Mental and Behavioral Health in HIV Care: Reducing Obstacles, Building Resilience

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Disclosures

This speaker has no significant financial relationships with commercial entities to disclose.

This slide set has been peer-reviewed to ensure that there are no conflicts of interest represented in the presentation.
At the end of this presentation participants will be able to:

1. Define the concept of “person-centered care.”
2. Define the term mental/behavioral health and discuss features of poor mental/behavioral health that create challenges for HIV linkage and engagement in care.
3. Explain the meaning of the term trauma-informed care and give an example of a strategy that integrates trauma-informed care into the healthcare setting.
4. Discuss the term resiliency as it relates to a person’s emotional wellbeing.
5. Identify communication strategies and techniques that assist medical case managers talk about behavioral health issues with individuals infected with HIV in a culturally conscious manner.
Workshop Agreements

- Learning is Fun!
- Be curious
- One voice
- Respect Other’s Opinions
- Don’t Yuck Someone’s Yum
- Land the Plane
Getting to Know You Activity
Mentimeter Question #1
What is Your Favorite Color?
What Does This Mean to YOU?

- “When you change the way you look at things, the things you look at begin to change!”

  Wayne Dyer
Mental Health/Behavioral Health

- **Mental health** is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”¹

- It is estimated that only about 17% of U.S adults are considered to be in a state of optimal mental health.² There is emerging evidence that positive mental health is associated with improved health outcomes.

Mental Illness

- Defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.”
Mental Health/Mental Illness

- Continuum - not static

Mental health

Mental illness
The Components of Mental Health

- Physical
- Biological
- Social
- Emotional
- Cognitive

Positive mental health is an important part of staying healthy when living with HIV.
Behavior Defined

1. **a:** the manner of conducting oneself  
   **b:** anything that an organism does involving action and response to stimulation  
   **c:** the response of an individual, group or species to its environment

2. The way in which someone behaves

3. The way in which something functions or operates
Behavioral Health Constructs

Emotional well-being

- Emotions are skills for living
- Important to recognize our emotions so that we can know ourselves
- Behavior helps us to control our emotions
- Allows us to recognize emotions in others.
- Helps us formulate relationships and collaborate with others
Behavioral Health Constructs

Psychological well-being
- self-acceptance
- personal growth
- spirituality
- self-direction
- resiliency
Behavioral Health Constructs

**Social well-being**
- social acceptance
- sense of community
- feelings of self-worth and the ability to contribute to society
The Benefits of Diagnosing and Treating Individuals for Behavioral Health Disorders

- Decreased morbidity and mortality
- Improved quality of life
- Reduced transmission of HIV virus
Facilitators and Barriers to Receiving Behavioral Healthcare

**Facilitators**
- Accessible Integrated Healthcare
- Normalization of Behavioral Health Care

**Barriers**
- STIGMA
- Lack of Problem Awareness
- Denial Related to Fear of Consequences
- Limited Behavioral Health Treatment and Care Resources
The Effects of Culture on Mental Health

How does culture affect the definition of mental illness?

- In some cultures mental illness is *incomprehensible* – there is an inability of the general population to understand the motivation behind the behaviors; this causes stigma and shame for the individual and their relatives.

- Culture often determines those individual and group behaviors that are deemed appropriate and inappropriate in a society; this is called *cultural relativity*.

Culture, HIV and Mental Illness

- Beliefs, norms, values and language affect how individuals experience illness.
- Individuals and families may go to great lengths to prevent others from learning that a family member is HIV-positive and/or mentally ill.

# Co-occurring Stigma: Behavioral Health, HIV

## The Adverse Effects

Individual and family experiences of:

- disgrace and shame
- exclusion and rejection
- alienation and labeling
- exploitation and abuse
- overt and covert ridicule
- interpersonal violence

## Interventions to Mitigate

- Learning about the cultural and social aspects of stigma
- Mental health literacy, cultural awareness and person centered care strategies designed to encourage screening/testing and care seeking behaviors
HIV Stigma and Behavioral Health

- More than HIV: Judith's Story
- https://youtu.be/9Gvl1EU2nMo
Culture, HIV and Mental Illness

- Herbal treatments, special diets, spiritual prescriptions and traditional medicines exist in many cultures to treat a wide variety of conditions.

- A nonjudgmental and collaborative approach to HIV and behavioral health care helps to identify viable treatment strategies that are agreeable to the patient and the healthcare team.
Behavioral Health Services
Agreements and Coordination are Key

- Staff of different agencies working together on a case by case basis to ensure that clients receive appropriate services
- Involves all levels of staff
- Does not change the way agencies operate or the services they provide
- A agreement between partners to avoid overlap and create a culture of cooperation

“…providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensures that patient values guide all clinical decisions.”

Person-Centered Care

- Institute of Medicine Crossing the Quality Chasm: A New Health system for the 21st Century (2001)
Everything Starts with the Patient

A patient doesn’t care how much you know until they know how much you care (about them as a person).
Patients as Partners

“Instead of treating patients as passive recipients of care, they must be viewed as partners in the business of healing, players in the promotion of health, managers of healthcare resources, and experts on their own circumstances, needs, preferences and capabilities.”

Coulter (2011)
People living with HIV frequently experience…

DEPRESSION
Prevalence of Mental Illness in HIV

- Prevalence for the general population is based on a 2004 estimate using the most recent U.S. Census data, as reported in National Institute of Mental Health, The Numbers Count: Mental Disorders in America.
- "Any disorder" refers to any of the four disorders specified; no comparable data are available for the general population.

