

# From Child Sexual Abuse to Adult Sexual Risk

Trauma, Revictimization,  
and Intervention

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## CHILD SEXUAL ABUSE AND HIV: AN INTEGRATIVE RISK-REDUCTION APPROACH

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In recent years, researchers have noted a significant association between child sexual abuse (CSA) and HIV (e.g., Wyatt et al., 2002; see also chap. 3, this volume, for a detailed discussion of this issue). This association has important implications for HIV prevention and intervention. First, the fact that women who contract HIV are more likely to have been sexually abused as children suggests a continuum of victimization, such that early victimization may confer greater sexual risk-taking and likelihood of revictimization, resulting in HIV infection. Thus, the possible pathways between CSA and HIV need to be elucidated to prevent further negative outcomes. Second, the implications for HIV research and intervention are significant. Sexual abuse during childhood is associated with disturbances in the self that pervade an individual's development, and these disturbances are likely to maintain HIV risk behaviors unless ameliorated. Therefore, individuals who are

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HIV-positive and have a history of CSA may face "double jeopardy" for negative outcomes, including additional risks for reinfection, sexual revictimization, physical impairment, and nonadherence to HIV treatment that are beyond those associated with HIV infection. Intervention approaches for HIV-positive women with sexual abuse histories need to consider pathways of risk, ameliorate the disruptions in development that result from CSA, and address the additive and interactive influences of HIV and CSA on health outcomes. In this chapter, we present an overview of the consequences of CSA that may lead to higher risk for HIV, offer a critique of early intervention paradigms, and present an integrative risk-reduction approach for HIV-positive women with CSA histories, currently in clinical trial, that addresses the link between CSA and HIV in a developmental and cultural context. Finally, preliminary findings from the intervention and implications for future directions are discussed.

### CONSEQUENCES OF CHILD SEXUAL ABUSE

The consequences of CSA, manifesting in multiple aspects of the self, have been copiously documented. They include cognitive impairments, affective dysregulation, adverse physical health, and risky behavior, all of which occur in a context of disrupted development. For example, women who experienced early and chronic sexual abuse had a sevenfold increase in HIV risk behavior and markers of risk, such as injection drug use, sexually transmitted diseases (STDs), and engagement in anal sex without condoms (Bensley, Van Eenwyk, & Simmons, 2000). The effects of sexual abuse found in this study appear to be different for men, suggesting a gender-specific, disrupted path of development for women. Other risk behaviors have been associated with CSA, including; earlier onset of sexual activity (Brown & Finkelhor, 1986; Donalson, Whalen, & Anastas, 1989; Riggs, Alario, & McHorney, 1990), greater number of partners (Ganz, Wyatt, & Loeb, 1998), and prostitution (Widom & Kuhns, 1996). The social-affective functioning of women with CSA histories have also been shown to be impaired. Female CSA victims have poorer judgments about people and situations (Smith, 1992) and report more loneliness and less satisfaction with their social support (Gibson & Hartshorne, 1996; Rhodes, Ebert, & Myers, 1993).

Because the relationship of CSA to later functioning in each of these areas is reviewed more comprehensively elsewhere in this volume, we direct the reader to these chapters. For the relation between CSA and HIV risk behavior and health outcomes, see chapter 3 (this volume). For CSA and cognitive processing, see chapter 6 (this volume). For CSA and its effects on social and affective functioning, see chapter 7 (this volume).

On the basis of a review of the literature, the specific mechanisms linking CSA to later HIV infection can be ascertained and posited. That is, the

experience of CSA appears to affect the development of girls through a number of vectors, encompassing cognitive, affective, and behavioral factors, often with profound effects. Because of the significant impact of CSA in women, intervention strategies with women dually affected by CSA and HIV must address all of these consequences as well as the interactive, reciprocal effects of CSA and HIV.

