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# Gathering Trauma Narratives: A Qualitative Study on the Impact of Self-Identified Traumas on People Living with HIV (PLWH)

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## Abstract

**BACKGROUND—**Trauma—emotional, physical, and psychological—is common and associated with increased risk behaviors, low rates of care engagement and viral suppression, and overall poor health outcomes for people living with HIV (PLWH). This article presents the results of 15 in-depth, semi-structured interviews with PLWH in the southeastern United States in which participants identified a trauma and described its long-lasting impact on their lives. Participants' trauma narratives described a wide range of traumas, including childhood sexual abuse, the loss of a loved one, and their HIV diagnosis.

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**METHODS—**Systematic qualitative analysis was used to delineate beliefs about causes, symptoms, treatments, quality-of-life, and health implications of trauma.

**RESULTS:** Fifteen participants completed the semi-structured interviews that lasted on average 32 minutes. Participants described a wide spectru of personal trauma that occurred both prior and subsequent to their HIV diagnoses. The types of trauma identified included physical, sexual, and psychological abuse inflicted by intimate partners, family members, and/or strangers.

**LIMITATIONS—**A chief limitation of this study is selection bias. Additionally, the participant selection and content of the trauma narratives might have been affected by the surrounding context of the parent study centered on HIV, aging, and psychosocial stress. It is also difficult to interpret the distinction between discrete trauma experiences and the diagnosis of HIV, leading to potential information bias.

**CONCLUSION—**This study highlights the importance of social support in coping with trauma and the effect of trauma on health-related behaviors. It also illustrates the need for additional research on the topic of trauma and trauma-informed care for PLWH. Understanding how different types of trauma affect individuals' lives is necessary to inform recommendations to provide better care for PLWH.

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Traumatic experiences have major impacts on individual and community health, especially for those who already experience significant health disparities due to their socioeconomic status. Trauma—emotional, physical, psychological—is common and associated with increased risk behaviors, low rates of care engagement and viral suppression, and overall poor health outcomes for people living with HIV (PLWH) [1–7]. Intimate partner violence, for example, has been associated with PLWH having a CD4 count, or T-cell count, less than 200 [8]. Although the clinical management of HIV infection has improved, the role of trauma-informed care for PLWH needs further development, particularly in the southeastern United States, the current "epicenter" of new HIV infections in the nation. Rates of new HIV infection have been rising in the southern US, while they continue to fall in cities like New York and San Francisco that historically had the highest incidence and prevalence [9].

The burden of trauma may have lifelong impacts on the mental and physical health of PLWH, including high rates of post-traumatic stress disorder (PTSD) [10, 11]. Evidence also suggests that multiple incidences of trauma are significant predictors of AIDS-related mortality [12]. PLWH are more likely to experience trauma and be victims of childhood sexual abuse [13–15]. Compared to women without HIV, women living with HIV experience more than twice the national rate of psychological trauma from intimate partner violence [16, 17]. Further, a history of trauma may have major implications on reproductive health for PLWH, both in terms of desire and in optimizing health outcomes.

Family planning and reproductive health are salient issues for many PLWH with reproductive desires, similar to their HIV-negative peers [18, 19]. In one 2012 study, the desire for pregnancy was twice as high in women living with HIV with a history of childhood sexual abuse compared to women living with HIV without a history of childhood sexual abuse [20]. Thus, examining the associations between trauma histories, HIV clinical outcomes, and reproductive health is needed to better understand how trauma affects reproductive desires and health for PLWH.

Standard quantitative methodology has been the mainstay for conducting the majority of HIV-related trauma studies, leaving an opportunity for qualitative approaches to further describe how trauma and health intersect for PLWH [11, 21, 22]. Qualitative research can examine the richness of individual accounts and can be used as a tool to complement quantitative studies. Accordingly, the purpose of this qualitative study was to examine personal descriptive accounts of trauma and the effect of trauma on patients' sexual and reproductive health and decision-making.