Epidemiology of Depression in HIV

- Depression is the most common mental health disorder in people living with HIV (PLWH).

- The prevalence of depression in HIV-infected clinic populations has been estimated to range from 50-60%.

- Depression is the most common reason for psychiatric referral.

- For most domains of functioning and well-being, depression is more debilitating than most medical conditions.

- Despite the high reported prevalence among PLWH, depression frequently remains undiagnosed and untreated.


Identification of Individuals with Depression and Other Behavioral Health Disorders

1. Screen
2. Assessment
3. Diagnosis
4. Treatment Goals
5. Treatment Plan
6. Evaluation
Talking or Not Talking About Emotions

The most common reasons for patients not wanting to discuss behavioral health concerns with their provider are:

- not wanting to be put on medication
- privacy of their medical records
- anxiety about who might have access to their medical files
- fear of being referred to a mental health professional
- concern of being labeled a person with a mental problem

STIGMA
Screen to Identify Major Depressive Disorder (MDD) in a Primary Care Setting

- Fewer than 50% of patients with MDD are identified by their primary care providers

Diagnostic Tools

- Diagnosis: PHQ-9; QID-SR\textsubscript{16};
- PHQ-9 and the QID-SR are reliable diagnostic tools that also provide severity parameters which can help decide on an action plan.

PHQ-9: Patient Health Questionaire-9 Kroenke et al. J GenIntern Med, 2001;16(9)606-13
Behavioral Health Assessment

- Personal Information
- Appearance
- Behavior
- Speech
- Affect and Mood
- Thought Process
- Perceptual Disturbances
- Cognition
Goals of a Behavioral Health Assessment

- Establish rapport
- Obtain understanding of problem
- Assess for risk factors & psychological functioning
- Perform mental status examination
- Identify behaviors/beliefs/areas to be modified to effect positive change
- Establish a medical diagnosis
- Discuss findings with client
- Formulate a plan of care with client
Intervention

Basic Level
- Individual and/or group counseling
- Self-care activities
- Health teaching
- Case management
- Health promotion and maintenance

Advanced Level (All or the above plus)
- Pharmacological (prescription)
- Psychotherapy
When to Refer to a Behavioral Health Specialist

- Acute risk of suicide
- Psychotic symptoms, signs of dementia or bipolar disorder
- Patients with limited or non-response to treatment
- Provider comfort level
First Line Treatment for MDD

- **Psychotherapies**: “talk therapy” like cognitive behavioral therapy (CBT), interpersonal therapy (IT), psychodynamic therapy, etc.
- **Medications**: antidepressants, most commonly, selective serotonin reuptake inhibitors (SSRIs)
- **Neurostimulation**
  - electroconvulsive therapy (ECT)
  - transcranial magnetic stimulation (TMS)
- **Combination of psychotherapy and medication**
Complementary Therapies for Depression: Rigorous research still needed

- Yoga
- Light therapy
- Physical exercise
- Mindfulness-based therapies
- Relaxation therapies
- Music therapy


National Center of Complementary and Integrative Health: https://nccih.nih.gov/health/depression.htm
Mentimeter Behavioral Health and HIV: Check your knowledge

The case manager is planning strategies to prevent behavioral health disorders among individuals living with HIV in the community. Given the top 5 leading causes of behavioral health disorders worldwide, the case manager should give priority to which one of the following areas of behavioral health?

A. Strategies to elevate mood
B. Interventions for reality orientation
C. Drug and alcohol education
D. Stress management
Check your Knowledge: Answer and Rationale

“A” is correct. Strategies to elevate mood would become the priority because major depression is the primary leading cause of mental disability worldwide and is a primary health concern for individuals living with HIV.
Outcomes Compared to Goals

Behavioral Health Disease Management Outcomes

- Identify expectations
- Outcomes refer to the end results of treatment to improve behavioral health: “mental/emotional well-being and/or actions that affect wellness”
  - Avedis Donabedian, M.D., the foremost expert on quality and outcomes

Construct Short-term and Long-term Goals

“People with goals succeed because they know where they’re going.” — Earl Nightingale
Behavioral Health Outcome or Patient Goal?

1. Patient will take antidepressant as prescribed every morning at 10am.

2. Patient will demonstrate a clinically significant reduction in baseline symptom severity as evidenced by a total score of 14 or below on the PHQ9 in 6 weeks.

3. Patient will take a brisk walk for 30 minutes every day at 5pm.
Behavioral Health Outcome or Patient Goal?

1. Patient will take antidepressant as prescribed every morning at 10am.  
   **Patient Goal**

2. Patient will demonstrate a clinically significant reduction in baseline symptom severity as evidenced by a total score of 14 or below on the PHQ9 in 6 weeks.  
   **Health Outcome**

3. Patient will take a brisk walk for 30 minutes every day at 5pm.  
   **Patient Goal**
EVALUATION

- Evaluate patient outcomes
- Additional data collection
- Reassess
- Revise plan
- Maintenance
People living with HIV often experience…

ANXIETY
Prevalence of Anxiety

- Anxiety disorders are the most prevalent psychiatric disorders in the general population (lifetime prevalence 25%)

- In individuals infected with HIV, the prevalence rate of anxiety disorders has been shown to be as high as 36%

- Cohen & Gorman (2001) found that anxiety was present in up to 70% of patients in an urban HIV clinic
HIV and Anxiety