### EARLY HIV INTERVENTION MODELS

For almost two decades HIV research has been guided primarily by several theories, namely the theory of reasoned action (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Fishbein, 1980), the theory of planned behaviors (Ajzen, 1991; Ajzen & Fishbein, 1980), the health belief model (Becker, 1974), and the AIDS risk-reduction model (Catania, Kegeles, & Coates, 1990). Upon examination, it may be noted that these theories have several major underlying assumptions that stand counter to much of female socialization and values of a number of ethnic, cultural, and religious groups:

1. Individuals, understanding their personal risks, should prioritize disease transmission and learn the necessary skills.
2. Sex is always planned, anticipated, and consensual.
3. Decisions about sex are made on an individual, rather than interpersonal, basis.
4. If individuals so choose, they have the ability to negotiate issues such as pregnancy, disease prevention, condom use, or sexual practices.
5. Pregnancy is not a wanted outcome.

These major assumptions that underlie earlier intervention approaches may not be applicable to women, particularly ethnic minority women, for several important reasons. First, inherent in these assumptions is the idea that an individual comes with an uncomplicated sexual history. However, the fact that as many as 50% of HIV-positive women have CSA histories (Wyatt et al., 2002) places an ahistorical approach in question. Decisions about sex are often based on past experiences. Previous coercion or pressure from partners, fear of being harmed, or incidents of sexual and physical trauma often complicate decision making in sexual interactions. These factors may encourage individuals to subjugate their personal needs and safety in order to allow partners to make decisions regarding sex.

Sexual abuse before the age of 18 can impair one's sexual autonomy even further. In these cases, sexual contact is often initiated by someone older and with more experience and power. The perpetrator may dictate what kind of sexual experiences should be engaged in, and, as a result, women often fail to develop a sense of their own sexual needs apart from those of

their partners. They may gravitate to other partners who make decisions for them and develop a pattern of abdicating control of their sexuality. Therefore, they may not develop the skills to assess their personal risks, allowing role expectations and emotions to predominate decisions regarding pregnancy, contraceptive or condom use, and sexual practices in which they engage (Wyatt, Newcomb, & Riederle, 1993). In addition, in situations in which there is overt coercion and physical threat, disruptions to the development of security and trust can be pervasive and long-lasting.

Second, these theories overlook societal, cultural, gender-specific, and economic factors (Amaro, 1995). For example, among a sample of undocumented Latina immigrants, HIV was considered a concern secondary to finances, even though the women suspected their partners to be nonmonogamous (Romero, Wyatt, Chin, & Rodriguez, 1998). The emotional bond with sexual partners is a factor important to many women and needs to be incorporated into the decision making. This is exemplified by the distinction women make between a partner she has had children with and other partners. That is, if a woman loves and has had children with a partner, she may be less likely to evaluate her risks for disease transmission apart from her commitment to maintain a family. In spite of personal risks, women may be more influenced by their emotional bond with a partner and consequently do not protect themselves from unwanted outcomes. Women are socialized to value love, trust, and intimacy and may be willing to risk personal safety to maintain these values (Chin, 1999). In collectivistic cultures, these values are even more prominent. As evidenced by studies on Latino and Asian women, a collectivistic orientation may lead to greater accommodation of others' desires and the tendency to maintain group harmony at one's personal expense (Chin & Kroesen, 1999). Thus, not only are gender role expectations and values important, but the interaction between gender and culture should also be considered.

The assumptions of the primarily cognitive models have socialized researchers and health care providers to assume that the primary issues related to health promotion and HIV-related risk reduction were relevant for all groups. Consequently, interventions for women were developed on the basis of these theories and these assumptions. Unfortunately, when populations at risk did not make the expected behavior changes or did not sustain them for long periods of time, it was sometimes assumed that they were knowingly engaging in risky behavior and were resistant to change. In other words, victim-blaming occurred. For example, in the Black community, the HIV prevention messages continue to include some of the six assumptions described earlier, but the rates of HIV are still increasing at an alarming rate. Researchers and clinicians may interpret these rates as an indication of risky sexual and drug practices but may not be aware of the history of general, STD-related, and HIV-related health disparities that

continue to exist, or the gender-based and cultural values that are in contradiction with the six assumptions.

