	Yes	4 years	Yes	No	Yes	Yes
07	33	Partner	11	0	No	10 years	Yes	Yes	Yes	No
08	30	Partner	12	0	No	6 years	Yes	^b Yes	^b Yes	^b Yes
09	46	Partner	10	2	No	8 years	No	Yes	Yes	^b Yes
10	36	Partner	8	2	No	3 years	No	^b Yes	Yes	^b Yes
11	25	None	11	3	No	<1 year	No	Yes	^b Yes	^b Yes
12	28	Partner	12	1	Yes	NR	Yes	No	^b Yes	^b Yes
13	33	Partner	11	1	Yes	4 years	Yes	^b Yes	No	^b Yes
14	26	Partner	8	1	Yes	9 years	No	No	Yes	Yes
15	18	Partner	11	pregnant	No	3 years	Yes	No	No	Yes

NR = Not reported

^b Reported more than one perpetrator.