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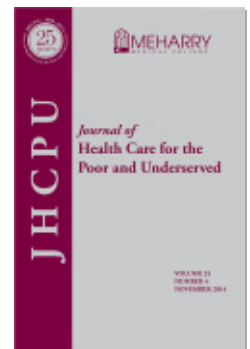


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HIV-Positive Black Women with Histories of Childhood Sexual Abuse: Patterns of Substance Use and Barriers to Health Care

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Abstract: A constellation of factors contributes to Black women's health including stressors and traumatic experiences. Their psychological adjustment and substance use can further affect their health status. The purpose of this study was to examine patterns of substance abuse and barriers to health care among HIV-positive Black women with histories of childhood sexual abuse (CSA). Baseline data on a community sample of 75 Black HIV-positive women were analyzed to assess and identify drug use, alcohol use, participation in an alcohol or drug treatment program, and communication skills with providers, all of which may act as barriers to health care. Findings indicate that substance use is a significant health problem, with 83% of the participants having used at least one substance regularly and 28% having engaged in regular injection drug use. Barriers to health care included confidentiality issues, poor financial resources, difficulty getting an appointment, excessive waiting to see a health care provider and obligation to care for others. Contrary to past research, poor communication between the participants and the providers did not seem to be a barrier to health care utilization for these women. Early traumatic experiences, including CSA, regardless of whether incidents involved penetration, may exacerbate the problems faced by HIV-positive Black women. Implications for future research and culturally relevant prevention and intervention programs are discussed.

Key words: Black women, trauma, HIV serostatus, drug use.

Women of color are one of the fastest growing HIV-positive populations in the United States.¹ Although Black and Latina* women together represent about one-fourth of all U.S. women, they account for 83% of the female AIDS cases reported in 2003.¹ In the past 15 years, the distribution of AIDS cases in California

*The term Black includes African descended women who self-identify as Black or African American who may have been born in America or other parts of the world. Similarly, the term Latina includes self-identified women of Latin/Hispanic heritage.

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has changed dramatically, reflecting what was being described nationwide as the changing face of AIDS. In 1991, 15% of new AIDS cases occurred among African Americans.² By 2001, this proportion had increased to 53% of all California AIDS cases, even though the percentage of African Americans in the general population had slightly decreased.² While HIV/AIDS affects all groups, Black women are at heightened risk.³ In order to address issues related to this rising epidemic, we must look beyond traditional HIV knowledge and skill based approaches. Inherent in assumptions in most HIV and substance abuse prevention research is the idea that, for the most part, women have uncomplicated and consensual sexual histories.⁴ Although past non-consensual sexual experiences, including childhood sexual abuse (CSA), are associated with sexual risk-taking, interventions for HIV-infected women rarely teach strategies for coping with past trauma along with risk reduction skills. These coping strategies often include drug and alcohol use.⁵

There are other factors that serve as barriers to HIV prevention. Gender role and cultural beliefs that complicate women's expectations and influence decision making skills and communication with partners in sexual relationships and with families are rarely integrated into HIV-prevention efforts.⁶ HIV-related risk-reduction for ethnic minority women requires strategies that address values and beliefs as well as past and present behaviors that can increase risky sexual and drug use practices.

Prevalence of childhood sexual abuse. One of the most salient factors that increase risks for HIV infection is a history of childhood sexual abuse (CSA).⁶ However, histories of sexual abuse before age 18 are common among women. Childhood sexual abuse is unwanted or coerced sexual body contact prior to the age of 18.⁷⁻⁸ Variations in definitions and research methods notwithstanding,⁹ it is estimated that the prevalence of CSA in the United States is approximately 33% in community samples of females under the age of 18.¹⁰⁻¹²

CSA and HIV risks. Early sexual victimization is associated with greater sexual risk-taking, including earlier onset of consensual sexual activity, lower condom self-efficacy, less frequent and inconsistent use of condoms,¹³⁻¹⁶ and higher rates of sexually transmitted infections (STIs).^{6, 17-18} Wyatt and colleagues⁶ reported that HIV positive women were 2.5 times more likely to report sexual abuse before age 18 than a HIV-negative cohort. Black women with histories of CSA also have reported higher rates of unintended pregnancy,¹¹ and are less likely to use contraceptives, including condoms.^{15, 18, 19} Histories of violence have both physical and psychological outcomes, including symptoms of post-traumatic stress disorder (PTSD), difficulty in perceiving health dangers realistically, and mental health symptoms.^{11, 18, 20-27} Research is only beginning to address the effects of histories of personal violence on HIV risks, especially for women of color.^{4, 28}