- Anxiety: a normal response
- Anxiety: a disorder
  - Primary
    - Adjustment, panic disorder, post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), social anxiety disorder (SAD), obsessive compulsive disorder (OCD)
  - Secondary Anxiety
    - HIV-associated illness, other medical illnesses
- Anxiety: a side effect
  - Secondary to medications
    - Antiretrovirals, antihypertensives, bronchodilators, steroids
  - Secondary to drug use (stimulants, alcohol, etc.)
Anxiety and HIV

- Symptoms (Short Film about Health Anxiety)
- https://youtu.be/i5H-CggI1iw
Screening and Diagnostic Tools

Screening:
- PHQ4 or PHQ9
- Hospital Anxiety and Depression Scale (HADS)
- Hamilton Anxiety Scale (HAM-A)

Diagnosis:
- Specific modules of the Structured Clinical Interview for the DSM-V (General Anxiety Disorder)
- Mini-SPIN (Social Anxiety Disorder)
Anxiety Disorders and HIV: Screening, assessment and diagnosis

Among individuals diagnosed with HIV and presenting with anxiety symptoms, the most common disorders in order of prevalence are:

- adjustment disorder with anxious mood
- generalized anxiety disorder
- panic disorder

- Anxiety disorders are common among individuals diagnosed with depression so screen for both
- Many clinics screen patients diagnosed with HIV for both depression and anxiety every 6 and/or 12 months

Treatment of Anxiety

- Similar to treatment for major depressive disorder

- **Psychotherapies:** “talk therapy” like CBT (cognitive behavioral therapy), IT (interpersonal therapy), psychodynamic therapy, support groups, etc.

- **Medications:** antidepressants (SSRIs) and benzodiazepines
  - In substance use disorders (SUD) → buspirone, antiepileptic drugs [(AEDs) tiagabine, gabapentin]

- Combination of psychotherapy and medication

Behavioral Health and HIV Treatment and Care

CRITICAL INTERVENTIONS ALONG THE HIV CARE CONTINUUM & CLOSING GAPS IN CARE
HIV Care Continuum and Corresponding Coordination Strategies

- **Diagnosis**
  - Routine HIV Testing
  - Target Testing

- **Linkage to Care**
  - Case Management

- **Retention**
  - Case Management
  - Adherence Counseling

- **ART**
  - Case Management
  - Adherence Counseling

- **Viral Suppression**
  - Case Management
  - Adherence Counseling

- **Coordination Strategies**
  - Depression
  - Anxiety
  - Distress
  - Psychosocial Treatment and Care
  - Substance Use Disorders

- **Psychosocial Treatment and Care**
  - Depression
  - Anxiety
  - Distress

- **Viral Suppression**
  - Case Management
Living with HIV in Days, Months, Years

- After 3 years with HIV, I still get scared!
What is happening for this patient?

JM is a 39 year old Latino male, currently out of HIV care for 3 years, who is being seen in clinic for a lacerated left eyebrow and lip. He tells the Emergency Department (ED) physician that he was struck in the face by glass when some guys in a red truck threw a bunch of bottles at his truck while he was parked on the side of the road. JM’s friend brought him into the ED.

The ED physician interrupts and says, “Looks like a brawl to me. Let’s clean and stitch up that face of yours and send you home.”

The patient is wringing his hands and says to the provider, “I’m getting real tired of all of this. This whole thing makes me ‘nervios’ (nervous). I was just minding my own business. I can’t sleep at night anymore.”
You are a case manager and finished seeing one of your patients who is also in the ED. JM’s nurse stops you in the hall and tells you that JM seems very “jittery” after his scary altercation. The nurse wonders if you would see JM, if he agrees. You agree and JM agrees.

**Question #1**
How should the case manager best begin the conversation with JM?

A. Make introductions and say/ask, “Do you know who did this? I wonder what you did to deserve such a terrible thing?”

B. Make introductions and say/ask, “I am very sorry to learn about the injuries you experienced today. How are you feeling right now?”
Question #1

How should the case manager best begin the conversation with JM?

A. Make introductions and say/ask, “Do you know who did this? I wonder what you did to deserve such a terrible thing?”

B. Make introductions and say/ask, “I am very sorry to learn about the injuries you experienced today. How are you feeling right now?”
Mentimeter Question
Closing Gaps in HIV Care for JM

Question #2

What area(s) of concern should the case manager discuss with JM to ensure that any gaps in HIV care are addressed?

A. HIV status and barriers to care
B. Trauma Informed care
C. Anxiety and depression symptoms
D. Culturally responsive care
E. All of the above
Mentimeter Question
Closing Gaps in HIV Care for JM

Question #2

What area(s) of concern should the case manager discuss with JM to ensure that any gaps in HIV care are addressed?

A. HIV status and barriers to care
B. Interpersonal violence experiences
C. Anxiety and depression symptoms
D. Culturally responsive care
E. All of the above
Mentimeter Question
Closing Gaps in HIV Care for JM

Question #3

What cultural knowledge will specifically help the case manager to better explore behavioral health concerns with JM?

A. All migrant workers cannot read or write
B. Homosexuality is not a practice of Latino/Hispanic men
C. “Nervios” is a Caribbean/Latino term that describes behavioral symptoms
D. Stigma never causes shame among Latino/Hispanic males, only females
Question #3

What cultural knowledge will specifically help the case manager to better explore behavioral health concerns with JM?

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What is happening for SR?

- 43-year-old Black African American female in distress
- Age 26- diagnosed with bi-polar disorder
- Age 32- diagnosed with HIV
- Seriously suspicious of landlord who has been piping sleeping gas into her apartment for weeks
- Recently experienced death of close friend who was HIV-positive
- Patient’s sister has brought the patient to the clinic for evaluation
Mentimeter Question
Closing Gaps in HIV Care

Question #1

What should the priority of care be for SR at this time?