In an effort to address the deficits of previous models' applicability to women, we developed an intervention specifically for women who are HIV- and CSA-positive, integrating contextual and developmental factors. Below we describe our approach and present some preliminary findings.

## THE WOMEN'S HEALTH PROJECT

### Conceptual Overview

The Women's Health Project (WHP), a 4-year intervention study funded by the National Institute of Mental Health, was designed to address limitations of contemporary intervention models by incorporating historical and contextual factors that influence women's decision making and risk behaviors. Among current HIV risk-reduction studies, not enough attention has been paid to the role that prior victimization, specifically CSA, has had on the maintenance of high-risk behaviors. The WHP consists of an integrated curriculum that is grounded in key elements of HIV risk reduction (specifically, sex risk and drug risk), adherence interventions that emphasize women's issues, and a focus on increasing self-efficacy to perform lower risk behaviors as well as providing systemic support to sustain change (Sikkema, Winett, & Lombard, 1995; Wingood & DiClemente, 1996; Wong, 1995). It should be noted that in this intervention, HIV risk reduction refers not to the prevention of infection but rather to the prevention of reinfection, particularly by a more virulent or treatment-resistant strain of the virus, as well as to lowering the possibility of transmission to a partner. Concurrently, the WHP incorporates key aspects of treatment for CSA survivors, including short-term, trauma-focused groups that use didactic and group-process format and peer modeling of disclosure (Cole & Barney, 1987; Gold-Steinberg & Bутtenheim, 1993; Lundberg-Love, 1990; Roth & Newman, 1991). Components of the engagement model, including using cultural values as motivators for behavior change and peer mentors to model self-disclosure, are utilized as well (Longshore, Grills, & Annon, 1999). The uniqueness of this intervention lies in integrating well-established components of sexual abuse interventions with successful elements of HIV interventions in both content and format.

The intervention targets five areas of outcomes: (a) HIV-related sexual risk behavior, (b) HIV-related drug risk behavior, (c) HIV treatment adherence, (d) interpersonal behaviors, and (e) psychological functioning. Specific outcomes measured in these domains include the frequency of condom use with main and casual sex partners, the use of drugs or alcohol before or during sex, medication regimen adherence, health services utilization, inter-

personal conflict and resolution, depression, anxiety, trauma symptoms, self-esteem, and coping.

These outcomes are hypothesized to be proximally influenced by cognitive, affective, and behavioral factors: (a) self-efficacy for each of the five outcome domains (cognitive); (b) sexual health domains consisting of body awareness, sexual socialization, sexual health behaviors, and consequences of trauma (affective); and (c) skills for each of the five outcome domains (behavioral). Thus, these are the vectors of change as conceptualized in the intervention. Concurrently, elements of CSA and trauma interventions relevant to each topic are incorporated, addressing the developmental deficits stemming from CSA that may serve as roadblocks to change. Specifically, cognitive and affective disruptions in the development of the self and their links to behavior are addressed.

Background factors are also assessed and analyzed for their relationship to the proximal factors. These include demographic characteristics (i.e., age, education, marital status, ethnicity, and socioeconomic status), health factors (disease stage, HIV treatment, substance abuse treatment, STD, and pregnancy history), cultural background (acculturation, discrimination history, ethnic identity), psychological history, and trauma history, including the onset, severity, and extent of CSA.

In addition to the developmental context, the participants' social and cultural contexts need to be considered also. To ensure that the curriculum comprehensively addressed the needs of a diverse population of HIV-positive women, pilot groups of Black, Latina, and White women tested the relevance of the information. To offer the groups in Spanish to women who were monolingual or bilingual but preferring to speak Spanish, prior to translation, an advisory committee of Latina professionals in the fields of HIV, child abuse, social work, and public health reviewed and made revisions to the curriculum. The goal of the Spanish translation was to ensure appropriate cultural nuances and language differences across multiple countries of origin, including Mexico, El Salvador, Guatemala, Puerto Rico, and Costa Rica.

