
Desired Characteristics of HIV Testing and Counseling among Diverse Survivors of Intimate Partner Violence Receiving Social Services

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Despite recent calls to integrate HIV testing into social services addressing intimate partner violence (IPV), few studies have reported on survivors' perspectives regarding the desired characteristics of this integration. The purpose of this study was to describe desired characteristics of HIV and sexually transmitted infection (STI) testing services from a survivor's perspective. A qualitative descriptive approach was taken to describe the perspectives of IPV survivors who may or may not have accessed this service. Four focus groups were conducted with a diverse sample of English and Spanish speakers ($N = 25$) who sought services through a family justice center and associated shelters. Focus groups were recorded, transcribed, and analyzed using conventional content analysis. Three themes were identified, including (1) peace of mind; (2) interacting stigmas and traumas; and (3) making testing easy, comfortable, and tailored. The findings of this study have the potential to influence survivor-centered practices and policies regarding the integration of culturally informed HIV/STI and IPV services.

KEY WORDS: *culturally tailored interventions; domestic violence; health disparities; partner abuse; sexually transmitted infections*

Intimate partner violence (IPV)—physical, sexual, or psychological abuse or stalking within an existing or previous intimate relationship (Smith et al., 2018)—is a pervasive social problem with significant health consequences. In fact, one in four women and one in 10 men in the United States report experiencing physical or sexual abuse or stalking from an intimate partner and report consequences related to that abuse (Smith et al., 2018). One consequence that has been associated with IPV is HIV and other sexually transmitted infections (STIs) (Campbell et al., 2008; Maman, Campbell, Sweat, & Gielen, 2000; Sareen, Pagura, & Grant, 2009). Although the exact strength of this relationship has not been well established, it appears that, in the United States, women who report recent IPV are between 1.5 and six times at greater odds of acquiring HIV or another STI than their nonabused counterparts (Gonzalez-Guarda, Peragallo, Urrutia, Vasquez, & Mitrani, 2008; Li et al., 2014).

Several pathways contribute to the heightened risk of HIV/STIs among individuals experiencing IPV, including (a) increased engagement in sexual

risk behaviors among both the individuals experiencing and those committing IPV, such as having unprotected sex, multiple sex partners, and sex under the influence of alcohol or drugs; (b) immunodeficiency as a result of the physiological and psychological consequences of violence; (c) forced sex with an infected partner; and (d) reduced ability to negotiate condom use and other safer sexual practices because of lack of control over sexual decision making (Campbell et al., 2008; El-Bassel, Gilbert, Wu, Go, & Hill, 2005; Maman et al., 2000; Rountree, 2010). In addition, individuals who are HIV positive are at increased risk for experiencing subsequent IPV, particularly after disclosure of their HIV status to their partner (Gielen et al., 2007; Machinger, Wilson, Haberer, & Weiss, 2012; Mulrenan et al., 2015). The interaction between IPV and HIV, often referred to as *syndemic*—co-occurring epidemics with synergistic effects in marginalized communities—calls for unique interventions that more closely target these intersecting risks (Marshall, Fowler, Walters, & Doreson, 2018; Singer & Clair, 2003). This article provides insights from the survivors' perspectives regarding the

desired characteristics of HIV and STI testing when integrated into social services organizations addressing IPV.

INTEGRATING HIV AND IPV SERVICES

Providing widespread access to HIV testing and linkage to care, particularly among high-risk populations, is a public health priority and one of four key focus areas outlined in the 2015 update to the *National HIV/AIDS Strategy for the United States* (Office of National AIDS Policy, White House, 2015). The Federal Interagency Working Group on the Intersection of HIV/AIDS, Violence Against Women and Girls, and Gender-Related Health Disparities was established to support the objectives of the *National Strategy* and provide specific recommendations for addressing the intersection of HIV and IPV (Interagency Federal Working Group, White House, 2013). This working group, among others, has called for increased efforts to integrate HIV testing within existing IPV services, such as shelters and other social services agencies, as a strategy for increasing testing among this vulnerable population. Integrating HIV services into established IPV programs may be an important strategy for increasing the availability of HIV services that are sensitive to IPV survivor needs. Survivors of IPV often require numerous services (for example, social, legal, housing) and can experience challenges coordinating service needs. Providing multiple services at the same location can reduce these challenges and increase the likelihood of service engagement.

