



# HIV COUNSELOR PERSPECTIVES

## Intimate Partner Violence and HIV

Intimate partner violence (IPV) is abuse that occurs between two people in a close relationship—for example, people who are dating, married, partners, or ex-partners. While it often begins with emotional abuse, it can also include threats, sexual violence, and physical violence, and can refer to a range of damaging behaviors—from a single incident of abuse to ongoing battery. In the past, this abuse was known as “domestic violence,” “wife battering,” or “spousal abuse,” but now the term “intimate partner violence” is often used because of three facts: people who are not married or living together can be in abusive relationships; abuse can occur in both gay and straight relationships; and because people of any gender can be victims as well as perpetrators of abuse.

For many reasons, it is difficult to measure exactly how much intimate partner violence occurs. The lack of a consistent definition of IPV makes estimating prevalence a problem.<sup>1</sup> Just as importantly, IPV is believed to be underreported because of victims’ fears of shame, stigma, or escalating violence as a result of reporting.<sup>2</sup> The 2007 California Health Interview Survey (a large, general population telephone survey) found that one-sixth of Californians

(about 3.7 million people) reported that they had experienced physical violence as adults from an intimate partner. Approximately 5 percent (more than a million Californians) had been forced to have sex by an intimate partner.<sup>3</sup>

A recent review of studies on the intersection between IPV and HIV found that among both HIV-positive and HIV-negative women, self-reported rates of IPV are high: more than 60 percent of women across studies reported having been physically or sexually abused by an intimate partner in their lifetime. In the 2007 California Health Interview Survey, twice as many California women (21.1 percent) as men (11 percent) reported being victims of physical IPV. Eight times as many women (8 percent) as men (1 percent) reported being victims of sexual IPV.<sup>3</sup>

### Partner Violence and Health

Intimate partner violence results in a number of serious health consequences, including depression, anxiety disorders, substance abuse, eating disorders, gynecological problems, a variety of physical injuries, and death.<sup>2</sup> It is also associated with sexually transmitted diseases, including HIV.

Many of the same groups of people are disproportionately affected both by

HIV and IPV. This includes both Black women, who report higher rates of IPV than White women (although it is unclear how much of this difference is related to willingness to disclose abuse) and men who have sex with men, who experience higher rates than heterosexual men.<sup>2,4,5,6</sup> A history of childhood sexual abuse increases both the likelihood of experiencing IPV as an adult and the probability of acquiring HIV.<sup>7,8,9</sup> The 2007 California Health Information Survey found that sexual minorities were approximately twice as likely as heterosexual adults to report IPV: while 16.7 percent of heterosexual participants reported IPV, 27.9 percent of gay and lesbian participants and 40.6 percent of bisexual adults reported experiencing IPV. Because so many HIV testing clients may have experienced IPV, it is important for HIV test counselors to be aware of the ways that intimate partner violence may be affecting their clients and the clients’ risk for HIV transmission.<sup>3</sup>

### How Can IPV Increase HIV Risk?

There are several ways that intimate partner violence can lead to HIV infection—including physical, practical, psychological, and emotional factors that can increase vulnerability to

HIV disease. Many people who are physically abused by partners are sexually violated or coerced as well. The National Institute of Justice estimates that forced sex occurs in approximately 40 percent of battering relationships.<sup>10</sup>

Violence may escalate if the victim refuses to comply with specific demands (such as demands for oral, anal, or vaginal sex, sex with friends of the perpetrator, sex work with others, sex without a condom, or sex under the influence of drugs or alcohol). Forced sex with an HIV-positive partner presents a direct risk of HIV infection to the victim, a risk that can be increased if there is inadequate lubrication, tearing, or other trauma that could cause blood contact as well as sexual transmission.<sup>11</sup>

Even if sexual violence is not part of the client's experience, other sorts of physical and emotional abuse can be barriers to HIV prevention. Abuse is about power and domination over the victim, and perpetrators may monitor all aspects of a victim's life,<sup>2</sup> restricting access to medical care, prevention services, money, transportation, and social support. Shame, embarrassment, and fears of reprisal often keep the victim from disclosing the abuse to family and friends. Over time, this often leads to the victim becoming extremely isolated. Many victims feel that the abuse is somehow their own fault, and this adds to already low feelings of self-worth.

Like other forms of oppression, intimate partner violence can create feelings of severe stress and powerlessness—damaging the survivor's sense of identity, control, and initiative.<sup>12</sup> Most HIV prevention efforts are designed to empower clients, building on their sense of their own worth and ability to make sexual and health choices and to communicate with partners about their

choices and needs. Therefore, IPV is a significant barrier to HIV risk reduction. Many survivors may realistically assess that they have little control over whether condoms are used, whether their partner gets tested for HIV, and whether their partner has other sexual or drug-using partners. In the end, people living with the threat of abuse may be much more concerned about preventing a physical or emotional attack today than preventing a serious but treatable illness like HIV in the future. Survivors may have the sense that they do not have much of a future to protect anyway.