## Methods

### Patient Population and Eligibility

Semi-structured, in-depth interviews were conducted with PLWH who receive care at the Infectious Diseases Specialty Clinic (IDSC) at Wake Forest Baptist Medical Center in Winston-Salem, North Carolina. The IDSC provides HIV primary medical care services to 2,110 people living with HIV/AIDS in a largely rural 30-county region of Western and Central North Carolina and southwestern Virginia. Clinic patients are predominantly African American (63%) and increasingly female (33%). Thirty-seven percent of clinic patients are uninsured and over half (62%) live at or below the federal poverty guidelines.

A subset of participants (N = 15) was drawn from a parent study (N = 42) being conducted at the same institution that assessed the interaction of HIV, stress, and aging, and the feasibility of a cell phone-based stress reduction intervention. Interviews collected from the subset enhanced our understanding of the lived experience of PLWH in the context of the larger quantitative dataset and interactions of the study team with participants. These combined elements are what we refer to in this paper as their *personal trauma narratives*. Inclusion criteria for both studies included: documented HIV-positive serostatus, being a patient at the IDSC for at least 12 months, being at least 21 years of age, being prescribed an anti-retroviral (ART) regimen for at least 6 months, being fluent in English, and having consistent access to a smartphone. Written informed consent was obtained prior to beginning the interviews. All participants in the parent study were eligible for the qualitative interviews and given the option to participate at the time of consent. Interviews were conducted until the enrollment goal of 15 was met. Participants who completed the trauma interview received a $10 gift card. The study protocol was reviewed and approved by the Wake Forest School of Medicine Institutional Review Board.

### Qualitative Interviews

Interviews were conducted between June and August 2017 by 1 of 3 trained study personnel. Interviews were conducted face-to-face, digitally audio recorded, and transcribed verbatim. The interview guide was semi-structured and designed to encourage participants to delve into their own histories of trauma to the depth and extent they were comfortable. Questions elicited discussion of the impact of personal trauma(s) on current sexual/reproductive health behaviors/perceptions and the desire for a family. First, participants were asked to define "trauma" in their own words, and then identify and describe a personal trauma. Interviewers probed during discussion, as necessary, to clarify elements of the trauma and behavior changes the trauma may have instigated. The interviews then transitioned to explore how those experiences may have affected subsequent behaviors and perceptions, specifically regarding reproductive and sexual health.

### Data Analysis

Thematic analysis was conducted on the transcripts [23]. One of the interviews was not recorded, so the field notes were used in analysis. The initial codes were derived from the textual data, and additional codes were added as additional concepts and themes emerged from the data. Each transcript was coded by two members of the research team. Disagreements in coding were discussed until consensus was reached between the team members.

Final coding was entered into ATLAS.ti (v.8.0), and the study team, in collaboration with Qualitative and Patient-Reported Outcomes (Q-PRO) staff, iteratively reviewed and summarized reports of all coded segments. Recurrent themes were determined by their prevalence and salience in the data.

Transcripts were sorted into 2 groups: semi-structured interviews with individuals who revealed same-sex relationships/attraction at any point in their narratives (N = 5), and opposite sex relationships/attraction only (N = 10). During analysis, data were compared between groups to identify any potential differences.

## Results

Fifteen participants completed the semi-structured interviews. Interviews lasted on average 32 minutes (range: 17:29–58:11). Demographic characteristics of the participants are shown in Table 1. The range of self-identified trauma is summarized in Table 2.

### Trauma Experiences

Participants described a wide spectrum of personal trauma that occurred both prior and subsequent to their HIV diagnoses. The types of trauma identified included physical, sexual, and psychological abuse inflicted by intimate partners, family members, and/or strangers. Other traumas reported in the interviews were personal loss (including death or illness of a loved one, rejection by others, homelessness, and loss of stability) and personal illness unrelated to physical abuse (pneumonia, tuberculosis, toxoplasmosis, HIV).