Interventions are currently being developed to integrate HIV testing and linkage to care services into community-based settings that serve survivors of IPV (Gonzalez-Guarda, Williams, Williams, Lorenzo, & Carrington, 2019; Johnson, Johnson, Beckwith, Palmieri, & Zlotnick, 2017). As these interventions are developed and implemented, a focus on trauma-informed approaches is critical. A trauma-informed approach “realizes” that trauma is widespread and has significant consequences; “recognizes” the signs and symptoms of this trauma; “responds” by integrating knowledge about this trauma in the practices, procedures, and policies of serving institutions; and intentionally “resists” retraumatizing those being served (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, p. 8). Although there is an increased awareness of the importance of trauma-informed approaches in HIV prevention

and treatment, descriptions of how this approach can be achieved are still lacking in the literature (Sales, Swartzendruber, & Phillips, 2016). To support these efforts, it is critical that social workers understand IPV survivors’ perspectives on the desired characteristics of HIV testing to ensure that these interventions are trauma informed and appropriately meet the unique needs of survivors.

Previous research shows that HIV testing is supported by survivors, as is the integration of HIV testing into IPV service agencies (Brown, Weitzen, & Lapane, 2013; Draucker et al., 2015; Williams, Gonzalez-Guarda, & Ilias, 2017). Individuals who report a lifetime history of IPV are more likely to have received an HIV test compared with those without a history of IPV, possibly because of an increased awareness of risk (Brown et al., 2013; Nasrullah, Oraka, Breiding, & Chavez, 2013; Rountree, Chen, & Bagwell, 2016). Two recent studies examined the acceptability of getting an HIV test at an IPV social services agency and found that survivors were supportive of this opportunity and felt that it was better to have testing done at an IPV social services agency, because it was a safer, more supportive environment that was better equipped to address their needs (Draucker et al., 2015; Williams et al., 2017). Despite this general acceptance, survivors face unique barriers to HIV testing, including fear of postdiagnosis violence from partners, social isolation that limits access to care, emotional readiness, and the potential for retraumatization during the testing process (Draucker et al., 2015; Maher et al., 2000; Rountree, 2010; Williams et al., 2017). To reduce barriers and improve quality of testing for survivors of IPV, it is crucial that HIV testing procedures be developed and conducted in a manner that is consistent with the unique needs and preferences of those affected by IPV. To better inform future interventions, the goal of this study was to examine the desired characteristics of HIV/STI testing services from the survivors’ perspective.

METHOD

Design

This study was conducted by a community-academic partnership between a family justice center and a research-intensive university in South Florida (Gonzalez-Guarda et al., 2019). A descriptive qualitative research design (Sandelowski, 2000) was used to explore desired characteristics for HIV testing among survivors of IPV accessing services at a site where testing was available. We

chose a qualitative research approach because of the sensitivity surrounding this stigmatized population. Since scant knowledge exists on the desired characteristics of HIV testing from an “insider’s” perspective, investigators wanted to “get inside the black box” of how HIV testing could be improved for survivors of IPV. Therefore, a participatory research approach was used to inform social workers on action improvements for HIV testing and counseling for the study population (Padgett, 2016). A total of four focus groups (two in Spanish and two in English, $N = 25$) were conducted. Institutional review board approval was obtained from the university partner prior to initiating study activities.