Some survivors turn to drugs and alcohol to cope with these feelings, and to numb the other physical and emotional pain of abuse. The relationship between victimization, substances, and HIV is complex. Women who have been abused either as adults or as children are more likely to use alcohol and drugs.<sup>11</sup> Using substances can increase vulnerability to HIV exposure in a variety of ways—by impairing judgment, coordination, and planning, decreasing inhibitions, and in other ways. In some cases, perpetrators coerce their partners into injecting drugs with them or others as a means of control, which can lead to HIV transmission.<sup>11</sup>

### How Can Counselors Respond to IPV?

Intimate partner violence presents huge challenges both to HIV risk reduction and to HIV test counselors. Counselors are by nature caring people. It would be easy for a counselor to feel frustrated with a survivor who is not ready to leave, angry at a perpetrator, and powerless at the counselor's inability to "fix" the situation, or overwhelmed by the desire to rescue a client who is in an unsafe situation. Keeping the follow-

ing strategies in mind will help you be most effective with your clients who are IPV survivors, and will also help keep you from "burning out," that is, becoming exhausted in your helping role.

#### *Learn About the Dynamics of IPV.*

You don't have to become an expert, but understanding some of the dynamics of IPV can help you become a better counselor. One frustration that many people in helping positions face is wondering why victims don't just leave their abusers. Leaving, however, is much easier said than done.

Intimate partner violence often follows a cycle with three main phases. Phase One is "tension building," during which stress, anger, blaming, and arguing escalate. Phase Two is "acute battering," which includes violence such as hitting, strangling, slapping, confining, using weapons, and sexual and verbal abuse. Phase Three is the "honeymoon period," during which the relationship seems more calm, and the perpetrator may make excuses for the violence, may promise that it will never happen again, or may try to "make up" for the abuse in other ways.

The hope that a perpetrator might change is only one of the reasons why victims of IPV may choose to stay in situations where they are abused. Other powerful reasons include: financial dependence on the abuser; low self-esteem (especially after being worn down by long-term abuse); and not wanting to break up the family. Further, for victims who are immigrants, language barriers or fear of deportation may make seeking help difficult. Some victims believe that they should be able to better "manage" the perpetrator's behavior: ("If I just did everything the right way, he wouldn't explode."<sup>12</sup>) Victims are often isolated from fam-

## When Can I Talk with Clients About IPV? How Do I Ask?

- **During Pretest Counseling** (for example: “Many people have had the experience of violence with their partners. Has your partner ever hurt you physically or sexually?”)
- **During Risk Assessment** (for example: Are you in a relationship in which you have been physically hurt, or in which you feel threatened?)
- **During Sexual History Taking** (for example: “Have you ever had a partner or ex-partner force you to have sex or do sexual things you didn’t want to do?”)
- **During Discussion of What Might Happen if the Client Tests HIV-Positive** (for example: “How do you think your partner (or ex-partner) might react if you were to tell him that you tested HIV-positive?”)
- **Whenever Partners Are Discussed** (for example: “Tell me about how you and your partner handle conflict or disagreement.”)
- **During Risk Reduction Discussions** (for example: “Has your partner ever refused to have safe sex?” or “What happens when you disagree about what to do sexually?”)
- **After Results Disclosure** (for example: “Who are you going to talk with about your result today?” or “How do you think your partner might react to hearing your result?”)
- **When Providing Referrals:** (for example: “There are options and resources available. This is the number for an agency that helps people make plans to get safe and figure out their next steps.”)

Adapted from the New York State Department of Health Guidelines for Integrating Domestic Violence Screening into HIV Counseling, Testing, Referral, and Partner Notification. 2002; <http://www.health.state.ny.us/nysdoh/rfa/hiv/guide.htm>.

ily and friends, either because the abuser discourages contact with them, because the victim fears they will take the abuser’s side, or because they are angry that the victim has returned to the abuser so many times.

Perhaps most importantly, many victims are afraid to leave because the abuser has made threats to harm or kill the victim, the victim’s children, other family members, pets, or even himself or herself. Abuse often gets worse when a relationship ends, and women are more likely to be killed by their abusers when they leave the relationship, or are already separated or divorced, or are attempting to report the abuse.<sup>13</sup> This makes the decision to leave even more difficult, and the importance of making a plan of safety, and getting support to leave and begin a new life even more crucial.<sup>14</sup>

### *Get Comfortable Asking About It.*

Routinely ask questions that can help screen for intimate partner violence among clients. While some providers are concerned that clients will react negatively to questions about IPV, many people who come in for health care services appreciate being asked about it.<sup>15</sup>