Although participants were asked to identify a primary trauma and how it affected their lives, 13 participants discussed multiple traumas that were not exclusive of one another. Thus, it was difficult to assess a primary trauma in a precise way. Some events were briefly mentioned but not necessarily expressed as traumas or given further detail by participants (such as initial HIV diagnosis). Personal loss(53%), personal illness (47%), and sexual assault/abuse (40%) were the most common types of trauma identified by participants. Given the non-linear direction of the interview responses, the effects of various traumas and HIV are discussed simultaneously because they were blurred together in the narratives of the participants. For some participants, HIV infection and the trauma they associated with the diagnosis itself were secondary to other traumas, including sexual assault (see Table 1).

Individuals who reported same-sex relationships/attraction, particularly the males, described a great degree of psychological abuse—abuse that occurred for an extended and ongoing period of time. This was less evident in individuals who reported opposite sex relationships/attraction only. There were otherwise no differences identified between the 2 groups, so the remainder of the results are discussed for the entire sample (see Table 2).

## Trauma-related Themes

Primary themes that emerged from the data included: 1) psychosocial effects of trauma, 2) sexual and reproductive health, and 3) positive coping mechanisms.

## Psychosocial Effects of Trauma

Participants detailed many psychosocial effects of trauma in their interviews. They identified ways trauma caused isolation, distrust, and anger, and affected their mental health.

**Isolation/distrust.—**Many participants discussed a deep sense of distrust as a result of traumas, including their HIV diagnosis. They reported being selective with whom they discuss their traumas, usually preferring to maintain privacy around people they do not trust. They did not readily disclose their experiences for fear of judgment, stereotyping, or stigma, often resulting in social isolation. As one participant remarked,

> It’s hard to let someone in, to let them know that you’re HIV positive, that you’re a gay male, because people have the tendency to draw their own conclusions of you without getting to know the person themselves. And so I mostly isolate myself…I want to be in one [a relationship], but who are you going to get to open up and let you know that they are going to accept who you are? Or what you have?
>
> (Male, 52)

Another participant articulated a similar outlook but tied it directly back to the trauma of being bullied when he was younger.

> I look back and I think what a huge part that played in the way I act with others and look at the world…it really impacted my social life, my need for surrounding myself with people. I told myself I didn’t need people because I was afraid I would be devastated again, so for most of my life I’ve not had that many friends…it’s tough being a homo…and it’s tough being effeminate to boot.
>
> (Male, 64)

This narrative of distrust was prevalent for all 5 of the participants who had same-sex relationships/attractions.

Two women also expressed distrust, mostly toward men. One participant who suffered a near-death assault by her boyfriend in 2005 stated:

> I almost just gave up on men, and then after that, in 2008, when I got the diagnosis [HIV], I was like, ‘This is it.’ Had it not been for a guy, I wouldn’t have this…[it] caused me to be leery of men, period.
>
> (Female, 45)

Another participant who was diagnosed with HIV as a teen said, *I heard a rumor that the guy had HIV, but it was a rum*or. *And when I asked him about it, he said, 'No, I'm negative.'* (Female, 38). After learning of her HIV diagnosis, she knew he had lied to her about his status.

While most discussions of distrust and isolation focused on one-on-one intimacy or friendship with others, 3 out of the 15 narratives mentioned institutional sources of distrust, ranging from the American prison system and military to physicians and hospitals.

One participant discussed deep institutional distrust. He stated that he was arrested for shoplifting from a department store, which resulted in incarceration where he believed he contracted HIV from a contaminated injection in the infirmary. He espoused distrust of the department store, the penal system, and the medical providers at the facility. He wondered:

> …if they did that to me purposefully, they probably could have done that to someone else. You know, the Tuskegee experiment… Sometimes I want to research, find out, how many people did that happen to—any other people? See, was it systematically did? But I don't have that kind of education to do that. But they did it to me. They may have did it to someone else.
>
> (Male, 65)

He expressed that his experience bred institutional distrust that extended beyond his own health to affecting how he parented his children. He discussed his regret about encouraging his son to join the military:

> …only bad decision I made I think now, right here now, that I made with my boys is sending them to the military. If I had that to do again I wouldn't do it, because my baby boy is kind of messed up. And I beat myself up about that a whole lot. …the army tells a great big lie.
>
> (Male, 65)

