Caring for Persons with Early Childhood Trauma, PTSD, and HIV: A Curriculum for Clinicians

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Abstract

Adherence to medical care enables persons with HIV and access to care to live longer and healthier lives. Adherence to care improves quality of life, prevents progression to AIDS, and also has significant public health implications. Early childhood trauma-induced posttraumatic stress disorder (PTSD) is one factor that has been identified as an obstacle to adherence to both risk reduction and HIV care. We developed a four-hour curriculum to provide clinicians with more confidence in their ability to elicit a trauma history, diagnose PTSD, and address trauma and its sequelae in persons with HIV in order to improve adherence to medical care, antiretroviral medications, and risk reduction. The curriculum was designed to address the educational needs of primary care physicians, infectious disease specialists, psychiatrists, other specialists, psychologists, social workers, nurses, residents, medical students, and other trainees who provide care for persons infected with and affected by HIV.

Keywords: early childhood trauma, PTSD, HIV, AIDS, risk reduction, HIV clinicians, curriculum, nonadherence

The pain of brutal physical, sexual, and emotional trauma during childhood is often intolerable and is associated with posttraumatic stress disorder (PTSD) and defensive psychic numbing, dissociation, and dependence on alcohol and other substances to anesthetize residual pain. Childhood trauma-induced PTSD is multifactorial in nature and can have familial, cultural, ethnic, socioeconomic, and political determinants. Trauma can be caused by sex trafficking of the young, physical or sexual abuse by parents, siblings or other family members, or sexual molestation by teachers or spiritual leaders. Severe emotional trauma can be caused by neglect, deprivation, parental illness, injury, or death, and witnessing violence at home. Mutliple traumatic events and retraumatization increase chances of developing PTSD and increase morbidity in PTSD. Adolescent and adult survivors of severe childhood trauma may have risky sexual behaviors and poor partner choice, engage in commercial sex work, eating disorders, substance use disorders, and vulnerability to HIV infection and nonadherence to HIV risk reduction and medical care (1-10). Victim blaming is commonplace in sexual perpetration (11), which can lead to further isolation, less social support, and more risky behaviors in trauma

survivors. Risky behaviors include unprotected sexual encounters, non-disclosure of HIV seropositivity to sexual partners, and sharing of needles or drug paraphernalia in injecting drug users. These behaviors can lead directly to transmission of HIV infection and have serious public health implications. There are also indirect risks for HIV transmission. These risks include high rates of sexual contact with multiple partners, sexual contact with injecting drug users, and sexual abuse (in which women are particularly vulnerable to HIV infection). Furthermore, alcohol and other substances such as cocaine and methamphetamine are associated with intoxication, disinhibition, and riskier sexual behaviors. Some drug users practice unsafe sex with multiple partners in exchange for drugs or money, providing a bridge for HIV to spread from high HIV prevalence populations to the general population. While transmission of HIV is multifactorial, prevention of transmission is possible through adherence to risk reduction, HIV medical care, and antiretroviral medication.

Adherence to HIV medical care and antiretroviral medication has positive patient outcomes with decrease in viral load to undetectable (12-15). The higher the viral load, the easier it is to transmit the virus and lower or undetectable viral load is correlated with lower transmission rates. Thus, through recognition and treatment of childhood trauma-induced PTSD, we may be able to decrease the spread of HIV by improving adherence to risk reduction behaviors and HIV care.