A. Telephone the patient’s psychiatrist, leave a message and wait for a reply.
B. Send SR and her sister back home to rest up and give more time for the antipsychotic medications to start working again.
C. Notify SR’s psychiatrist and expedite getting the patient and her sister safely to the ED for further evaluation.
D. Tell the sister that SR’s behavioral health issue is not within the primary care team’s realm of treatment and that they should go to the psychiatrist’s office for assistance.
Question #1
What should the priority of care be for SR at this time?

A. Telephone the patient’s psychiatrist, leave a message and wait for a reply.
B. Send SR and her sister back home to rest up to see if the antipsychotic medications she restarted will start working.
C. Telephone SR’s psychiatrist and develop a plan with the sister to get SR safely to the hospital for admission for rest and stabilization.
D. Tell the sister that SR’s behavioral health issue is not within the primary care team’s realm of treatment and that they should go to the psychiatrist’s office.
Question #2

Once SR’s acute behavioral health problem has been stabilized, what should the priority of care be to address the patient’s HIV and primary health care?

A. Assess the patient’s knowledge of safe-sex practices
B. Discuss and encourage adherence to mood stabilizing and antiviral medications
C. Assign a peer advocate to escort the patient to weekly group therapy sessions for person’s living with severe mental illness and HIV
D. Screen the patient for evidence of a mood disorder so that she can be permanently placed in a group home for the severely mentally ill.
Question #2
Once SR’s acute behavioral health problem has been stabilized, what should the priority of care be to address the patient’s HIV and primary health care?

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D. Screen the patient for evidence of a mood disorder so that she can be permanently placed in a group home for the severely mentally ill.
Nonjudgmental Integrated HIV and Behavioral Health Care

COMMUNICATION AND BEHAVIORAL CONSIDERATIONS
Behavioral Health Disorders
Communicating with Patients

- **Refrain** from arguing
- **Provide** a calm quiet environment
- **Speak** slowly and clearly
- **Set** boundaries
- **Practice** mental health first aid
- **Provide** trauma informed care

Empathy

4 Elements of Empathy

- See their world
- Appreciate them as human beings
- Communicate understanding
- Understand feelings

CC Michael Sahota 2012
Language Matters

Language is powerful – especially when talking about addictions. Stigmatizing language perpetuates negative perceptions.

“Person first” language focuses on the person, not the disorder.

When Discussing Addictions...

**SAY THIS**
- Person with a substance use disorder
- Person living in recovery
- Person living with an addiction
- Person arrested for drug violation
- Chooses not to at this point
- Medication is a treatment tool
- Had a setback
- Maintained recovery
- Positive drug screen

**NOT THAT**
- Addict, junkie, druggie
- Ex-addict
- Battling/suffering from an addiction
- Drug offender
- Non-compliant/bombed out
- Medication is a crutch
- Relapsed
- Stayed clean
- Dirty drug screen
Hope and Encouragement
Invite the Client to Be Curious About What They Can Do
Behaviors (What we see)
The Iceberg Illusion

Success is an iceberg

Persistence
Failure
Sacrifice
Disappointment

What People See
SUCCESS!

What People Don’t See
Goals
Dedication
Hard work
Good habits

Illustration by
Original credit to Sally Shaywitz, of the Yale Center for Dyslexia and Creativity
Strength-Based Care
Body and Mind

STRESS, TRAUMA AND DISTRESS
Positive Stress

NOT ALL STRESS IS BAD

- Eustress is positive stress
- Positive stress results in improved concentration, and increased performance, motivation and energy

- Positive stress can put strain on the body physically, emotionally and even socially, but it can be pleasurable
- Examples: running a race, taking an exam to pass a course, successful completion of a challenging task
Eustress and Performance

Stress Performance Connection

General Adaptation Syndrome
Hans Selye

Negative Stress is Distress

DISTRESS

- Loss of motivation, reduced effectiveness in performing tasks, physical, mental and behavioral consequences
- Places a great deal of strain on the body, physically, emotionally, and socially
- Examples: heavy workload, overwhelming obstacles, no rest during long work schedules, little sense of control over outcomes
Consequences of Negative Stress

Body
- headaches
- frequent infections
- taut muscles
- muscular twitches
- fatigue
- skin irritations
- breathlessness

Mind
- worrying
- muddled thinking
- impaired judgement
- nightmares
- indecisions
- negativity
- hasty decisions

Emotions
- loss of confidence
- more fussy
- irritability
- depression
- apathy
- alienation
- apprehension

Behavior
- accident prone
- loss of appetite
- loss of sex drive
- drinking more
- insomnia
- restlessness
- smoking more

http://healingartsce.com/yogaoldbodymindpg3.html
Change Direction: Address Stress

know the five signs.

Nearly one in every five people, 42.5 million Americans, have a diagnosable mental health condition. Our friends, neighbors, co-workers, and family members may be suffering emotionally. They may not recognize the symptoms or ask for help.