Childhood sexual abuse and substance abuse. Drug risk behavior may also be influenced by histories of sexual abuse. Drugs may help women to cope with PTSD or other trauma symptoms, avoid the intrusive images associated with past trauma, and cope with the emotional effects of CSA. These effects hinder women's chances of learning more effective coping skills. As a consequence, women who reported early and chronic sexual abuse are reportedly seven times more likely to engage in certain HIV-risk behaviors.¹⁷ They have specific markers of risk, including intravenous drug

use, sexually transmitted diseases (STDs), and anal sex without condoms.¹⁷ Research suggests that Black women with histories of sexual trauma have more severe problems with substances than those without such histories.²⁹ The problems include addiction to more substances, being admitted to the hospital or emergency room more often for health issues related to their substance use, and attending more substance abuse treatment programs.²⁹

Substance use and HIV risks. Sex and drug related behaviors that increase risk for HIV infection often intersect in a mutually reinforcing pattern of risky behavior.³⁰ For example, women with drug dependence problems may trade sex for drugs. This pattern of dependence may further impair judgments about sex, increase risk-taking behaviors,³¹ and intensify mental distress in HIV-positive patients.³² Although high rates of substance use and abuse are related to HIV infection, once infected, reductions from lifetime to recent levels of substance use among ethnic minority youth have been noted.³³ Lightfoot and colleagues³⁴ recently reported that in their cross sectional survey of adults living with HIV in four major metropolitan cities, women who were older and were aware of their HIV status for a long time were more likely to reduce levels of lifetime substance use. The importance of screening for substance use among women with HIV in treatment and community settings has been emphasized.³⁴⁻³⁵ It is possible that substance use for these women may decrease over time but they may not receive services for the factors that may have led to their becoming HIV infected.

What do clinicians and service providers need to know to improve delivery of services to Black women? Service providers from community-based organizations are more likely to be acutely aware of the needs of HIV-positive Black women than researchers are. In June 2003, the UCLA AIDS Institute sponsored a one-day conference titled *Women, Trauma, and HIV Risks*. Community-based organizations and state-level groups met with research investigators to form the Women's Health Initiative (WHI). The WHI meeting grew out of the lack of attention to the numbers of HIV-positive women who reported past and current sexual abuse and substance use within the HIV clinic case manager-patient relationship. Staff from the 32 organizations represented were untrained to address these issues, and had no community resources to offer women or referrals to other clinics or organizations for services. There were few, if any, programs that centrally addressed substance abuse used to cope with histories of sexual or physical violence for men or women, regardless of HIV serostatus.

While service providers may better understand Black women's needs, they need to understand the relationship between regulation problems (such as depression and PTSD symptoms) and CSA survivors using drugs and alcohol to minimize their trauma. Substance abuse treatment programs also must address the short and long-term effects of sexual abuse in the areas for which the patient is seeking treatment. It is possible that targeted programs for substance abuse and CSA survival may be needed.

Given that a large number of Black women are in need of such an integrated approach, interventions, resources, or treatment models must be culturally congruent in order to highlight culture-based strengths that can enhance behavior change and coping.

Childhood sexual abuse, health outcomes, and health care utilization. Childhood sexual abuse can affect long-term physical health outcomes and health care utilization in adulthood.³⁶ Women with CSA histories have higher utilization rates for general medical care, including more doctor visits, hospital admissions, emergency room visits, surgical procedures, and somatic complaints than those with no history of sexual abuse.^{35–39} Survivors of CSA also report physical symptoms more frequently, intensely, and in greater number than non-abused patients.^{39–40} Furthermore, a history of CSA is associated with significantly higher annual health care costs^{40–41} and affects women’s abilities to protect and to preserve their sexual health.⁴² Given the long-term symptomatology associated with a history of CSA, it is important for health care professionals to screen for trauma histories among female patients in medical clinics regardless of serostatus.⁴³

What factors prohibit Black women from using services? Understanding the barriers to health care faced by Black women with HIV is critical given the potential effects on morbidity and mortality. Black women are at risk for not fully using necessary antiretroviral medications due to limited access, patient or provider knowledge, or attitudes about the treatment.^{44–45} While a trusting relationship with one’s health care providers typically enhances adherence to both medications and overall treatment plan, this may be missing for many Black women.^{46–47} Because HIV-positive women, particularly women of color, are likely to experience barriers that compromise adherence, such as perceived discrimination by providers^{48–49} and perceived power differences,⁵⁰ a significant number may not reap the benefits of new medications and therefore may continue to experience negative health outcomes. Particularly among Black women, various financial and structural barriers have been identified, including transportation, childcare, having no regular health care provider, lack of insurance, availability of appointments, having to wait too long for appointments, and degree of satisfaction with the quality of their health care.^{51–52}

Given the limited knowledge we have about HIV-positive women with histories of CSA, this paper will provide descriptive information regarding lifetime and more recent substance use patterns. Possible obstacles to health care that may be differentiated by patterns of substance use among these women will be discussed. This information can help health care providers and clinicians provide more comprehensive assessment and intervention services. Further, by understanding this information within a cultural framework, theoretical models and interventions can better address the needs of these women.