The privacy of the counseling session can help protect the client’s safety and encourage the client to share information about sensitive subjects, including IPV. This is another reason why it is important to counsel clients alone, even if they come to the test site accompanied by another person. See the box on Page 3, “When Can I Talk With HIV Testing Clients about IPV? How Do I Ask?” for some suggestions on how to bring up the topic of IPV during the counseling and testing session, while

keeping the session focused on HIV. Talk with your peers and supervisor about how they bring up these issues with clients. Even under the most supportive circumstances, some clients will still not feel comfortable disclosing abuse, but when a client does disclose, it is important for the counselor to express support and concern, for example, by saying something like, “I believe you, and I’m concerned about your safety. It is not your fault, and you are not alone. There is help available.”<sup>16</sup>

*Know Your Role, and Make Good Referrals.* It is crucial to realize that you probably can’t “fix” the client’s situation in one 40-minute counseling period. At the same time, you can help the client identify strategies to reduce HIV risk that can work in the context of the client’s life. Because of your limited role,

knowing the resources available to help your client is critical. Ask your supervisor about your site's protocol for IPV screening and referral. Also be aware of any mandated reporting requirements or other legal issues at your site related to intimate partner violence.

Making appropriate referrals is one of the most valuable services that you can offer clients in this situation. As always, follow the client's lead. What kind of resources does the client believe would be helpful? If the client is able and willing to accept a referral to a domestic violence hotline, counselor, or shelter, these can provide a lifeline to safety. Learn whether there are domestic violence shelters in your area and whether they will serve male and transgender survivors.

Other psychosocial referrals, including food, clothing, and benefits resources, legal services, substance abuse treatment, harm reduction services, or emergency childcare, may be a first step to greater stability. Be aware when making referrals that some abusers monitor the victim's communications, including e-mail, computer search histories, phone calls, and written documents. Keep referrals to a few that the client believes will be most immediately helpful, and talk with the client about how he or she might be able to access the resource most safely.

Clients who test HIV-positive or preliminary positive and are also living with intimate partner violence face special challenges. Helping clients explore the possibility of sharing their results with partners is one aspect of posttest counseling. Counselors can ask, "Who knows that you are here today?" or "How do you think that your partner might react to hearing that you tested positive?" or "How

does your partner handle bad news?"

In some cases, being told that he or she has been exposed to HIV can spark violence in the abusive partner,<sup>16</sup> so screening for IPV is one of the key steps in offering Partner Services to clients.<sup>17</sup> Even though these third-party disclosure services are confidential (the person notifying the sexual or needle-sharing partner is never told who may have exposed him or her to HIV), if the client believes that there is a risk of domestic violence as a result of partner notification, dual and third-party notification will not be done, and self-disclosure should be discouraged.<sup>17</sup>

Linkage to medical care, and adherence to a medical treatment plan are critical factors in promoting HIV-positive people's health. Yet IPV can be a significant barrier to health care—because of the violent partner's controlling behaviors, such as physical abuse, confinement, surveillance and stalking, threats and intimidation, and because the victim may feel too depressed, traumatized, or helpless to seek care in a consistent way.<sup>6</sup>

#### *Stay Neutral and Client-Centered.*

Be sure that you ask questions in a neutral and nonjudgmental way. Try to use language that normalizes the experience of being a survivor and talking about intimate partner violence. For example, you can lead in by saying, "No matter how well they get along, every couple has disagreements at times. How are those handled in your relationship?"

Use reflections, including reflections about feelings. "The last time you had a fight, things got really out of hand, and it frightened you. You didn't really feel like having sex afterward, but you were afraid to say no."

When a client discloses abuse, it is helpful to tell the client that "It is not

OK that your partner is hurting you," or "You don't deserve to be hit—no one does," but don't become another controlling voice in the client's life by telling the client what to do. (For example, "You have to leave. It's the only way.") Simply interacting with the client in a way that shows your respect for the client and your belief in the client's ability to make choices is a step in the right direction.

Follow the client's lead, and if the client is willing to do so, explore the connections between abuse and HIV risk. Help the client make their own connections between the abuse and HIV risk, and highlight contradictions the client expresses. For example, if the client says that his partner seems to take pleasure in penetrating him without using adequate lubrication, and that as a result he sometimes has rectal bleeding, the counselor might respond, "Let me see if I've got this right. On the one hand you've mentioned that your partner's behavior isn't really a problem and you've also stated that your partner has sex with you in a way that causes you pain and makes you feel concerned about HIV. What do you make of all this?" Counselors can also highlight clients' ambivalence: "You love him and you also realize that some of his behaviors aren't working for you, and are making you concerned about getting HIV. Tell me more about that."