- Not feeling like yourself?
- Are you feeling agitated?
- Are you feeling withdrawn?
- Taking care of yourself?
- Are you feeling hopeless?

the campaign to change direction

#ChangeMentalHealth  www.changedirection.org
- The Ryan White Story 1986
- https://youtu.be/QRBHTtJfrew
SCREENING FOR STRESS AND DISTRESS

- Perceived Stress Scale (PSS)
- Life Events Checklist
- The Distress Thermometer
The Distress Thermometer

First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

<table>
<thead>
<tr>
<th>Extreme Distress</th>
<th>No Distress</th>
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<td>10</td>
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Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

**YES NO**

**Practical Problems**
- Child Care
- Housing
- Insurance/financial
- Transportation
- Work/school

**Family Problems**
- Dealing with children
- Dealing with partner
- Dealing with close
- Friend/relative

**Emotional Problems**
- Depression
- Fears
- Nervousness
- Sadness
- Worry
- Loss of interest in usual activities
- Spiritual/religious concerns

**Physical Problems**
- Appearance
- Bathing/dressing
- Breathing
- Changes in urination
- Constipation
- Diarrhoea
- Eating
- Fatigue
- Feeling Swollen
- Fevers
- Getting around
- Indigestion
- Memory/concentration
- Mouth sores
- Nausea
- Nose dry/congested
- Pain
- Sexual
- Skin dry itchy
- Sleep
- Tingling in hands/feet

**Other problems**
Life Events Checklist (LEC-5)

**Instructions:** Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you’re not sure if it fits; or (f) it doesn’t apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

<table>
<thead>
<tr>
<th>Event</th>
<th>Happened to me</th>
<th>Witnessed it</th>
<th>Learned about it</th>
<th>Part of my job</th>
<th>Not sure</th>
<th>Doesn’t apply</th>
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<td>1. Natural disaster (for example, flood, hurricane, tornado, earthquake)</td>
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<td>2. Fire or explosion</td>
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<td>3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)</td>
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<td>4. Serious accident at work, home, or during recreational activity</td>
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<td>5. Exposure to toxic substance (for example, dangerous chemicals, radiation)</td>
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<td>6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)</td>
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<td>7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)</td>
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<td>8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)</td>
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<td>9. Other unwanted or uncomfortable sexual experience</td>
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<td>10. Combat or exposure to a war-zone (in the military or as a civilian)</td>
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<td>11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)</td>
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<td>12. Life-threatening illness or injury</td>
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<tr>
<td>13. Severe human suffering</td>
<td></td>
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<tr>
<td>14. Sudden violent death (for example, homicide, suicide)</td>
<td></td>
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<tr>
<td>15. Sudden accidental death</td>
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<tr>
<td>16. Serious injury, harm, or death you caused to someone else</td>
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<td></td>
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<tr>
<td>17. Any other very stressful event or experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Stress and Distress

- FACES of HIV: Omar's Story
- https://youtu.be/PKxDWZ6s2Dg
Stress Management
TRAUMA

Trauma is a term used to describe a distressing event or events that may have long lasting harmful effects on a person’s health and wellbeing.

1. People living with HIV are more likely to have experienced trauma during their lifetime.
2. Persons who identify at LGBTQ are more likely than individuals who identify as heterosexual to have experienced:

   - Interpersonal violence (IPV)
   - Childhood maltreatment
   - Trauma to a close friend/family member
   - Unexpected death of a family member

Whetten, K et al. (2008) Trauma, Mental Health, Distrust and Stigma Among HIV-positive Persons: Implications for Effective Care, *Psychomatic Medicine* 70:531-538
Traumatic Events

WHAT IS A TRAUMATIC EVENT?

OUT OF A 100% POPULATION, 70% SUFFER FROM PTSD AFTER A TRAUMATIC EVENT

WITNESSING DEATH OR INJURY
PHYSICAL ASSAULT
COMBAT
SEXUAL ASSAULT
ACCIDENTS
NATURAL DISASTER
CHILD SEXUAL ABUSE


http://www.makingpeoplewhole.org/healing-ptsd.html
Adverse Childhood Experiences (ACEs)

- Can, but doesn’t have to result in serious short and long term health consequences
- Should be addressed in healthcare visits during childhood, adolescence and adulthood to prevent negative consequences and support healthy development and overall wellness

National Public Radio Article on ACEs
Link: https://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean
- My HIV Journey: Depression and Social Anxiety
- https://youtu.be/Si_sQGZ60XA
Intimate Partner Violence (IPV)

- physical, sexual or psychological harm caused by a current or former spouse or partner
- wide continuum of experiences
- occurs in all cultures, genders, age and socioeconomic groups
- healthcare professionals may themselves have experienced this type of distress

Mentimeter
Interpersonal Violence (IPV)

IPV occurs when one person uses power and _______ over another through physical, sexual or emotional threats or actions, economic control, isolation, or other kinds of coercive behavior.
Interpersonal Violence (IPV)

IPV occurs when one person uses **POWER** and **CONTROL** over another through physical, sexual or emotional threats or actions, economic control, isolation, or other kinds of coercive behavior.
Barriers to Screening for Trauma: Misinformation, Denial, Bias

- VLOG :: Fighting in a Same-Sex Relationship.. Is it Domestic Violence?
- https://youtu.be/nOO6wm_oJtw
“individuals with a trauma history rarely experience only a single traumatic event, but rather are likely to have experienced several episodes of traumatic exposure.”
Prevalence of Trauma in the United States

- 60% of adults experience abuse or other types of trauma during childhood
- Men are at greater risk than women for being exposed to traumatizing events
- Lesbian, gay, bisexual, and transgender persons are likely to experience various forms of trauma
- People who are homeless report high levels of trauma preceding their homeless status; additional traumas frequently occur while they are homeless

Prevalence of Trauma Among Persons Living with HIV

- Recent studies continue to report high rates of trauma among persons living with HIV (PLWH) and often at higher rates that those reported in people who are HIV-negative.