Sample and Setting

Individuals were recruited from a large family justice center in South Florida and partner shelters. A family justice center is a social services-oriented organization that aims to provide wraparound services for survivors at one location to circumvent survivors from having to go to various locations to address their myriad potential needs such as housing, legal services, temporary economic relief, protective orders, and mental health counseling (Gwinn, Strack, Adams, & Lovelace, 2007). Research personnel were present at these sites and approached individuals who were accessing services to inform them of the study and explore their interest in participating. Flyers were also distributed by advocates at these locations. To be eligible to participate in the study, participants had to self-report a history of IPV, be 18 years of age or older, and speak English or Spanish. Previous experience with HIV testing was not part of eligibility, as the team wanted to hear perspectives from both those who had sought testing and those who had not.

Procedures

Interested candidates were screened for eligibility in person or over the phone. If eligible, they were asked for their preference in participating in a focus group in Spanish and English. Spanish and English focus groups were then scheduled according to the candidate’s availability and were held either at the family justice center or one of the shelters. At the beginning of the focus groups, food was provided to participants. The moderator and comoderator provided an overview of the study, reviewed the informed consent, established ground rules for the groups (for example, confidentiality, speaking one

at a time), and answered questions from participants. Once informed consent was obtained, recording of the focus group began.

A semistructured interview guide based on previous qualitative research with this population (Williams et al., 2017) was used to guide the discussion. The guide started with a general question (“What are your thoughts about offering testing and counseling for HIV and other STIs at a domestic violence agency?”) and was then followed by more specific questions regarding desired characteristics for testing (“What recommendations do you have for improving the quality of HIV testing for survivors of IPV?”). When discussing IPV services with participants, we used the term “domestic violence,” because “IPV” was less familiar to them. At the end of the focus group, participants were compensated \$30.

Analysis

All focus groups were transcribed and analyzed in their original language by bilingual researchers. Conventional content analysis as described by Hsieh and Shannon (2005) was used to conduct these analyses. This approach is appropriate when theory and research are limited, there are no a priori codes to be imposed on the data, and an inductive approach is desired to describe the phenomenon. Transcripts were analyzed in their original language to avoid losing meaning through translation. Bilingual and bicultural researchers analyzed the two Spanish versions of the transcripts. Each transcript was independently coded by two researchers using the same steps. First, each transcript was reviewed to obtain an overall impression of the discussion. Then, researchers conducted line-by-line coding to identify meaning units in the transcript. *Meaning units* were defined by the team as meaningful, undivided components of the transcripts that responded to our central questions (Chenail, 2012). These codes were then organized into categories and subcategories and then into themes through various steps to increase the level of abstraction. The coding was conducted using NVivo 9. When the four transcripts were coded, the researchers met to discuss major themes until consensus was reached. Any areas of disagreement were addressed by referring to the original data to come to an agreement on how the text and labels used for the coding fit within the major themes.

RESULTS

Participant Characteristics

Participant characteristics are summarized in [Table 1](#). All but one of the participants were women ($n = 24$, 96 percent), the majority of whom were young or middle-age adults ($M = 34.09$, $SD = 8.30$). Most participants reported being Hispanic ($n = 16$, 64 percent) or Black ($n = 8$, 32 percent), and over half the sample had some college education or higher ($n = 13$, 52 percent). Over half of the participants were living in shelters at the time in which focus groups were conducted ($n = 17$, 68 percent), and approximately half participated in the Spanish-speaking groups ($n = 9$, 36 percent). While all participants had been tested for HIV at some point in their life, fewer than half of them were tested through the family justice center or at the shelters ($n = 8$, 32 percent). As previously noted, three major themes emerged from the focus groups: (1) peace of mind; (2) interacting stigmas and traumas; and (3) making testing easy, comfortable, and tailored (see [Figure 1](#)).