**Anger.—**Three participants reported anger as a primary response to trauma. After learning of his HIV diagnosis, one participant exclaimed that *"inside I was a rage"* (Male, 65), while another woman initially felt anger toward the male partner from whom she contracted HIV, saying, *"I want to kill him."* She then went through a period of thinking: *"I am going to die anyways so I might as well do whatever … I want to do… because you'll be dead once you get this."* (Female, 38)

The same respondent attributed her emotional response to her identified trauma (her parents moved her family from her childhood home) as the reason for her HIV diagnosis, explaining that she was angry and *"felt like rebelling was the only thing to do. I was breaking into people's houses…going in and out of jail and prison the whole time…I really did try and get into a lot of trouble"* (Female, 38). She also engaged in unprotected sexual encounters as part of her rebellion, which was how she contracted HIV.

**Mental health.—**The trauma of HIV diagnosis led to anxiety, depression, and suicidal ideation as reported by 7 of the participants. One woman reported compounded effects due to her HIV diagnosis and husband's death, relating that *"it affected my nerves. I had more anxiety. I stayed depressed all the time"* (Female, 61). Another respondent had a primary trauma of rape, in addition to HIV, which continued to cause anxiety and recurring flashbacks. Another participant explained that during the time surrounding his diagnosis he *"felt like [giving] up hope. And not knowing the things I know now about living with HIV, I felt like that was a death sentence then"* (Male, 52).

Yet another male, who experienced cognitive dissonance around his sexual expression of having sex with men, questioned whether his sexual behaviors were due to his primary trauma of molestation at school and being teased for acting feminine. This dissonance prompted suicidal ideation because *"it [his sexuality] made my life almost a living hell"* (Male, 54).

## Sexual and Reproductive Health

**Sexual practices.—**Five participants articulated a decrease in sexual libido. For 4 other participants, the decision to abstain from sexual intercourse was intrinsically tied to their traumas. A participant who was raped twice said, *"I just can't trust people. Because nobody is going to openly admit to me that they have a STD"* (Female, 50). Another female participant who identified a primary trauma of childhood sexual assault stated: *"I don't like sex…I don't like the ejaculation…I don't like what men ask you to do…but I do get lonely, though, lonely for company, not sex"* (Female, 54).

Conversely, 2 other participants reported a continuation or increase in high risk sexual activity subsequent to their traumas. As one participant said, *"[after the HIV diagnosis]… I was still engaging in risky behavior. I wasn't telling people, I mean I didn't care. As long as I was in denial."* (Female, 45)

Another participant articulated his struggle surrounding the use of condoms: *"I kind of live uninhibited when it comes sexually…I don't do the condom thing…I need to take better actions because I would never want to harm anybody"* (Male, 30). Although he stated he would never want to harm anybody, not using condoms carries potential harm for any of his sexual partners.

Others were markedly affected by their trauma of HIV diagnosis and resolved to use condoms and educate the next generation about them. One participant stated:

> Before I found out I had HIV, I was probably sleeping with 4,5,6 guys every day…[Now], I live with my protection. Safety, condoms…I tell [my teenage niece] all the time, 'Please wait until you get married, or at least till you finish college before you have sex. Please, please please wait. Please. Because you'll be dead once you get this'
>
> (Female, 38).

While some participants reported engaging in high risk sexual behaviors after experiencing trauma, others continued their low risk sexual behaviors. One participant said there was no change in her sexual behaviors: *"Well, I use protection. But I've had the same sex partner for 11 years. So nothing's changed"* (Female, 59).

Another theme that emerged was a shift in the gender of sexual partners as a result of past trauma. One participant whose primary trauma was a near-death assault by her boyfriend said, *"… I started thinking, 'Well, maybe I should just be with females'"* (Female, 45). Other participants were unhappy with their sexual behavior, but it was difficult to extrapolate a direct link between their behaviors and their traumatic experiences. One male participant who has sex with men explained that he did not like it: *"It's almost like I'm addicted to it…I'm with the same sex but I don't even like doing it"* (Male, 54). Another man wondered if the psychological trauma of his past played a role in his engagement in same-sex relationships thereafter: *"Would I have ever had sex with all these guys and have the HIV if not? Would my confidence with women have been different?"* (Male, 30).