- Breezing and colleagues (2015) found reported rates of violent trauma among individuals living with HIV to be between 10 and 90%, depending on the study.

- In a cohort of men self identifying as MSM in the deep south and living with HIV the respondents who were MSM were more than twice as likely to have experienced sexual and/or physical abuse than those male respondents who identified at heterosexual.

- Among women living with HIV in the US, 61% have been sexually abused (5 times greater than the national rate).
The Effects of Trauma on Individuals

People who have experienced trauma are:

- 15 times more likely to commit suicide
- 15 times more likely to become an alcoholic
- 4 times more likely to develop a sexually transmitted disease
- 4 times more likely to inject drugs
- 3 times more likely to use antidepressant medication
- 3 times more likely to be absent from work
- 3 times more likely to experience depression
- 2.5 times more likely to smoke tobacco
- 3 times more likely to have serious job problems

https://rumpydog.files.wordpress.com/2015/03/trauma-infographic-1.jpg
Trauma to Recovery Begins with Identification

On Becoming Trauma Informed

“I’m right there in the room, and no one even acknowledges me.”
Implement Trauma Informed Care (TIC)

WHAT HELPS?
Creating a Trauma-Informed environment using the following five principles:

SAFETY

CHOICE

EMPOWERMENT

COLLABORATION

TRUSTWORTHINESS

CREATING AREAS THAT ARE CALM AND COMFORTABLE

PROVIDING AN INDIVIDUAL OPTIONS IN THEIR TREATMENT

NOTICING CAPABILITIES IN AN INDIVIDUAL

MAKING DECISIONS TOGETHER

PROVIDING CLEAR AND CONSISTENT INFORMATION


Please feel free to contact authors at sw-ittic@buffalo.edu.
To learn more about us visit our website at http://www.socialwork.buffalo.edu/research/ittic/

http://www.socialwork.buffalo.edu
Screening for Trauma

Screening

“I’m concerned about your emotional well-being as well as your physical health and I’d like to ask you a few questions.”

Primary Care PTSD Screen (PC-PTSD)

Description
The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the V A. The screen includes an introductory sentence to care respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?
   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES / NO

3. Were constantly on guard, watchful, or easily startled?
   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?
   YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.
IPV Screening: RADAR for Women

RADAR: A DOMESTIC VIOLENCE INTERVENTION

R = ROUTINELY SCREEN FEMALE PATIENTS
Although many women who are victims of domestic violence will not volunteer any information, they will discuss it if asked simple, direct questions in a nonjudgmental way and in a confidential setting. Interview the patient alone.

A = ASK DIRECT QUESTIONS
"Because violence is so common in many women’s lives, I’ve begun to ask about it routinely":
"Are you in a relationship in which you have been physically hurt or threatened?" If no, “Have you ever been?”
“Have you ever been hit, kicked or punched by your partner?”
“Do you feel safe at home?”
“I notice you have a number of bruises; did someone do this to you?"

If patient answers yes, see other side for responses and continue with the following steps:

IPV Screening: RADAR for Men

RADAR for Men: A Domestic Violence Intervention

R = Routine inquiry
A = Always ask
D = Document findings
A = Assess safety and lethality
R = Respond

Domestic violence (DV) remains a common problem encountered by clinicians in the practice of medicine. Traditionally, screening for DV has focused on female victims. This approach ignores the reality that men are commonly involved in DV, both as perpetrators and victims.

DV is a risk to your patient’s health. A lack of provider interest in a patient’s health risks communicates to the patient that the status quo is acceptable. Screening for DV must provoke a helpful, positive response which does not humiliate or punish, but which focuses on improving the health, well-being and safety of all our patients. Asking men about DV is a way to protect women, children and men from the consequences of DV.

R = Routine inquiry of all male patients 14 and older
Some patients will not volunteer information concerning the presence of DV, but will talk freely about it when asked. Asking your male patients about domestic violence should be a routine part of medical care, whether the patient appears to be involved in DV or not. We expect health care providers to ask their male patients at a first visit and on a yearly basis.

In addition to routine inquiry, providers should ask about DV whenever patients present with risk factors such as substance abuse; PTSD; financial stressors such as job loss or foreclosure; unexplained bruises or injuries; or depression. Abuse may increase during pregnancy; partners of pregnant women should be asked about DV.

A = Always ask
Below are several questions you might ask your patient to assess his involvement in a violent relationship. You may also want to notify the patient of exceptions to confidentiality. Specifically, if
## IPV Screening: The Relationship Chart

The Relationship Chart

During the past 4 weeks, how often have problems in your household led to:
- Insulting or swearing?
- Yelling?
- Threatening?
- Hitting or pushing?