The format of the intervention also reflects the developmental context of women with CSA histories. Emphasis is placed on women prioritizing their own goals in a realistic manner set within an accepting environment. For instance, an individual's goal may be to reduce a particular behavior rather than eliminate it. The opportunity to select her own goals, rather than have them outlined for her, results in a personalized treatment program embedded within a standardized curriculum. As such, while addressing those aspects of risk hypothesized to affect HIV-positive women with CSA histories in general, we move away from the "one-size-fits-all" model to a more individually tailored one. Individuals are asked to explicitly grapple with the idea of how reasonable risk reduction is in a given area, given current partners and environmental constraints. Women learn how the decisions they make impact

and are affected by important people in their lives. Not meeting goals is viewed as a learning process, and discussion regarding relapses is encouraged to better address barriers to change and prevent setbacks in the future.

The multiethnic composition of the groups requires that the curriculum is culturally sensitive and teaches women to appreciate and understand each other's experiences. Group members struggle with past decisions and experiences; how each woman faces current challenges and perceives her past is unique. The nonjudgmental atmosphere inherent to the groups allows for women who are at different stages of the healing process to feel valued and accepted. This allows women to break the cycle of self-blame by placing their decisions in the context of past life experiences. By increasing understanding of the connection between the past and present, women are able to come to terms with decisions they have made and clear the way for the possibility of change. The stage is then set to change the cognitive, affective, and behavioral patterns that were developmentally constructed.

Many of the WHP participants have never disclosed their experiences with CSA prior to the intervention. Some participants had shared what happened to them, only to be punished or told they were lying about the incident. This isolation serves as a barrier for some women and makes attending the groups and disclosing to group members a daunting task. Some of these women come to group "brimming over," ready to talk about what happened to them, yet feeling intimidated and uncertain. Therefore, to encourage and facilitate participation, we ensured that transportation and child care are provided if needed. Furthermore, for many participants, a nutritious meal serves as an incentive also. Other items (e.g., movie passes, tickets to performing arts and sporting events, cosmetic products) are also provided as reinforcers when available.

## **Intervention Curriculum**

### *Content*

The 11-week intervention addresses HIV risk behaviors, interpersonal behaviors, health behaviors, and psychological status by focusing on the sexual histories of participants and their link to current cognitive, affective, and behavioral patterns. Throughout the sessions, the impact of CSA on women's functioning is emphasized to help survivors make important links between past traumatic experiences, HIV infection, and current functioning. A technique that has been incorporated into the curriculum to emphasize the association between past trauma and abuse, HIV status, and current functioning is a narrative that each woman is asked to write every week about the abuse incident and its consequences (Pennebaker, 1997). The purpose of the narrative is to enable cognitive restructuring of traumatic experiences that may result in positive emotional and physiological results. This technique has



been demonstrated to be effective with different groups of trauma victims, including victims of rape and Holocaust survivors (Pennebaker, 1997; see also chap. 9, this volume). Participants are asked to write narratives of the sexual abuse experience and/or being HIV-positive. Women who are not comfortable with writing are given a tape recorder to use to record their most traumatic experiences. The writings are not shared and are kept confidential. Throughout the sessions, the groups are taught and practice a problem-solving technique that is applied to each topic to facilitate decision making. "Keeping females in a healthy place" (KFNHP) is the motto used to aid participants to cue in to the necessary steps in problem solving and decision making when faced with a particular situation or dilemma. For example, the first word, *keeping*, beginning with K, triggers participants to ask themselves about a particular situation, "What do you know?" The second word, *females*, beginning with F, refers to the question, "How do you feel?" The third word, *in*, cues participants to the question, "What do you need?" The fourth word, *healthy*, recalls the question, "What is holding you back?" And the final word, *place*, serves as a cue for the question, "What is the plan?" Therefore, by continually using the KFNHP technique, the participants learn to approach situations by considering knowledge and information, emotional responses to the problem often stemming from their abuse experiences, what is needed to solve the problem, what obstacles exist, and formulating a plan for resolution.