**Reproductive behaviors.—**Five participants had never wanted children or had completed their families prior to their trauma, so current reproductive health perceptions were not affected. Those discussing their HIV diagnosis as a trauma verbalized that childbirth varies greatly pre and post diagnosis. One participant said, *"Well, now I think my life might have gone in another direction…I just so happened to have my baby girl two years before I was diagnosed"* (Female, 50).

Although most participants' trauma did not impact their reproductive behaviors, for some who were still of childbearing age after HIV diagnosis, there was a significant impact on childbearing wishes. As one participant said: *"I don't even entertain the idea really of kids any more…. you just start having to dream differently. Your dreams change…"* (Male, 30).

Three participants articulated a direct link between their HIV diagnoses and their childbearing wishes. *"When we first got married, we wanted 4 kids. But because of the illnesses I've had, we've sort of got only one,"* one participant said (Male, 54). Another participant, who has 2 children—1 of whom is HIV positive—said,

> I got one positive and one negative so, I feel guilty about that…I had her, I had my tubes tied, cut and burnt. But I kind of regret that I did, because now I can't have no more kids at all… because of my last daughter, I don't want no more kids…I got her infected. I feel like it's my fault…I want another baby, but I don't want to bring another baby into the world… because it's 50/50
>
> (Female, 34).

Trauma directly played a part in reproductive decisions for 3 participants who had their children before their HIV diagnosis. One participant tearfully shared that, as a result of childhood molestation, *"[I] wanted my children because I wanted somebody to love me"* (Female, 54). Another participant had 3 children before her trauma of sexual assault, and after experiencing this trauma, chose tubal ligation so that she would have no more children.

### Positive Coping Mechanisms

All participants (15) in this study spoke about coping mechanisms for dealing with their trauma. The subthemes identified within the larger coping mechanisms theme were social support, support groups and treatment centers, and religion.

**Social.—**Coping mechanisms identified among participants often involved social support through various interpersonal relationships, including family members, partners, friends, therapists, counselors, sponsors, and religion. Five participants cited a need for healthy coping to handle the psychological effects of their traumas. While participants acknowledged a desire for social acceptance, they reported caution in establishing trust and relationships, making social support all the more valuable. In one participant's words:

> …Once you let it out, start talking with somebody that you feel comfortable talk[ing] to, that you knew that it ain't going to go running across town and told. Well it's like somebody's taken plastic from your nose and mouth that's had you smothered. It's a big relief, you know
>
> (Male, 52).

Participants recognized social support as having a role in coping and recovering from trauma by fulfilling the desire for unconditional love and acceptance. The participant's role of parent/caregiver served as a source of coping through social support for the majority (N = 13) of participants. They were motivated to stay healthy and substance-free in order to reciprocate love and to care for those around them. Various participants reported finding purpose in being able to provide care and be present for others, whether it be a parent, spouse, child, sibling, or taking care of church members. One participant often referred to how proud he was of his daughter and how much meaning he found in his strong bond with her. Having shared his history of trauma, including his HIV diagnosis, with his daughter, he felt relief in being able to be open and honest with her and knowing she still loved him, stating: *"But like I said, I have my daughter, when I go through anything I can just absolutely be honest with her"* (Male, 54). Another participant noted how his two sons motivated him to seek recovery from substance abuse and to stay clean, stating:

> "Right there before I got clean and I had marks all up and down my hands then. My little boy, he was about 2 or 3, and I had him on my lap… and he said, "Dad…" [gesturing to the top of his hand], and it cut my heart. And it wasn't too long after that that I got clean."
>
> (Male, 65)

This same participant also repeatedly referred to his responsibility of caring for his brother who has a disability as motivation to stay healthy. *"My purpose is caring for my brother… my mother died, and I just felt that my purpose is being here is for him and I don't want to mess that up no kind of way"* (Male, 65).