Peace of Mind

Focus group participants described the importance of being tested for HIV and other STIs as a way of establishing peace of mind. Many acknowledged their increased risk for HIV and identified being worried about having been exposed to HIV or another STI by their abusive partner. Although the participants described the HIV testing process as stressful, they perceived it as a necessary activity as

they sought closure from the violence and began healing from both a physical and psychological health perspective. As one English-speaking female participant stated,

For me that [HIV testing] took off some of my stress. It's maybe five minutes looking at that thing going, "I hope it doesn't have two lines, or whatever, one line." And I'm just there. But it relieved stress for me, like she said, with the closure. Yeah, that touched my heart. I was like, yeah. It definitely brought that OK, at least that's not one thing . . . I don't have to worry about that. Now, let's get all this other crap out of the way.

The desire of having "one less problem" to deal with related to their abuse consequences and possible exposure to HIV/STIs resonated strongly across the different focus groups and was described as a strong component of that peace of mind that participants were seeking.

Participants also wanted peace of mind in knowing that they would not transmit HIV/STIs to another intimate partner. Transmitting HIV to another person was described similarly to the transmission of violence. HIV testing was seen as a potential way they could break "the chain," a term that they also used to discuss the pattern of abuse. As the Spanish-speaking male participant described, "I decided to do it [HIV testing] because it is my health, and I do not wish, if the opportunity would arise, to infect someone else. I do not want to do that wrong to someone else."

Last, participants described wanting to have the peace of mind of knowing their HIV status for their children. Participants who were parents wanted to be healthy for their children. Whereas both parents and nonparents perceived HIV testing as a way they could "take control of their health," for parents, part of this control was being able to be there for their children. As one Spanish-speaking female participant explained,

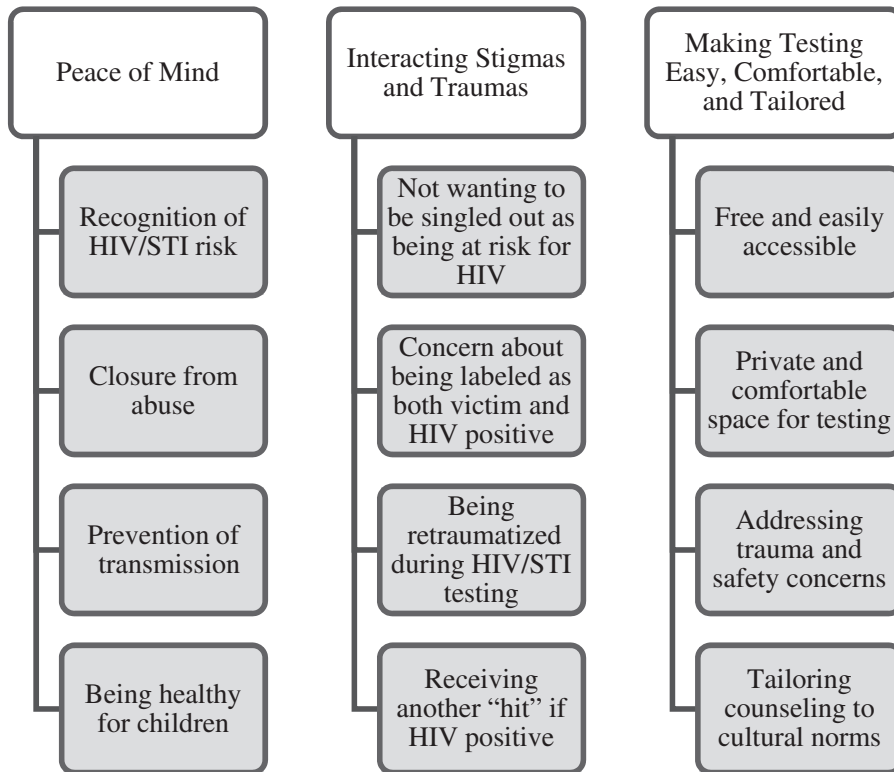
Well, for me the fear, and the children. I said, when they told me, like he said, many things went through my mind, and I said, "In the name of God, let me be good, let me be clean," and I thought, well, in my children. That if I had that disease, you understand, for my children, for my children I did it.