Another important aspect of the curriculum focuses on enhancing women's support networks. Support is increased using various techniques, including assigning "peer buddies" in the first week, emphasizing interconnectedness among participants, and making relevant community referrals throughout the intervention. Given that the groups are composed of women from a variety of cultural, racial, and religious backgrounds, these issues are directly addressed throughout the curriculum. For instance, during the first session, each participant is asked to talk about what religion she was brought up with and which holidays she celebrated as a child. Participants are also asked to describe where they come from, their cultural heritage, and other past experiences they feel have affected them. These disclosures are thought to broaden understanding of and sensitivity to experiences that differ from one's own. In later sessions, participants discuss how they learned to think about their bodies, which body parts are acceptable to touch, and their feelings about male and female anatomy. Facilitators elicit a list of words participants use for body parts to construct a common terminology for discussions of sexual health. When discussing triggers for risky behaviors, participants are asked to identify historical, cultural, and religious experiences that may prevent a woman from protecting her sexual health (e.g., strong religious beliefs regarding the acceptability of using birth control may trigger anxiety and feelings of guilt when asked to use a condom). Language barriers that impede communication with medical providers are also discussed.

The intervention assists participants' management of psychological status by beginning each session with a 5-minute check-in time comprised of a relaxation technique (a combination of guided imagery, breathing, and thought-stopping) to enhance participants' ability to relax and manage feelings of distress throughout each session. Particularly with CSA survivors, distress may arise from recalling the abuse experience during groups, and stress management and coping is an important component both in and out of these sessions. Each session ends with a 5-minute check-out time in which participants review successful personal coping strategies and positive affirmation techniques to enhance well-being.

The specific order and content of the curriculum is as follows. In Week 1, the participants receive a comprehensive orientation to the intervention, which includes a discussion of ground rules, disclosure issues, spiritual and cultural beliefs, and the 11-week program agenda. Week 2 is devoted to assessment of risky sexual and drug behaviors and identification of myths related to HIV. Weeks 3 through 11 are devoted to the topics of treatment adherence and health behaviors, sexual issues, interpersonal communication, and drug and alcohol use by self or partner, each of which are addressed weekly rather than in a modular approach. This enables the facilitators to address each participant's stage of change (Prochaska & DiClemente, 1982) across topics. Prochaska and DiClemente identified six stages that an individual may go through in the process of changing a problem. These stages include precontemplation (not yet considering the possibility of change), contemplation (awareness of needed change), determination (considering how to change), action, maintenance, and relapse. In using this more integrated approach, continuity and continued impact are ensured, allowing participants who are absent in one or two sessions to still gain information across areas. Each week integrates the past abuse experience with current functioning, emphasizing the relationships among past abuse and sexual and interpersonal functioning, self-concept, and affective status. Finally, Week 11 addresses termination, in which a graduation ceremony takes place with certificates and family members present to celebrate achievements and progress made by the participants.

#### *Format*

The format of the curriculum consists of didactic presentations, demonstrations for mastery, role-modeling and role-playing, group discussion, homework assignments, audiovisual stimuli, and health education materials (e.g., condoms, penis models, pill boxes). It is structured, with a balance between psychoeducational content and clinical process. Sessions are held once a week for 2 hours in duration, with a brief 10-minute break in the middle. Participants are asked to arrive a half-hour early for refreshments. This refreshment period enables late arrivals without interfering with group content.

Much thought was also given to the pacing of the presentation and discussion of sexual abuse and other difficult aspects of the curriculum. Because of the highly sensitive nature of the material covered, we took pains to ensure that the most difficult information was embedded in each individual session in a way that allowed the women to begin and end each session with somewhat benign material (i.e., starting with how was their week and progressing toward their goals in a given area). Care was given to place the break at an appropriate time during the session, and facilitators check in with each participant as the session closes. Similarly, the most challenging abuse-related material is placed in the middle sessions, allowing for participants to desensitize to some of the early, more fact-oriented material and begin to learn the tools to disclose past experiences in a comfortable and healthy manner.