The relation between early childhood PTSD and HIV infection is strong and complex and the two conditions have many risk factors in common (16). A history of traumatic events or symptomatic PTSD can be obtained in many persons living with HIV (17). In one study, 65% of persons living with HIV infection reported being sexually abused as children (7). On the other hand, PTSD has been shown to impact the functioning, medication adherence, and levels of depression in people living with HIV and to be associated with more readily detectable viral loads (18, 19). Depression, a common comorbidity of PTSD in people living with HIV (20), is also associated with lower CD4 levels and treatment adherence (21). Most prevalence studies of psychiatric disorders in persons with HIV and AIDS do not include assessment for PTSD. The early prevalence studies (22-24) included major depression, dysthymia, generalized anxiety disorder, panic attacks, and substance use disorders. The reasons for lack of inclusion are

multifactorial. These include diagnostic factors, diversity of populations studied, vast changes in the HIV pandemic, and political and financial issues relevant to research funding. Initial studies were comprised of case reports and case series. Early prevalence studies focused primarily on gay men in high endemic areas or on high-endemic geographic areas of the world. Since PTSD is hard to diagnose and often associated with other psychiatric disorders, it may be easily overshadowed in population-based surveys. The most frequently cited prevalence study is that of Bing and colleagues (24) and does not include PTSD. Despite the strong interrelation, PTSD is often not diagnosed at all in general prevalence studies of psychiatric disorders in persons with HIV and AIDS but has been documented in small prospective and retrospective studies of other issues in ambulatory HIV clinics and an AIDS nursing home (25-27).

Early childhood trauma-induced PTSD may result in nonadherence to risk reduction and HIV medical care. HIV clinicians may lack access to HIV psychiatrists and other mental health professionals. Clinicians can benefit from understanding how to evaluate for early childhood and other trauma and how to diagnose and treat PTSD, which can in turn lead to improvements in patient and clinician satisfaction as well as in outcomes of care.

Members of the Academy of Psychosomatic Medicine HIV/AIDS Psychiatry Special Interest Group (28) and the World Psychiatry Association Section on HIV Psychiatry developed this curriculum in response to information gathered in a region-wide needs assessment by the Pacific AIDS Education Training Center at Charles R. Drew University of Medicine and Science (See Appendix A). The needs assessment included key informant interviews by leading clinicians in high volume HIV clinics. One such location, the OASIS Clinic, specializing in providing care to underserved populations in South Los Angeles, serves 1500 registered patients ranging in age from 10 to 88 years; 84% are men, 14% women and 2% transgender. The patient population is comprised of 65% African-American, 34% Latino, and 1% Caucasian individuals. Clinicians serving the patient population include four HIV physicians, one nurse practitioner, eight nurses, five social workers, 3 social work interns, 3 case managers, and four part-time substance abuse counselors (student interns working under supervision). There are no psychiatrists.

In his key informant interview, Dr. Wilbert Jordan, Medical Director of the clinic, identified untreated trauma as the single most significant barrier to treatment adherence in his clinic. Local Master's level HIV mental health clinicians identified untreated trauma as one of their top

three training needs. Implementation of this curriculum led to improvement in the ability of HIV clinicians to help their patients with trauma and PTSD adhere to care (see Appendix B).

Curriculum Goals and Objectives

The goal of this curriculum is to provide HIV clinicians with more confidence in their ability to elicit a trauma history, diagnose PTSD, and address trauma and its sequelae in persons living with HIV in order to improve adherence to medical care, antiretroviral medications, and risk reduction. In particular, it is expected that upon completion of the curriculum, participants will be able to:

1. Integrate the assessment for early childhood and other trauma into routine history taking
2. Understand and interpret the signs and symptoms of trauma sequelae
3. Diagnose PTSD
4. Develop a differential diagnosis of psychiatric disorders associated or concomitant with PTSD
5. Formulate treatment approaches for their HIV-positive persons living with a history of trauma
6. Improve adherence to risk reduction, medical care, and antiretrovirals
7. Enhance the therapeutic alliance with traumatized patients

It is often difficult to elicit trauma histories from anyone who has been exposed to physical, sexual, or emotional trauma, especially during childhood. Persons who have been abused as children may have amnesia for the experience, may repress the abuse, or may feel ashamed for having caused, deserved, or instigated the abuse. In addition, survivors of abuse may feel guilty and ashamed of their participation in the event even if it was accompanied by threats of death to themselves or others for disclosure. Childhood trauma perpetrated by parents, siblings, parental surrogates, or other close relatives causes disruptions in secure attachments and bonding during critical phases of development, which results in long-term difficulty with trust in authority figures such as teachers, employers, or clinicians. Therefore, education about trauma and its sequelae as well as trauma history taking can be of help in gaining patients' trust, acquiring a

better history, and improving adherence. This curriculum is designed to provide the knowledge and skills needed to manage the clinical encounter with such patients.