Sometimes it is especially difficult to stay client-centered when the client or the client's situation reminds us of something we have experienced ourselves. Many counselors are survivors of abusive romantic relationships or family violence, and it can be tempting to believe that what worked (or didn't work) in those relationships will also work (or not work) for the client. It is



critical at these moments to remember that clients are the experts on their own experience and the particular context of their situation. Avoid telling clients what they should or shouldn't do. It is fine to use "third-personing" to talk about options with the client, such as, "Sometimes clients tell me that they found talking to a counselor helpful. How do you think that would be for you?"

#### *Think Small, Manageable Steps.*

Change is a process, not a single event. The session can facilitate the process of change in many ways. It offers clients living with IPV and at risk for HIV important information about their health and risks for HIV; a place to discuss options to reduce risk that will work in the context of the client's life; the statement that the abuse is not OK and that help is available; and a caring, respectful encounter with a health care provider—which can both bolster a client's sense of self and make it more likely that

the client will seek help in the future.

One starting point in identifying further risk reduction steps is asking clients about steps they already take to reduce the risk of HIV, since any successes might provide clues to build on. When and how is the client able to exercise control or decision making in the relationship?

Just as most clients will not completely eliminate HIV risk from their lives, so too the client living with IPV may not make an immediate, dramatic change as a result of one counseling session. Acknowledge that the client is dealing with a complicated, difficult situation, and reflect any of the client's statements about making positive changes. For example, a counselor might say, "It sounds like things have been up and down with your partner, and you are wondering how much longer you can stay without something changing. You've thought about getting your GED as one way

to have more control over your life and your job prospects. What do you need to do to make that happen?" and "How do you think that having more job opportunities would help you take care of your health?" and "What's something that you can do to reduce your risk of getting HIV while you are working on this plan?"

*Take Care of Yourself.* It isn't easy to work with clients who are experiencing violence and trauma. You may find yourself experiencing intense feelings—wishing that you could do more, feeling powerless to help, and feeling worried about the risks the client will continue to face from both HIV and violence. All of these feelings are normal, and they may be especially intense for those of us who have experienced violence. In these situations, getting support from colleagues and friends, supervision, and time away from work to take care of yourself are even more important. ■

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# Test Yourself

## Review Questions

1. *True or False:* According to the 2007 California Health Interview Survey, sexual minority adults were half as likely to report intimate partner violence as heterosexual adults.
2. According to the 2007 California Health Interview Survey, approximately what percentage of Californians reported that they had experienced physical violence from an intimate partner as adults? a) 11 percent; b) 17 percent; c) 23 percent; d) 29 percent.
3. *True or False:* If a woman living with intimate partner violence can just find a way to leave her abuser, she is unlikely to experience further violence.
4. *True or False:* Given the counselor's limited role, offering referrals is a crucial piece of assisting HIV test counseling clients who are experiencing intimate partner violence.
5. Intimate partner violence often follows a cycle with three main phases. These are: a) "tension building," "escalation," and "physical violence"; b) "acute stress," "escalation," and "the honeymoon period"; c) "tension building," "acute battering," and the "honeymoon period"; d) "verbal abuse," "physical abuse," and "the honeymoon period."
6. *True or False:* When a client discloses abuse, it is often helpful to respond in a way that conveys the message: "It's not OK that your partner is hurting you. It isn't your fault. Help is available."

## Discussion Questions

1. When you are counseling an HIV testing client whom you suspect has experienced intimate partner violence, what is it that you find most difficult? How do you get support in dealing with this challenge?
2. How can counselors keep the test counseling session as HIV-focused as possible, while still addressing concerns about intimate partner violence and safety?
3. What is your site's protocol for screening and referral of clients experiencing intimate partner violence?
4. How can counselors help create an environment where clients will feel as comfortable as possible discussing intimate partner violence?
5. What do you see as the key connections between intimate partner violence and HIV risk for your clients?

## Answers to Review Questions

1. *False. Gay and lesbian adults were almost twice as likely as heterosexual adults to report IPV, while bisexual adults were between two and three times as likely to report having experienced IPV.*
2. *b.*
3. *False. Abuse often gets worse when a relationship ends, and women are more likely to be killed by their abusers when they leave the relationship or are already separated or divorced.*
4. *True.*
5. *c.*
6. *True.*



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### Executive Director:

James W. Dilley, MD

### Editor:

Robert Marks

### Author:

Michelle Cataldo, LCSW

### Clinical Advisor:

George Harrison, MD

### Reviewers:

Barbara Adler, LMFT,

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### Design & Production:

Lisa Roth

### Proofreading:

Suzy Brady, Jessie

Murphy, Lawrence Sanfilippo

### Circulation:

Stephen Scott

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### Contact Us:

Michelle Cataldo, LCSW

UCSF AIDS Health Project, Box 0884

San Francisco, CA 94143-0884

415-476-2626

e-mail: michelle.cataldo@ucsf.edu

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