Table 1: Demographic Characteristics of Study Participants (N = 25)

Variable	M (SD)	n (%)
Age (years)	34.09 (8.30)	
Female		24 (96)
Race/ethnicity		
Black or African American		8 (32)
Hispanic		16 (64)
Education		
Some high school or less		4 (16)
High school diploma or GED		7 (28)
Some college or associate degree		11 (44)
Bachelor or graduate degree		2 (8)
Received HIV/STI testing in social service agency		8 (32)

Notes: STI = sexually transmitted infection. Data on age, race/ethnicity, and education were missing for one participant.

Figure 1: Themes and Supporting Categories for Desired Characteristics for HIV/STI Testing among Survivors of Intimate Partner Violence



Note: STI = sexually transmitted infection.

Interacting Stigmas and Traumas

Although participants wanted the opportunity to receive HIV testing, many described not wanting to be singled out as being at increased risk for HIV solely because they were survivors of IPV. As one English-speaking woman stated, “I don’t think it’s [HIV] typical to domestic violence women. Anybody is.” Part of the reluctance of not wanting to single out survivors of IPV as being at risk for HIV was because of the double stigma. Participants already felt stigmatized because they were “victims” of IPV and did not want another label of HIV that could potentially further devalue them. For example, an English-speaking Hispanic female participant described how frustrated she felt when her provider treated her with pity because she was a “victim” of IPV. As she stated,

I don’t think people shouldn’t be treated with pity or “poor thing,” any different than you

are, just because you had to come here [shelter]. Not like homeless people . . . we just need to get out of a difficult situation, and there are a lot of types. It’s like, don’t treat me like that. I’m able to take my own decisions. . . . I can’t tell how a boyfriend is going to be, I can’t tell he is going to be so dominating, and I didn’t like it and I’m happy to be out of the situation I was in, and I just feel I can’t stand that, and people come here, I don’t want to be pitied. I don’t want to be treated any different. I want to be treated like anybody else.

Participants also described the possible retraumatization of having an HIV test when already addressing the existing trauma of IPV. For example, an English-speaking African American female participant stated, “You know, we are distraught, and we don’t want to hear about no HIV testing. But you know, our first time with our counselor, you

know they encouraged us.” Participants described how the HIV testing process was more stressful to them because they had already experienced other traumatic experiences during childhood, during their recent experiences with IPV, and with loved ones who had been infected with HIV or died from AIDS. The retraumatization was described as both part of the HIV/STI testing process and in connection to receiving the results. For example, one English-speaking woman said,

I think it’s very important when you have somebody who has a trauma like that, you know, have been in a situation of domestic violence and treat them like a child that are scared of needles, they need that kind of compassion, I think that’s very important.

Another Spanish-speaking woman talked about not wanting to experience another “hit” by receiving the diagnosis of HIV.

Making Testing Easy, Comfortable, and Tailored

The participants of the study emphasized the importance of making HIV/STI testing “easy and comfortable” for survivors of IPV. Participants believed that “a lot of women would get the test here [an IPV social services agency] simply because a lot of women don’t take initiative or the doctors themselves.” Part of what participants described as being “easy” included the importance of making the HIV/STI test free and available where they were already obtaining other necessary services related to their abusive experience. Participants also thought that it would be more comfortable for survivors of IPV to get tested if they did not feel that they had to go to a public place where there would be opportunities for people to judge them. As one female, Spanish-speaking participant described,

She says, I am not sure if she was understood, but she says that this place is very safe to do it [HIV/STI testing] and that she agrees with her friend that people in general don’t like . . . don’t like that people see you enter a bus, a public place, or a strange place, because they are going to think, they had a lot of partners, they did this, they did that, and here it is more private and you feel more comfortable in a supportive environment.