The course is implemented through a written curriculum, PowerPoint presentations and slide handouts, a bibliography (29), two textbooks (30, 31), and a four-hour interactive training program. This four-hour training program is described below and can be accessed online at http://hivtrainingcdu.org/hivandptsd (29). The program that was developed and implemented was designed as a four-hour intensive program to fit the schedule and needs of clinicians at a very busy HIV clinic.

Taking a Trauma History

The first hour of the course teaches how to prepare for and conduct a trauma assessment in a sensitive and compassionate way utilizing both routine history taking and a trauma checklist. Course participants are taught how to provide a safe, non-stigmatizing setting before starting a trauma assessment, which is essential for a successful clinical encounter.

The first hour also provides a brief introduction to some of the screening instruments that have been validated or are commonly used in the HIV-infected population. For a description of other psychiatric screening instruments developed for use in medically ill patients, refer to references 30 and 31. Some of the instruments covered in this session include the Hospital Anxiety and Depression Scale (33), distress thermometer, Beck Depression Inventory, Beck Anxiety Inventory, 16-item substance abuse (SA)/mental illness (MI) Symptoms Screener (SAMISS), Client Diagnostic Questionnaire (CDQ), and TSC-40 Trauma Checklist.

Participants learn about providing an interview setting with the right balance of privacy and sense of security for the patient, ways to start the interview with particular emphasis on greeting and handshaking, reassuring the patient about confidentiality of his/her information, using information elicited by questionnaires, and time management of the session. The hour concludes with some specific techniques and questions for eliciting clinical history of traumatic events since many patients have a hard time discussing or even remembering such a history.

Diagnosis of PTSD Including Differential Diagnoses

PTSD is of particular importance in caring for persons with HIV disease because of its association with non-adherence to risk reduction and medical care (33, 34). Intimate partner violence and childhood emotional, physical, and sexual trauma are all risk factors for HIV infection as well as for PTSD. The estimated prevalence of PTSD in persons with HIV and AIDS ranges from 30% (16) to 42% (35).

The second hour of the course provides a review of the diagnostic criteria for PTSD, techniques for eliciting a PTSD history, and differential diagnosis in HIV-positive population. PTSD is often overshadowed by other multimorbid psychiatric disorders in persons with HIV and AIDS. Diagnosis is further complicated by repression or retrograde amnesia for traumatic events, fear of stigmatization, difficulties with forming trusting relationships, and non-adherence to care.

Differential diagnosis is extremely extensive and includes a wide range of anxiety disorders as well as other psychiatric diagnoses in persons with HIV and AIDS, including mood disorders, cognitive disorders, substance use disorders, and some of the manifestations of HIV infection that can masquerade as psychiatric illness (36).

Brief Didactic Discussion of Basics of Caring for Survivors of Trauma and Treating PTSD

Through presentation of two case vignettes, the third hour is dedicated to an interactive discussion of some of the basic treatment options. Some of the treatment modalities discussed in this hour include crisis intervention, individual psychodynamic psychotherapy, couple and/or family therapy, bereavement therapy, psychoeducation, cognitive behavioral therapy, supportive group psychotherapy, supportive individual psychotherapy, drug and alcohol treatment, and pharmacotherapy. The majority of self-help resources for survivors of trauma are specific for survivors of sexual trauma and incest. We have found one program that accepts survivors of any childhood abuse including physical, sexual, emotional abuse and neglect. This program, the Adult Survivors of Childhood Abuse (ASCA) Support Groups (ascasupport.org) is available online as well as in support groups throughout the United States. The program also encourages the use of psychiatric care, encourages its members to be in psychotherapy and provides a more comprehensive approach to survivors of trauma. ASCA groups are 21-step self-help groups that can serve as an important adjunct to psychotherapy. The *ASCA Survivor to Thriver* Manual (37),

accessible at http://www.ascasupport.org/manual.php, is an excellent resource for survivors and their caregivers. Alcoholics Anonymous and other 12-step self-help programs are important resources where indicated.