**Support groups and treatment centers.—**Seeking help from various support groups and treatment centers was also identified as a positive coping mechanism and source of social capital to promote feeling heard and understood: *"Now that PTSD group stuff, Daymark and all that stuff helped, it did"* (Female, 45). Participants often mentioned a feeling of relief in being able to speak openly about their traumas with others and not having to worry about being judged. One participant recalled his experience of contacting his Alcoholics Anonymous sponsor after receiving the HIV diagnosis: *"I wanted to go get high when the doctor told me, told me and there was like a war inside of me, but once I* *told somebody it took all of the power away"* (Male, 65). Another participant also positively remarked on speaking about her trauma while in a treatment program, stating:

> "The lady, after I completed the program, that's when she first said I needed to bring it out, talk about this, talk about that, and I did. She said you have to forgive, and I did, and from then on I'm just okay"
>
> (Female, 55).

**Religion.—**Five participants discussed religion and spirituality, often speaking positively of their faith in God, prayer, and church attendance. One participant said,

> "I was in search of something and I really didn't find it until I got saved years later, until I changed my ways… I never questioned God because I know He was with me, because He said He'd never leave me or forsake me"
>
> (Female, 54). Another participant remarked similarly:
>
> "…the Lord's really been doing some amazing work in me and through me…but I think the Lord guarded me with that… He didn't cause it, He allowed it, and I acted inappropriate, too quick, too young…God gives you the grace for a war that's about to be raged on your life…"
>
> (Male, 30).

Instead of turning against or placing blame on religion, participants reported accepting responsibility for their past actions that brought them to their current situations and credited God with seeing them through their struggles.

## Discussion

Qualitative interview data provides us a rich context for better understanding the lives of PLWH. For this sample of 15, primary trauma-related themes include: 1) personal trauma is common and has lasting psychosocial effects, 2) it influences perceptions and behaviors related to sexual and reproductive health, and 3) it is often addressed with positive coping mechanisms. In their interviews, many participants shared accounts of serial traumas. These descriptions often blurred lines between the chronology of the events, causality/directionality, and the impact of the HIV diagnosis. Whether or not HIV was considered a trauma was sometimes unclear. It is uncertain if the "blurring" is a function of the participant's perception/expression of events, or the nature of the interview itself. The traumas described by participants varied greatly in type, frequency, impact, and length of time since occurrence. The psychological effects of traumas/HIV among these participants are immense, and for most require daily coping and ongoing social support.

### Psychosocial effects

We found that the psychosocial effects of trauma often manifested as anger, anxiety, suicidal ideation, isolation, and distrust. For many, finding positive coping mechanisms helped them avoid self-destructive behaviors and negative psychosocial effects of trauma. Spirituality was often cited as a coping mechanism, which may be somewhat specific to the culture of the southeastern United States [24, 25]. The interview experience itself was sometimes seen as a form of therapy, and many participants expressed gratitude for the ability to participate. The fact that some participants shared experiences that previously had not been disclosed points to the importance of social support in coping regardless of the context or source, as well as reiterating the need for additional research on the topic of trauma and trauma-informed care for PLWH [26].

### Sexual and Reproductive Health

Interestingly, trauma was seen as both a motivation for having children and as a reason to stop having children. Although many participants were past reproductive age at the time their trauma occurred, some participants found that their reproductive health behaviors changed as a result of their experiences of trauma. While we did not see trauma play a large role in reproductive decision-making for PLWH in this study sample, we did have one participant who experienced mother-to-child transmission of HIV. Although mother-to-child transmission rates are around 2% with anti-retroviral treatment, the participant who transmitted HIV to 1 of her 2 children saw the rate as 50% and afterwards chose tubal ligation as permanent birth control [17].

### Positive Coping Mechanisms

Participants recognized their need for healthy coping mechanisms in order to deal with the complicated psychological impact of HIV/trauma across many domains of life. Participants were very open to sharing about past trauma and offered insight into how their trauma shaped their lives. Most participants expressed a desire for companionship and love that was hard to find with a history of trauma and an HIV diagnosis. Many of the participants with children saw them as sources of unconditional love and support and have worked hard to make their children’s lives better than their own.