Participants believed that HIV/STI testing and counseling needed to be tailored for survivors of IPV in two major ways. The first was in regard to trauma and safety concerns. Participants were concerned about the partner notification practices with HIV/STI testing. They felt reluctant to provide their address and expressed concerns regarding the response of their abusive partners if they found out that they were receiving testing and the potential abuse that could result from that disclosure. One of the participants described this concern:

I was living with my ex at the time when I came here and I had to actually lie to him, tell him I was at work, my boss was covering for me in case he called because he had me on a very tight leash. And I remember when I would come here I had the phone saved under a girlfriend’s name, the whole nine yards. And when I saw that they were putting . . . she asked address and then something. And she’s like, “Don’t worry. We’re going to put this one here,” I was relieved because imagine not only . . . and then you’re stuck with him at home. When they come and then who knows? He could kill you. You never know. So I think the fact that you guys do that is amazing.

The other component of tailoring that was important for participants was based on culture. Culture was perceived as playing an important role in influencing not only the risk factors for violence and HIV/STIs, but also the desired characteristics of HIV/STI testing and counseling. For example, many participants discussed how culturally ascribed gender and relationship norms contributed to the perception that women had to endure abuse, infidelity, and unhappy marriages. As one woman said, “We endure a lot, women are made to endure a lot, endure until the end because we are married forever.” Participants shared their belief that HIV/STI counseling needed to address these norms. For example, one woman shared how she would not be able to ask her partner to put on a condom, something often discussed in counseling, because of fear of her partner’s reaction to that request. Women negotiating for condoms was not a normative behavior, especially within the context of an abusive relationship in which the individual being victimized did not have this level of control.

DISCUSSION

This study responds to increased recognition of the intersection of IPV and risk for HIV and other STIs by describing the perceptions of survivors of IPV regarding HIV/STI testing. Four focus groups with 25 survivors of IPV who were seeking services at a family justice center and connected shelters were conducted to gather their perspectives regarding onsite HIV/STI testing and counseling. HIV/STI testing and counseling appeared to be an acceptable and desired service to be made available as part of comprehensive services for survivors of IPV. In fact, participants described HIV/STI testing as a way of obtaining peace of mind and closure on their abusive relationship. However, because many participants expressed feeling stigmatized already and labeled by others because of their “abused” status, there was concern of having the additional label of being at risk for HIV/STIs. Participants provided useful recommendations for how HIV/STI testing and counseling services could be implemented in an IPV social services agency in a way that was feasible, acceptable, and tailored to the unique needs of survivors. The findings from this study can be used by social workers to tailor existing HIV/STI protocols for implementation in IPV social service agencies.

The major themes of this study extend the findings from other researchers regarding the importance of providing HIV/STI testing and counseling to survivors of IPV (Draucker et al., 2015; Williams et al., 2017). For example, Draucker and colleagues (2015) conducted focus groups with residents ($n = 18$) and staff ($n = 10$) of shelters and found that these stakeholders believed that HIV rapid testing in shelters was convenient and acceptable, providing survivors of IPV with the access to testing during a time when they were making critical decisions about their future. In this study, we document the important role that access to HIV/STI testing and counseling plays in helping survivors plan for the future during this important transition in their lives. As described by participants of this study, knowing their HIV/STI status was a way of getting closure from the relationship and being able to prevent infecting future intimate partners. HIV/STI testing was seen as a way for survivors to ensure their health in the future, not only for themselves but also for their children.

The interacting stigmas associated with IPV and HIV were identified as a concern for survivors of

IPV when asked about their perceptions of HIV/STI testing. Williams and colleagues (2017) studied the process that survivors of IPV undergo when making decisions regarding whether or not to get tested for HIV by interviewing IPV survivors ($n = 10$) and service providers ($n = 9$). These investigators noted the importance that feelings about the testing process itself played in making that decision (for example, trust in the counselor) and provided recommendations for integrating trauma-informed principles into HIV/STI testing following those outlined by SAMHSA (2014). This study extends these findings by highlighting the potential for providers to retraumatize survivors of IPV by labeling them at risk for HIV. Consequently, messages provided to survivors regarding the need for testing should strike a balance between communicating heightened risk for HIV/STIs without placing blame or labels.