Application of Concepts

In the last hour, clinicians present their patients with trauma and nonadherence and the instructor and other attendees discuss the evaluation and management, providing feedback on the quality of care provided.

Curriculum Evaluation

In order to evaluate the quality of the teaching, pre- and post-tests were designed to assess knowledge and were given before and after the training (see Appendix B). These demonstrated and increase in knowledge about trauma history-taking as well as an improvement in ability to recognize PTSD. The curriculum was evaluated by questionnaires asking participants' opinions about the degree the lecture met the course objectives, relevance to clinical care, novelty of material provided, and quality of teaching. Results were indicative of self-reported knowledge gain, improved ability to provide quality care and increased clinician confidence (see Appendix C). In the future we recommend building in the evaluation of the *effectiveness* of the curriculum in changing patient outcomes. This evaluation might include measures of pre- and post-training CD4s and viral loads, missed appointments, inpatient admissions, emergency room visits, and patient and clinician satisfaction rates. We also recognize that the implementation of this curriculum in four hours presents limitations and that a six two eight hour program would allow for more participation, interactive learning, and integration.

Conclusions

The curriculum that we designed and implemented for clinicians and trainees in an HIV clinic may have broader implications for educators as well as for public health. By learning how to take a trauma history and recognize and treat PTSD in persons with HIV, clinicians and trainees may be able to help improve adherence to risk reduction and HIV medical care. This in turn, can decrease HIV transmission and improve morbidity and mortality in persons with HIV and AIDS.

This curriculum can also improve clinician satisfaction since caring for nonadherent individuals can be frustrating and distressing.

Although a curriculum is not a substitute for psychiatric consultation and treatment, we hope that this educational model will be used as a means of enhancing clinical knowledge for staff at other treatment centers with similar needs and limited access to HIV psychiatrists and other mental health professionals.

Conflict of Interest

The authors have no conflict of interest.

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Appendix A Needs Assessment

Final Sept 1, 2009

PAETC Needs Assessment:

Key Informant Interview: Clinician

Question: What have been the biggest challenges in providing HIV care to patients over the past 2 years?

I. Challenges with Patients?

Probe:

1. What is your clinic policy on clinical management of HIV infected patients (keep or co-manage?)
2. Have you had difficulty

   retaining patients in care?

   a. Why have your patients fallen out of care? How have you addressed that?
   b. Issues with co-morbidities? Psychosocial issues? (substance use? Homelessness? Else?)
   c. What is your referral network?

   With patient adherence to ART meds? other?

II. Challenges with Providers (questions are for all members of the care team)?

Probe:

1. What are your workforce challenges?
   a. Turnover? Unfilled vacancies? Reasons for?
   b. Comfort with treating underserved populations (race/ethnicity, gender, trans, sexual orientation, homeless, corrections or former corrections)
   c. Comfort with managing treatment failure, resistance, STI screening, lipids, else?

2. What are your workforce strengths?
   a. ancillary resources you currently have that are or could be used to support HIV-infected pts? (diet, MH, CM, SW, alternative provider – i.e. acupuncture)

3. How do you assess your provider's knowledge and skill level?
   a. compliance with DHHS guidelines etc?
   b. do you trust your own tracking system?

c. how do you conduct staff development (how are your providers trained currently?)
d. future needs/skills/knowledge and types of providers

4. What has the AETC's role been with your clinic? How have we supported provider training? How would you like us to support provider training?

III. Clinic trends?

Probe:

1. What have been the biggest changes in the way your clinic has structured or restructured HIV care for patients, including changes in policies and procedures, patient demographics, and tracking patient care over the past 2 years?