In this study, 9 participants described substance abuse within their families and in their own lives, which is consistent with data showing high prevalence of substance abuse among PLWH [27].

Participants often turned toward support groups and treatment centers as a coping mechanism. The role of faith-based coping resources also merits further investigation since that was a common theme with this sample and in the southeastern United States in general [28].

## Limitations

A chief limitation of this study is selection bias. Volunteering to be interviewed on this subject may have selected for participants who are doing relatively well in their treatment and recovery processes, as those who are doing poorly may be less likely to volunteer to discuss their experiences. This could also explain in part the high degree of positive coping described. Additionally, the participant selection and content of the trauma narratives might have been affected by the surrounding context of the parent study centered on HIV, aging, and psychosocial stress. Younger participants or those with newer HIV diagnoses may have different experiences. It is also difficult to interpret the distinction between discrete trauma experiences and the diagnosis of HIV, leading to potential information bias.

Participants often discussed their lives with HIV and personal traumas interchangeably in terms of catalysts for behaviors and beliefs and may have identified their HIV diagnosis as a source of trauma more readily due to their understanding that the study was being done specifically with PLWH. Despite these limitations, the study results offer insight into traumatic experiences and their consequences for PLWH.

## Benefits

Seven participants expressed relief and gratitude for the chance to talk about their experiences with trauma during the interviews. Not only was the opportunity personally liberating for these participants, but they also felt that it might be helpful for others. Two participants spoke about experiences they had never shared with anyone before.

In future studies, the roles of addiction and institutional distrust should be more closely examined since these themes occurred repeatedly without direct prompting. Three participants cited institutional distrust, while 9 mentioned addiction. Taking the impact of addiction and institutional distrust into account can direct interventions to support comprehensive trauma-informed health care for PLWH.

## Conclusion

This study contributes knowledge to an area where there is increasing need in terms of patient care and best practices for PLWH who have prior trauma histories. A trauma-informed health care practice can identify patients who have experienced trauma, educate patients on the effect of past traumas on health, and can provide appropriate resources such as access to social work and behavioral health when needed [26]. This study highlights the importance of social support in coping with trauma and affecting health-related behaviors as well as illustrating the need for additional research on the topic of trauma and trauma-informed care for PLWH. Incorporating histories of trauma when examining health behaviors perceptions can contribute to building more comprehensive and effective models with which HIV care providers can better understand their patients and provide a high level of trauma-informed and compassionate care.

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## TABLE 1.

Participant Demographics (N = 15)

| **Characteristic** | **Median (Range) or Count (%)** |
|---|---|
| Age (years) | 54 (30–65) |
| Sex | |
| Male | 6 (40%) |
| Female | 9 (60%) |
| Race | |
| African Amerlcan/Black | 10 (67%) |
| White (non-Hispanic) | 5 (33%) |
| Highest grade or year of school completed | |
| 11th grade or less | 4 (27%) |
| High school or GED[*] | 7 (47%) |
| Some College | 1 (7%) |
| College or higher | 3 (20%) |
| Mean duration of HIV infection (years) | 20 years |
| Sexual orientation | |
| MSM[a] | 4 (27%) |
| WSM[b] | 9 (60%) |
| MSW[c] | 2 (13%) |
| MSB[d] | 1 (7%) |

[*] GED = General Educational Development

[a] Men who have sex with men

[b] women who have sex with men

[c] men who have sex with women

[d] men who have sex with both men and women

## TABLE 2.

Categories of Self-identified Trauma Experiences by Frequency

| **Types of Traumas Discussed**[*] | **N (%)** |
|---|---|
| Personal loss | 8 (53) |
| Personal illness | 7 (47) |
| Sexual assault/abuse | 6 (40) |
| Physical assault/abuse | 3 (20) |
| Psychological abuse | 3 (20) |

[*] There were 15 participants in the study, but 13 reported multiple trauma types. For example, an individual could report both sexual and physical assault.