Trauma is often thought of as an individual, interpersonal experience. But for those of us from marginalized communities, structural violence and oppression also contribute to trauma. In recent years federal agencies have increased their attention to the linkages between interpersonal violence and HIV. Abuse history, for example, has been found to impact vulnerability to HIV acquisition and health outcomes after diagnosis.

However, there has been little consideration of the ways in which trauma is differentially experienced across the lines of race, gender identity, class, sexual identity, and socioeconomic status, despite the fact that the domestic HIV epidemic disproportionately impacts Black and Latino communities. Better understanding the traumatic impacts of racism, economic distress, heterosexism, and other factors will significantly advance our efforts to achieve greater health and social equity for people living with HIV.

Our intention in writing about these issues is to raise awareness, spark critical dialogue, and inspire action towards a trauma-informed health care services landscape. The creation of spaces that recognize and respond to a combination of interpersonal, community and structural violence must be a priority for HIV prevention, care and other service delivery.

What is trauma?
To begin with, what do we mean by “trauma”? Trauma can be described as a singular or series of distressing experiences, disturbing occurrences that can leave lasting emotional scars. According to SAMHSA: “individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”

Trauma also exists at the level of communities. Historical trauma has been defined as “cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences.”

For communities that experience significant interpersonal and institutional discrimination, stigma, and violence inscribed in policy and practice, trauma is ever present. Thus, oppression has not only social consequences, but psychological, emotional, and physical consequences. Oppression is frequently internalized and deeply traumatic.

Raising Awareness Among Service Providers

An understanding of trauma as structural, not simply personal, allows HIV service providers and clinicians to assume that all of their clients come with a trauma history. Thus, service providers must also recognize and be sensitive to the ways power dynamics, racism, and cultural relevance in healthcare settings impact engagement in care. To address this, provider training and system change are necessary — beginning with an acknowledgment of the pervasiveness of trauma.

Reimagining Care

Another important step is changing the standard of care in service delivery for communities impacted by HIV. This requires a willingness to reimagine clinical settings, ensuring cultural relevance towards trauma-informed ends. In particular, understanding the traumatic impacts of racism and xenophobia, and instituting practices in clinical care that proactively address those can greatly enhance the quality of care for communities disproportionately impacted by HIV. The conceptual framework developed by Positive Women’s Network-USA (PWN-USA) and University of California, San Francisco (UCSF) provides initial guidance to providers in helping them incorporate principles of trauma-informed care into clinical practice.

Trainings for service providers and clinicians that focus specifically on how to care for patients from vulnerable communities, coupled with an understanding of the impacts of trauma, are critical. Topics may include basics of providing trauma-informed care and referrals and interventions to address the effects of trauma. Examining resources available in the community, including HIV clinicians, community-based organizations, trauma experts, and people living with HIV, can implement such trainings.

The creation of quality assurance measures is also necessary to evaluate how effectively service delivery and care environments are responding to trauma in the lives of their patients. Linkage to
interventions designed to help people heal from lifetime trauma should be prioritized as an aspect of service provision — especially for communities impacted by sexism, racism, transphobia, economic distress, homophobia and other forms of oppression.

There is still substantial work ahead in understanding how trauma-informed practices that integrate an understanding of historical trauma and the impact of racism can be applied in HIV service delivery settings. Some initial steps that can be taken toward this goal include: ensuring representation by communities heavily impacted by HIV in organizational leadership, particularly at the Board and Senior Management level; minimizing power dynamics between providers and patients, instituting a regular screening protocol for assessment of depression, anxiety, trauma and Post-Traumatic Disorder (PTSD), and integrating peer-based services and culturally relevant trauma interventions.

Engaging Diverse Stakeholders

There are multiple areas of impact where stakeholders can intervene now to ensure quality health care and to foster more work around the intersection of HIV and trauma. In addition to clinicians and care providers, advocates must fight for more research to develop interventions that promote healing from trauma experienced on all levels for people living with and vulnerable to acquiring HIV. Federal agencies focusing on trauma should include an intersectional lens in their work. Efforts should be made to build capacity among frontline HIV service providers to address the linkages between structural violence, stigma and discrimination, and trauma.

Towards an Anti-Oppression Framework in HIV Care, Treatment and Prevention

As we fight against inequality and health disparities, we must just as forcefully grapple with intersectionality in the lives of communities impacted by HIV. Racial justice and a commitment to anti-oppressive thinking has to ground our work. Service providers must have the tools and information to provide the highest quality care possible for all. Most importantly, healthcare provision must be rooted in a commitment to anti-oppression. Coupled with an awareness of the trauma that people of color and other oppressed communities enter clinical settings carrying, this commitment should reframe service delivery moving forward.

Further, awareness of the impact of trauma on the lives of many vulnerable communities also requires understanding resilience. The recognition of resilience opens up the opportunity to examine community assets, including the importance of culture and agency. These elements can be strengthened, built upon, and then inspire models of trauma-informed service delivery that is not only community driven, and culturally relevant, but asset-based. The conversation around addressing trauma must resist lingering in the realm of deficit.

If the appropriate steps are taken, more progress can be made to facilitate better health care outcomes for vulnerable communities. Recent advances in HIV prevention and treatment and prevention will not benefit communities most impacted by HIV unless we also deal with trauma in all its complexity.
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