In addition, as identified by the participants of this study and other studies examining HIV/STI testing perceptions among survivors of IPV (Draucker et al., 2015; Williams et al., 2017), the counseling involved after HIV/STI testing has been completed should consider safety risk for participants. This includes cautiously navigating policies related to partner notification of results to protect the victim’s safety. It also includes the recognition that the survivor’s risk for HIV/STIs is not solely in their control but rather influenced heavily by their partner’s risks and behaviors, as well as the cultural norms regarding gender, relationships, and sex that surround them. As such, HIV/STI counselors offering testing to survivors of IPV should be trained not only in trauma-informed practices, but also on how to assess and address multicultural and societal influences that may come into play during behavioral counseling. These tailored approaches to counseling will help social workers ensure safer, more realistic, and more acceptable plans to mitigate HIV/STI risks.

There are notable limitations of this study. First, the perspectives shared were mostly the perspectives of female survivors of IPV. Although there was one male participant in the study, we did not focus on the potential influence that sex or gender may have on experiences and perceptions of HIV/STI testing. This should be explored in the future to ensure that services are also tailored to the needs of male survivors. Second, this study was conducted with a small sample of survivors who

were already seeking IPV services. Consequently, we did not generate an understanding of the perspectives of individuals who have a history of IPV but have not sought out formal social services related to their abuse. Therefore, the findings from this study may only be transferable to populations of service seekers with characteristics similar to those of this sample. Finally, this study took place in a site that was already implementing HIV/STI testing by counselors who were practicing from a trauma-informed lens. This likely influences the positive views that participants had regarding HIV/STI testing. Important potential negative consequences related to the implementation of HIV/STI testing for survivors of IPV (for example, the potential to aggravate symptoms related to trauma) may therefore have not been uncovered.

This study has important implications for social work case managers and clinicians and also for administrators in social services organizations who provide case management and counseling support for IPV survivors. First, social workers should adopt a trauma-informed perspective (SAMHSA, 2014) in acknowledgment that the trauma sequelae of IPV heighten survivors' risks of HIV and other STIs, that the stress of HIV/STI testing can retraumatize survivors, and that an HIV diagnosis is an additional layer of stress for IPV survivors that can compound the trauma of IPV. As such, effective integrated social services for IPV survivors should include assessment of trauma symptoms before and after HIV and STI testing and also assessment of the frequency and severity of trauma symptoms. Second, social workers and administrators can develop community outreach efforts that educate regarding HIV and IPV and its effects on personal, interpersonal, cultural, and health needs of IPV survivors. Such efforts can begin with preadolescents and include survivors who have successfully resolved the traumas of IPV and HIV. Given the intersection of trauma, abuse, HIV, and other psychological and physical health conditions, connecting community members who have not experienced IPV or been infected with HIV but who are at heightened risk for either condition to survivors and to pertinent health care providers is paramount to mitigating the health impact of both conditions in society.

In summary, integrating HIV/STI testing and risk reduction counseling in social services organizations appears to be a feasible way to address the HIV/STI/IPV syndemic and an accepted service

for survivors of IPV who are seeking services related to their abuse. Survivors of IPV perceive knowing their HIV/STI status as an important aspect of obtaining closure from the abusive relationship and planning for the future. Service providers offering testing should rely on a trauma-informed approach and take precaution not to further stigmatize or retraumatize survivors during the testing and counseling process. Consideration should also be given to safety, partner characteristics, the control of HIV risk behaviors, and cultural norms when conducting counseling to ensure that tailored plans are designed to mitigate risks. **HSW**

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