2. What changes have you seen in your new HIV patients in the following areas
   a. demographics: age, sex, trans, race/ethnicity, sexual orientation, behavior, stage for incidence cases)
   b. co morbidities? (substance abuse, STI?)
   c.
3. What major gaps do you see?

4. Regarding issues we discussed today (*mention whatever they are -- i.e. changes in patient population and gaps*) -- can you comment on how you have integrated these issues translated into training topics for your providers or capacity building activities for your clinic infrastructure?

5. What do you see as future issues for the next 2 years?

6. Is there anything else you would like to add?

IX. Key Informant Interviews

✧ ***Los Angeles County***

Clinician key informant interviews were conducted with 4 medical providers in Los Angeles County.

◆ <u>Charles Drew University</u>

Phil Meyer, LCSW conducted a clinician key informant interview with Dr. Wilbert Jordan, Director of the OASIS Clinic in South Los Angeles

Clinic trends. Dr. Jordan reported that there has been a sharp increase in adolescents and women patients, both Latina and African American in his clinic. The overall patient population is aging. People are living longer and, along with HIV, have to contend with age-related health issues. The clinic has recently hired a bilingual/bicultural doctor to treat its ever-expanding Latino population. This move has served to increase the satisfaction of the clinic's Latino patients.

Patients. Co-morbidities are on the rise, with increasing numbers of patients living with co-existing substance abuse and mental health disorders. Drugs of choice in this region are crack cocaine and Vicodin (especially challenging because it is on the ADAP formulary and frequently requested for pain management). He sees a great deal of failure in substance abuse treatment because his patients are going into treatment at the direction of someone else, rather than being ready for treatment themselves.

Dr. Jordan noted that careful screening for substance abuse and mental health issues needs to be completed before treatment decisions are made. He believes that each patient should be seen by a mental health professional to help assess his/her readiness to adhere to treatment. He notes special challenges in the "incredibly high" incidence of childhood sexual abuse in his patient population and sees a gap in the expertise and number of mental health professional available to treat these issues. The history of childhood sexual abuse, along with chronic exposure to other traumas leave many of his patients feeling that they are really not worth taking care of … and this belief effects treatment in every way. As a result, many of his patients dealing with these issues are falling out of care. He cited that childhood trauma, along with substance abuse were the greatest barriers to adherence in his clinic.

Homelessness was identified as yet another key factor that affects adherence. He sees homelessness as a prevention issue – many of his young male patients who do not have stable living situations will have sex with men in order to have a place to stay for the evening.

Training Needs. Dr. Jordan believes his staff is already well trained – all of the doctors and practitioners providing services are certified HIV specialists and/or nationally recognized experts on HIV treatment. He does see the need to train staff on how to identify people with substance abuse and mental health issues at the very beginning of their treatment. Additionally, Dr. Jordan emphasized the importance of PAETC helping to bring more people "into the fold" – bringing new providers "up to speed;" and recommended that training efforts be discipline specific and not so general.

Appendix B Before and After Evaluation of Knowledge

1. Ideally, an initial psychological or psychiatric assessment in an HIV-positive person who reports a history of traumatic life events should include (you may pick more than one option):
   a. Assessment of mood or anxiety-related complaints
   b. Assessment of cognitive function
   c. Assessment of substance abuse history, current or prior
   d. Assessment for psychotic symptoms
   e. a and c
   f. a, b and c
   g. all of the above
2. HIV-positive persons who have experienced trauma may:
   a. Report amnesia
   b. Demonstrate repression of horrific events
   c. Refuse to discuss the traumatic event
   d. Demonstrate difficulty in developing trusting relationships with their clinicians
   e. Both a and b
   f. Both c and d
   g. All of the above
3. A clinician should avoid inquiring about history of traumatic events unless the patient mentions the traumatic history first. Select one: TRUE OR FALSE
4. A history of trauma is significant in evaluating for trauma sequelae *including all of the following except:*
   a. Dissociative symptoms
   b. Eating disorders
   c. Substance use disorders
   d. Commercial sex work
   e. Schizophrenia
5. The differential diagnosis of PTSD includes schizophrenia and schizoaffective disorder.