<table>
<thead>
<tr>
<th>None of the Time</th>
<th>![None of the Time Image]</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Little of the Time</td>
<td>![A Little of the Time Image]</td>
</tr>
<tr>
<td>Some of the Time</td>
<td>![Some of the Time Image]</td>
</tr>
<tr>
<td>Most of the Time</td>
<td>![Most of the Time Image]</td>
</tr>
<tr>
<td>All of the Time</td>
<td>![All of the Time Image]</td>
</tr>
</tbody>
</table>
# Safety, Trust and Transparency

## RETRAUMATIZATION

<table>
<thead>
<tr>
<th>What Hurts?</th>
<th>System (Policies, Procedures, &quot;The Way Things Are Done&quot;)</th>
<th>Relationship (Power, Control, Subversiveness)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having to continually retell their story</td>
<td>Not being seen/heard</td>
<td></td>
</tr>
<tr>
<td>Being treated as a number</td>
<td>Violating trust</td>
<td></td>
</tr>
<tr>
<td>Procedures that require disrobing</td>
<td>Failure to ensure emotional safety</td>
<td></td>
</tr>
<tr>
<td>Being seen as their label (i.e. Addict, Schizophrenic)</td>
<td>Noncollaborative</td>
<td></td>
</tr>
<tr>
<td>No choice in service or treatment</td>
<td>Does things for rather than with</td>
<td></td>
</tr>
<tr>
<td>No opportunity to give feedback about their experience with the service delivery</td>
<td>Use of punitive treatment, coercive practices and oppressive language</td>
<td></td>
</tr>
</tbody>
</table>
Trauma and Healthcare Access

Trauma may negatively influence an individual’s access and engagement in primary and/or HIV care:

- Avoidance of medical, dental and behavioral health appointments
- Non-adherence to treatment
- Postponing healthcare services until condition deteriorates and symptoms progress
- Misuse of medical treatment services (e.g.: emergency department and pain medication usage)
Practical Interventions in Providing Trauma Informed-Care

Safety First

- Ask if the client wishes to have the clinic room door “open” or “closed” while waiting for the provider.
- Ask permission before touching a patient, whether the touch is an empathic hug or pat on the shoulder or a physical examination procedure.
National Resources for IPV

National Domestic Violence Hotline

1-800-787-3224

24/7 Confidential Support
Suicide as a Consequence of Distress, Trauma and Behavioral Health Disorders

Self-destructive behaviors are maladaptive measures a person uses to restore inner equilibrium when overwhelmed or unable to cope with stressful life events.

- Every 11.9 minutes a person commits suicide.
- A significant percentage of patients who commit suicide will have seen their primary care clinician in the month before their suicide.
- The strongest risk factor for suicide is depression.
- In the US, suicide rates are highest in the spring.

http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2015/2015datapgs1.pdf?v=2017-01-02-220151-870
LGBTQ and Suicide

- LGBTQ youth who have experienced severe family rejection, due to their self-identity, are 8 times more likely to report attempting suicide.

National Suicide Prevention Lifeline
1-800-273-TALK (8255)

Warning Signs of Suicide

http://www.suicidology.org/resources/infographics
Suicide Prevention
Evidence-Based Practice

Zero Suicide

http://zerosuicide.sprc.org/toolkit/engage

Suicide Prevention Resource Center

- Electronic Health Record Friendly
- Suicide Prevention Lifeline 1-800-273-TALK (8255)
- All individuals identified to be at risk of suicide are engaged in a Suicide Care Management Plan (Pathway to Care)

The Trevor Project

www.thetrevorproject.org

- National Organization that provides Trainings for Professionals in LGBTQ competent suicide prevention
- Trevor Lifeline 866-488-7386
- Trevorchat
- Trevortext
- Trevorspace
- Trevor Support Center

Focus on LGBTQ youth ages 13 through 24 and their friends and allies
Columbia Suicide Rating Scale (C-SSRS)

- Rating Scale Successfully Predicts Suicide Attempts
- https://youtu.be/tWuUR-LaVal
**COLUMBIA-SUICIDE SEVERITY RATING SCALE**
*Screen Version*

<table>
<thead>
<tr>
<th>SUICIDE IDEATION DEFINITIONS AND PROMPTS</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that are bolded and <strong>underlined</strong>.</td>
<td>YES</td>
</tr>
<tr>
<td>Ask Questions 1 and 2</td>
<td></td>
</tr>
<tr>
<td>1) <strong>Wish to be Dead:</strong> Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.</td>
<td></td>
</tr>
<tr>
<td><em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
</tr>
<tr>
<td>2) <strong>Suicidal Thoughts:</strong> General non-specific thoughts of wanting to end one’s life/commit suicide, “<em>I’ve thought about killing myself</em>” without general thoughts of ways to kill oneself/associated methods, intent, or plan.</td>
<td></td>
</tr>
<tr>
<td><em>Have you actually had any thoughts of killing yourself?</em></td>
<td></td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</td>
<td></td>
</tr>
<tr>
<td>3) <strong>Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</strong> Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “<em>I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it… and I would never go through with it.</em>”</td>
<td></td>
</tr>
<tr>
<td><em>Have you been thinking about how you might kill yourself?</em></td>
<td></td>
</tr>
<tr>
<td>4) <strong>Suicidal Intent (without Specific Plan):</strong> Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to “<em>I have the thoughts but I definitely will not do anything about them.</em>”</td>
<td></td>
</tr>
</tbody>
</table>

http://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf
C-SSRS Initial

- C-SSRS Behavior Demonstration Video
- https://youtu.be/2Fk0XuQwcMc
# COLUMBIA-SUICIDE SEVERITY RATING SCALE

## Screen Version

<table>
<thead>
<tr>
<th>SUICIDE IDEATION DEFINITIONS AND PROMPTS</th>
<th>Since Last Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask questions that are bold and underlined</strong></td>
<td>YES</td>
</tr>
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<td><strong>Ask Questions 1 and 2</strong></td>
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<tr>
<td><em>Have you had these thoughts and had some intention of acting on them?</em></td>
<td></td>
</tr>
</tbody>
</table>
C-SSRS In the Field

- C-SSRS Screener Demonstration Video
- https://youtu.be/XS2nB9DySAo
National Resources for Suicide Prevention