### Group Facilitation and Training

Each session is conducted by a trained group facilitator in collaboration with a peer mentor. The facilitators have some formal education and clinical training with a female HIV-positive population, as well as knowledge of (and preferably clinical experience with) CSA survivors. However, to realize the goal of eventually transferring the curriculum to HIV service centers, we recognize that the existing staff at these centers may not meet each of our requirements for facilitators. For this reason, we have placed more emphasis on hiring facilitators with extensive clinical experiences with HIV-infected populations and CSA survivors rather than on level of education.

The role of the peer mentor is critical, as she models disclosure and continual development of the self that had been disrupted by CSA to participants. Locating appropriate peer mentors presents unique challenges. It is imperative to have individuals who are at a stage in their healing process in which they could tolerate hearing the stories of other CSA survivors (as well as experiences with HIV infection) without overly internalizing others' trauma and becoming debilitated themselves. The peer mentors must be comfortable with disclosing relevant personal experiences for the benefit of the participants. These women must have enough personal support (whether through individual therapy, other support groups, friends, and family) to be able to share their experiences with others. In addition, because the population of women targeted by the intervention is predominantly women of color (Black and Latina), we recruited women of comparable cultural and language backgrounds for the peer mentor positions.

Supervision is an important component of the intervention. Supervision addresses practical issues involved in facilitating groups as well as processing countertransference issues. Countertransference is a clinical term referring to the process by which personal experiences, cultural biases, and other beliefs or values may hinder facilitators' ability to be effective in group.

Such countertransference issues must be addressed on a consistent basis in supervision. Rescue fantasies among group facilitators are common. Because participants may lead chaotic lives, experience hardships, or engage in high-risk behaviors, facilitators may feel a need to "rescue" participants from these difficult experiences. Further, by being constantly exposed to detailed descriptions of such traumatic experiences from participants, facilitators may experience secondary trauma, an internalization of the participants' trauma, and become overwhelmed and debilitated themselves. Debriefing of secondary trauma may be helpful because of the challenging and sometimes overwhelming task of providing treatment for HIV-positive women who often have chaotic lives, disclose sexual abuse and other traumatic experiences, experience multiple illnesses, and address death.

### FINDINGS FROM THE INTERVENTION PILOT

The Women's Health Intervention was piloted on 5 participants prior to its actual start. The curriculum was administered over the course of 11 weeks as designed. At its conclusion, a focus group was conducted to broadly assess the domains of impact as experienced by the participants. The purpose of the focus group was as a manipulation check: to get a sense of whether the curriculum hit the domains of impact as conceptualized. Thus, we assessed the three proximal domains of change as targeted: cognitive, emotional/affective, and behavioral. The focus group lasted 2 hours, and the content was audiotaped and transcribed verbatim. Themes were extracted from the text inductively. Within each domain, several themes emerged inductively in response to open-ended questions, and themes from each domain appeared to interact with one another.

#### Cognitive Effects

One salient and reliable change described by the participants was how they viewed themselves. In response to an open-ended question about what they learned from the intervention, all of the participants indicated that their "self-worth," "self-esteem," and "regard for myself" increased. They attributed many of their risky behaviors to a lack of self-worth; for example, one participant stated that she did not take medications as instructed because she did not care enough for herself to fight HIV. As a result of an increase in self-worth, she became more active in her treatment:

This last time I went (to the doctor), I had specific questions to ask and he answered all of them. I wanted my medication reduced, and he said, why don't we change them. . . . I always resisted change, but this time I'm thinking, I want to do this, I am tired of the old ones and all its problems.

Other participants also pointed to greater self-regard as key in changing behavior in other realms. For example, one woman spoke about her inability to refuse sexual advances: "There were a lot of guys and I do not know how to put boundaries up." However, with respect to a recent incident, she reported,

On this trip there was somebody I really liked, and we kind of hit it off, but I was really proud of myself that I did not let things get further. That is something I would not be able to do before. I guess I see myself as being more important and I do not have to go for everything.