Methods

Women’s Health Project (WHP). The Women’s Health Project (WHP), funded by the National Institute of Mental Health (NIMH), was a four-year intervention study conducted from 1999–2003 to enhance decision making, decrease sexual and drug risks, increase adherence, and improve psychological adjustment for HIV-positive women with a history of CSA, specifically Black, Latina, and European American women, the three racial/ethnic groups at greatest risk for HIV/AIDS.⁵³ (Earlier papers provide more detailed information regarding the WHP.^{4, 54}) In this paper, baseline data on the Black women were used.

Participant sample. HIV-seropositive women were screened and enrolled if they were female, 18 years of age or older, self-identified members of the three targeted racial/ethnic groups (Black, Latino, and European American), had histories of CSA and showed no evidence of severe psychiatric, neurocognitive, or other physical limitations.

The women were recruited from Los Angeles County and surrounding areas between 2000 and 2003. Recruitment sites included community-based clinics, county hospitals, ethnicity- and AIDS-specific organizations, and drug rehabilitation centers. HIV-positive participants responded to flyers, print advertisements, and personal contacts. HIV serostatus was confirmed by enzyme-linked immunoabsorbent assay (ELISA) and Western Blot. A serology battery was also run to assess immune function as indexed by CD4 and CD8 count and CD4/CD8 ratio.

To determine whether or not a woman had a history of CSA, prior to study enrollment women were asked 9 screening questions that assessed sexual experiences against their will before the age of 18 with an adult or someone at least 5 years older. The 9 questions assessing CSA covered fondling, frottage, attempted or completed intercourse, anal penetration, penetration of the finger into vagina or anus, and oral copulation to either victim or perpetrator. These 9 questions were administered as a group; the women were asked to respond *Yes* if they had experienced any of the acts. A total of 398 women responded to the recruitment efforts and 163 met the eligibility criteria. Baseline interviews were administered to 143 participants; 12 potential participants were no-shows and 3 participants died before the intervention was completed. Each participant was interviewed face-to-face by an ethnically-matched trained female interviewer at the location of her choice, including her home, UCLA, or Drew Medical Center. For the Spanish-speaking Latinas, the interviewer was bilingual/bicultural. Following the baseline interview, for which women were reimbursed \$25.00, 75 were randomized to either the Control or Enhanced Sexual Health Intervention condition.

Measures. Women were administered the Revised Wyatt Sex History Questionnaire (WSHQ-R),⁵⁵ a 478-item structured interview that assessed demographic characteristics, psychological status, substance abuse, medication adherence, and sexual decision making. The WSHQ-R also assessed current and lifetime consensual and nonconsensual sexual experiences regardless of sexual orientation, as well as common sexual experiences within the context of a primary relationship. The WSHQ-R included the use of show cards that attempt to control for literacy and response bias to socially unacceptable questions. For the purpose of this analysis, variables were limited to substances, including drug and alcohol use, barriers to health care, and quality of communication with health care providers.

Demographic characteristics. Standard demographic data were collected (e.g., age, number of children). Employment was coded as not working outside the home (0) and working full or part-time (1). Relationship status was coded as living alone (0) or married/live with a partner (1).

Patterns of substance use. Five measures were used to identify patterns of substance use, history of regular drug use, lifetime injection drug use, history of regular injection drug use, problem drug use, and problem drinking. History of regular