   Select one: TRUE OR FALSE

6. Which of the following are appropriate psychotherapeutic modalities useful in the treatment of PTSD:

a. Individual psychodynamic psychotherapy

b. Couple and/or family therapy

c. Bereavement therapy

d. Psychoeducation

e. Supportive group/individual psychotherapy

f. All of the above except C

g. All of the above

7. Characteristic clinically observable signs and symptoms of posttraumatic stress disorder *can include all of the following except:*

a. Jumpiness (easy startle)

b. Cognitive impairment

c. Fearfulness

d. Watching the doorway or glancing around frequently

e. Restlessness

f. Emotional numbing

g. Tachycardia

8. Acute Stress Disorder symptoms associated with progression to PTSD include the following:

a. Numbing

b. Depersonalization

c. Sense of reliving the trauma

d. Motor restlessness

e. Occurrence within 30 days of the trauma

f. All of the above except E

g. All of the above

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Appendix C Clinician Program Evaluation Form

Program Date: 1-19-2011 **Program Title:** HIV and Post Traumatic Stress Disorder	To create your unique ID number, use the month and date of your birth, and the last four digits of your social security number. For example, May 29,123-45-6789 has the ID number 05296788.	**Your Unique ID Number** DOB: Mo. Date Last 4 Social

PROGRAM QUALITY

1. How would you rate the overall quality of the program?

1 2 3 4 5

Poor Excellent

2. How well did this program meet the stated learning objectives?

1 2 3 4 5

Poor Excellent

3. How would you rate the program content?

1 2 3 4 5

Poor Excellent

4. How would you rate the program format?

1 2 3 4 5

Poor Excellent

5. How would you rate overall quality of the faculty?

1 2 3 4 5

Poor Excellent

6. How would you rate the usefulness of this subject matter to your daily practice?

1 2 3 4 5

Poor Excellent

7. Would you recommend this training to your colleagues?

Yes No

8. Was the material presented in a manner that was free from commercial bias? Yes No

PROGRAM IMPACT

BEFORE Training			**AFTER Training**	
Novice	Expert	9. How would you rate your level of **knowledge** about	Novice	Expert

Novice Expert 1 2 3 4 5	9. How would you rate your level of **knowledge** about this content?	Novice Expert 1 2 3 4 5
1 2 3 4 5	10. How would you rate your overall **ability** to provide quality HIV care/services?	1 2 3 4 5
1 2 3 4 5	11. How would you rate your **confidence** to provide care/services to persons with HIV/AIDS?	1 2 3 4 5

12. I can apply the information or skills learned in my practice/service setting. **1** **2** **3** **4** **5**

Disagree strongly Agree strongly

13. Which *specific skill and/or information* that you learned will you use in your work with HIV/AIDS patients?

____

14. *How* will you apply the information or skill to your work? ______________________________

____

15. Rate your level of knowledge or skill for each learning objective (LO) before the training program and after the program.

Before Training				**After Training**		
Low	Medium	High		Low	Medium	High
1	2	3	*LO1: Understand and interpret the signs and symptoms of trauma sequelae*	1	2	3
1	2	3	*LO2: Develop a differential diagnosis of psychiatric disorders associated with or concomitant with PTSD*	1	2	3
1	2	3	*LO3: Through didactic presentation and case examples formulate*	1	2	3

PACIFIC AIDS EDUCATION AND TRAINING CENTER

PROGRAM EVALUATION FORM – Levels 1, 2, 3

COMMENTS AND FUTURE PROGRAMS

Which aspect(s) of the training were **most effective or useful**?

Which aspect(s) of the training **needed improvement**?

What are your suggestions for **future** HIV/AIDS-related continuing education programs?

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