Along with seeing boundaries between the self and others more clearly, the women gained a greater sense of self-worth, which also contributed to increased assertiveness. The participants indicated that "saying no" was something they were doing more often. For instance, one woman stated,

I must tell you, I always put the grandmother, the aunt who was sick, the kids before myself. Even the dog and the cat. I could be hungry and needy. . . . Not that I wanted to, I just thought that was what I had to do!

Her perspective now is slightly different: "I am not an object and (my partner) can't just pull me and say 'come on'." The realization that one can say no can also assert itself in a revictimization situation. One woman described a recent incident in a hospital: "I was tired and the nurse's aide helped me clean up in bed, but then he starts playing with my . . .<sup>1</sup> and I said 'Stop! What are you doing?'"

It is interesting to note that, in response to a question about what they had learned from the intervention, the participants did not include information about HIV. In fact, when specifically probed about whether they gained knowledge about HIV, they indicated that this was not the most salient or significant. Instead, they pointed to the link between their CSA experience and their current functioning—including drug use, interpersonal and sexual relationships, and treatment adherence—as enlightening, particularly because it was learned and shared in a group format. As one woman stated,

I learned that there are other women out there that were sexually molested, that I am not the only one. . . . Of course that was something new. We do not normally go around talking about these things (CSA). People would look at you like there was something wrong.

Hearing others' similar experiences and modeling from the peer mentor gave the women a sense of encouragement and empowerment: "I thought, if she did it, I could do it too."

### Emotional and Affective Effects

In discussing the impact of the intervention, participants cited some major emotional/affective changes. These themes emerged in response to an

<sup>1</sup>The participant trailed off here and did not describe more about this incident.

open-ended question without probes from the focus group leader. Surprisingly, an apparently strong emotional effect was a feeling of freedom and liberation, which was not specifically articulated in the study's aims. For example, one participant stated,

Not until I came to this group, along with women like myself, and (who) actually had the same type of feelings, was I able to talk about how I really felt about being molested . . . I found some freedom.

The women contrasted this newfound feeling with previous feelings of "stuff being trapped" inside of them. The process of opening up and sharing seemed to lead to feelings of "being free," as another participant stated, helping to "be able to live in every aspect of life, more freely." In turn, the feeling of liberation moderated the level of distress stemming from the HIV and lowered subjective stress in general. A third participant described a feeling very similar to liberation, calling it empowerment.

In addition to freedom and liberation and the concomitant decrease in stress, participants stated that they began to trust more, thus allowing feelings of intimacy to develop with the group facilitator, peer mentor, and other group members. How did trust develop in women who have personal histories that warrant mistrust? In response to a follow-up probe, the participants pointed to the peer mentor as a critical part of the process:

When I first saw the [peer mentor], my mind said: shit, all they are going to do is suck out our brain one more time. But when she introduced herself and said I am . . . and I have . . . then I went like: Oh, that kind of made all of us one, and we begun to open up.

Thus, having a facilitator with whom group members can identify serves to break down initial barriers to trust, higher in CSA victims and built up over time, and enhances the development of intimacy in the group.

### **Behavioral Effects**

Changes in self-perceptions and affect appeared to lead to behavioral change. One area of specific change voiced by the participants was a difference in their relationships with their partners. They stated that they began to communicate more assertively with their partners, leading to subtle but profound differences. To illustrate, one woman recounted an interaction with her husband:

The other day I got home a little late, and he said, you were not here when I got home so I thought I had to do all of the dishes. So I said, yes, so what is your problem?

Thus the participant was able to maintain her composure and sense of self-worth instead of feeling diminished by the interaction. Greater assertiveness was also expressed in the sexual realm:

Now I can communicate with my partner about my body, so everything about me changed. When I was really sick and could not do anything, that is when he wanted to have sex with me. And I did not want him to find somebody else. My husband is frisky to the life, but I said, I wish you could find other forms of recreation. And I feel really sorry for him, but you know, when you take those vows, together for better or worse . . . I reminded him of that.

Given that participants were more likely to assert their desires and needs with their sexual partners, especially with regard to sexual practices, their sexual risk is likely to decrease.