National Suicide Prevention Hotline

1-800-273-8255
24/7 Confidential Support
Case Management and Suicide

Suicide like all crisis situations, calls for ongoing evaluation

The Case Manager’s Action Plan

- Ensure therapeutic linkages have been established with public health or home health nurses, community mental health nurses, or psychiatric-mental health nurse practitioners once the client has been discharged

- Clients discharged after making a suicidal attempt should be linked with a mobile crisis unit
Wellbeing and Resiliency

NAVIGATING AND NEGOTIATING TO OVERCOME ADVERSITY
Let’s Learn

1. Define the term resiliency.

2. Describe the process of post-traumatic growth.

3. Discuss how healthcare professionals can learn to navigate the personal effects of “experienced” trauma and compassion fatigue when working with patients who have experienced trauma in the past and/or who are experiencing trauma in the present.
Resiliency

The ability to overcome adversity and continue along a path of healthy development.

Nearly everyone has or will experience some adversity in their life. Some of these experiences are more traumatizing than others.
Resiliency

Hard Things & Stressors:
- Not able to pay bills
- Not enough food to eat
- Violence
- Health problems
- Housing that does not feel safe

Good Things & Resources:
- People that you can count on
- Dependable transportation
- Safe housing
- A doctor you trust
- Having enough money

Things about You:
- Genetics and DNA
- Resiliency/ACE score
- Life story
- Personality

Resiliency is when the scale tips toward the good even when there are stressors and hard things.
Building Resiliency

- resilience is a social construct that identifies both processes and outcomes related to the way individuals culturally describe the experience of “wellbeing”
Survive and Thrive

- Everyone’s experience of traumatic events will be different
- How people are affected, cope and recover varies greatly
- Assuming that IPV and ACEs result in negative health consequences and social psychological maladjustments is not in harmony with providing culturally supportive care (care that is provided in culturally meaningful ways)
Post-Traumatic Growth (PTG) Theory

- Developed by Richard Tedeschi and Lawrence Calhoun (1995)

- Built on the premise that not all people who experience distress have negative outcomes

- People experience significant ‘life-changing psychological shifts in thinking and move from a place of fear, anger, resentment and hopelessness to one of healing, gratitude, purpose and hopefulness

- Changes experienced contribute to a personal process of change that is deeply meaningful to the individual
Post-traumatic Growth
What We Know

- “New Theory” in its early stage of development
- “Acceptance Coping” is a component
- “Reaching out” to a strong support network is a component
- Good analogy is “muscle building”
- Seems to be a process and an outcome
Resiliency and PTG: Not the Same

- **Recovery point is the difference**
- Resilience returns a person to their “pre-trauma” level of functioning
- **PTG allows an individual to thrive and flourish in ways they had never experienced before the trauma**
- An individual’s struggle with their new reality “post trauma” is critical to determining the level to which PTG occurs

Resilience and Post-Traumatic Growth

“Everyone has a right to have a present and future that are not completely dictated or dominated by the past.”

Karen Saakvitne
Resiliency

- Meet Carina: 15 and HIV Positive
- https://youtu.be/RCBmYNdWUf4
Compassion Fatigue

- “The cost of caring for others” (Figley, 1982)
- A state of tension and preoccupation with the stories/trauma experiences described by clients
Feeling Triggered

Compassion fatigue: The cost of caring
Empathy, Sympathy, Compassion and the Goldilocks Zone

Diagram:
- Under-involved
- Zone of Helpfulnessness
- Guiding
- Over-involved
Create a Strong Support Network
ENCOURAGING STAFF WELLNESS IN TRAUMA-INFORMED ORGANIZATIONS

As health care provider organizations move toward becoming trauma-informed, ensuring emotional wellness among professional and non-professional staff is a crucial requirement for providing high-quality care.
Summary: Behavioral Health and HIV

- The co-occurrence of behavioral health disorders for PLWH can seriously impact the course of HIV disease progression.

- Screening for the presence of depression, anxiety and other behavioral health disorders should be a routine component of HIV treatment and care across the lifespan.
Summary: Behavioral Health and HIV

- Behavioral health conditions in PLWH are often undetected due to the expectation of adjustment disorders that may accompany learning of one's positive status, the natural course of disease progression and the potential for ARV drug side effects and other drug-drug interactions.

- Behavioral interventions combined with psychopharmaceutical treatment have been shown to increase ARV adherence and improve health-related outcomes for PLWH.
Summary: Stress, Trauma and Distress

- How stress and/or a traumatic event(s) affect PLWH depends on many factors, including but not limited to characteristics of the person, the type and characteristics of the events(s), age and developmental level, the meaning attached to the trauma and various emotional sociocultural factors.

- The stress of learning one is HIV-positive and the associated experiences of living with HIV and other challenging co-morbidities creates opportunities for health professionals to “hold a safe” space for patients so that an integrated trauma-informed approach to treatment and care can be actualized.
Additional Resources on Trauma-Informed Care

**MENTAL HEALTH, RACE AND CULTURE**

**Handbook on Sensitive Practice for Health Care Practitioners:**

*Lessons from Adult Survivors of Childhood Sexual Abuse*


**Vicarious Trauma and Disaster Mental Health**

Understanding Risks and Promoting Resilience

Edited by GERTIE QUITANGON and MARK R. EVCES
Recommended Reading


- Collier, L (2016). Growth after trauma: why are some people more resilient than others and can it be taught? *Monitor on Psychology*, November, 48-52.


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Email- dcestaro@ufl.edu
Question, Comments and “Aha Moments”