Relationships with others were also affected, in particular those with children and treatment providers. The women uniformly expressed that they always took care of others first with great sacrifice to their own well-being. Even while tired or sick, the women still tended to others' needs. However, seeds of change were noted. For example, one woman stated:

I have learned to take a deep breath and say "it's not that serious" and then I am able to respond to whatever that is said to me. Even if it is from my old man, my mom, my kids, anybody. I can say no, I won't do that, or I will do it later.

These changes in interpersonal communication were echoed by the others, for example:

My sister is calling me to ask if I can baby-sit. I love my nephew, but there is no way I can take care of him when I can't even take care of me. And before I would have said okay even though I did not want to. But this here has helped me that I am the one who comes first.

In terms of treatment providers, improved communication with them, stemming from cognitive and affective changes, meant greater engagement in the treatment process and possibly increased treatment adherence. One participant noted that she began to call her physician assistant more often to discuss treatment options. She noted that although she had a good relationship with him, she had greater interest in her health now, and this was reflected in their interaction. Participation in the group spurred interest in nutrition, relaxation techniques, and stress management, suggesting that immediate effects may persist and perhaps lead to even greater change.

Consistent with increased feelings of trust and intimacy with others, greater engagement in social networks was also evident. Participants cited decreased isolation and greater elicitation of support from others.

## DISCUSSION AND CONCLUSION

Findings from the intervention pilot confirmed that the targeted domains of change, consist of cognitive, emotional/affective, and behavioral

factors, were addressed in the intervention. More specifically, they supported the idea that the developmental disruptions associated with CSA render HIV risk behavior resistant to change, and therefore must be addressed alongside HIV risk. This was demonstrated by participants' reports of feeling unworthy of good health, and therefore having little motivation to engage in self-protective or enhancing behaviors. Once self-regard was increased, engagement in safer behaviors (i.e., not having sex immediately with a new partner) as well as in the treatment process (i.e., communicating with treatment providers more) was evidenced.

In addition, the intervention appeared to begin to restore a sense of boundaries between the self and others, the development of which may have been disrupted by CSA. An appropriate sense of boundaries includes saying no when imposed on as well as being able to trust and be intimate with others when appropriate, both of which participants stated they lacked. After their participation in the intervention, however, the women indicated greater assertion of boundaries in family, treatment, and sexual situations, leading to lower HIV risk and greater health benefits. They also felt a greater sense of trust and intimacy with other group members, owing to the sharing of common experiences and the modeling of the peer mentor. This has led to greater use of social networks to elicit support and decreased isolation.

These initial findings support the integrated intervention as a promising approach for HIV-positive women with CSA histories. Because of the barriers CSA poses to the initiation and maintenance of protective behaviors, they must be addressed concomitantly with HIV risk-reduction strategies that, in the case of HIV-positive individuals, have the ultimate objective of the prevention of reinfection and transmission of the virus to others. In addition to the integrated content, the format of the intervention should also reflect the dual status of the women. Specifically, having a peer model seemed to be critical in catalyzing the development of the participants. The integrated format of the material, which allows for growth to build instead of compartmentalize, was another specific ingredient that appeared effective. We did not specifically anticipate the feelings of liberation that the participants so strongly cited. However, feelings of "being trapped" are consistent with CSA sequelae, and the intervention appears to ameliorate this effect.

## FUTURE DIRECTIONS

On the basis of pilot data, the integrated approach as conceptualized and implemented in the Women's Health Project appears promising. Whereas cognitive-behavioral models of intervention may be most efficient and effective for populations less encumbered by developmental disruptions and social considerations, an integrated approach may be the appropriate intervention paradigm for women, particularly those with CSA histories. Obvi-



ously, because of the limited sample size in the pilot and the qualitative nature of the data obtained, inferences about the efficacy of the intervention await the conclusion of the study. At the end of the clinical trial, we hope to address the main thesis of whether the intervention was effective, as well as other critical questions such as which subgroups of women are most influenced by the intervention, what components are effective, the degree to which each additional session affects outcomes (dose-response relationship), and the areas of outcomes most affected.

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