drug use was determined by asking participants their age at first regular use of each of the following 13 drugs: noncrack cocaine, crack cocaine, heroin, inhalants (i.e., glue, spray cans, gasoline), marijuana or hashish, hallucinogens (i.e., LSD, mescaline, peyote), amphetamines (i.e., crystal, methadone, methamphetamines), downers (i.e., reds, rainbows, Quaaludes), other opiates (methadone, morphine, codeine, demerol, dilaudid, percodan, opium), tranquilizers (i.e., valium, librium), PCP or angel dust, synthetic drugs (i.e., fentanyl, synthetic H), or ecstasy/MDMA. Mean age of regular drug use reflects the mean age of regular use across these 13 substances. For lifetime injection drug use, participants were asked if they ever injected any drug. History of regular injection drug use was determined by asking participants the age at which they began injecting each of the following drugs regularly: amphetamines (i.e., crystal, methadone, methamphetamines), heroin, other opiates (methadone, morphine, codeine, demerol, dilaudid, percodan, opium), noncrack cocaine, speedball, other drugs. Problem drug use in the past year was assessed using the Texas Christian University Drug Screen (TCUDS).⁵⁶ The TCUDS consists of 9 items identifying problem drug use. Scores range from 0 to 9. Problem drug use was based on a score of 3 or greater, indicating a likely diagnosis of drug dependence. Problem drinking in the past year was assessed using the Alcohol Use Disorders Identification Test (AUDIT).⁵⁷ The AUDIT consists of 10 items identifying problem drinking. Scores range from 0 to 40. Problem drinking was based on an AUDIT of 8 or greater.⁵⁸

Participation in a drug or alcohol treatment program. One item assessed whether or not women had ever participated in an alcohol or drug treatment program. Responses were coded as 1 (yes) or 0 (no).

Barriers to health care. Barriers to health care in the past 3 months was assessed using the short form of the MOS Perceived Access to Health Care Scale,⁵⁹ modified for the Women and Family Project.⁶⁰ The measure consists of 13 items identifying various factors that could be identified as barriers. Participants responded *not a problem* or *problem* to these items which covered such matters as finances, getting appointments, fear, refusal of care and discrimination.

Communication with provider. The Interpersonal Aspects of Care subscale of the Adherence Determination Questionnaire⁴⁷ was used to measure patient-provider communication and rapport. This subscale has an alpha reliability ranging from 0.81 to 0.85. Nine items assessed the quality of communication between the participants with their providers. Participants responded *never*, *rarely*, *sometimes*, *mostly*, or *always* to statements including, *doctors ignore what I say*, *doctors listen carefully to what I say*, *doctors answer all my questions*, *doctors use medical terms without explaining*, *I tell my concerns to the doctors*, *I make sure I understand doctors decisions*, *I make sure I know how to follow my treatment*, *I make sure doctors listen carefully to me*, and *I ask about terms I do not understand*.

Penetrative CSA. Incidents of CSA were categorized into those in which the participant reported penetration (known as severe CSA) and those that did not involve penetration (known as less severe CSA).

Statistical analyses. Descriptive statistics of substance use patterns, including drug and alcohol use, participation in an alcohol or drug treatment program, adult sexual abuse, barriers to health care, and communication with provider were

obtained. Bivariate analyses of the relationship between problem drug use and problem drinking were calculated with two-way table chi-squared; non-parametric and Fisher Exact test were used for small sample sizes.

Results

Demographic characteristics. The mean age of the 74 Black participants in the sample was 40 years. Regarding employment status, 97% reported not working outside of the home, while 3% worked full or part time. The relationship status of the majority (64%) was living alone, with 35% married or living with a partner. The women reported a mean of 2.5 children.

Patterns of substance use. When identifying history of regular drug use, participants reported an age of regular use for 13 different drugs; 83% of the participants reported having used at least 1 of the 13 substances regularly at some point in their lives. The following 4 substances were the most commonly identified as having been used regularly at some point in the participants' lives: 73% reported the regular use of marijuana or hashish, 61% reported crack cocaine use, 40% reported noncrack cocaine use, and 27% reported PCP or angel dust use. Heroin use was reported by 23% (see Table 1 for percentages of all 13 substances). The mean age of regular drug use across these 13 drugs was 17 years.

Over one in four (28%) of the participants reported having injected drugs at some point in their lives. The most commonly reported injection drug was heroin (17%) (see Table 1 for percentages of six injection drugs). Problem drug use was reported by 15% of participants. Problem drinking in the past year was reported by 10% of the participants. Finally, 54% of these HIV-positive Black women had participated in an alcohol or drug treatment program at some point in their lives.

Perceived barriers to health care. Participants reported the following five most common barriers to health care in the past three months: confidentiality issues (35%), financial problems (20%), having to wait too long (18%), having to care for others (15%), and difficulty obtaining an appointment (13%) (see Table 2).

Communication with provider. The following five descriptors of communication with health care providers were most commonly reported by this sample: *Always telling my concerns to the doctors* (95%), *making sure I understand doctors decisions* (95%), *always ask about terms I do not understand* (81%), *always making sure I know how to follow my treatment* (77%), and *always make sure doctors listen carefully to me* (75%) (see Table 3). However, 24% reported their doctors ignored what they said and 20% of the women reported that doctors failed to answer their questions.

Penetrative CSA. Severe incidents of CSA were reported by 85% of the sample. Fifteen percent of the sample described incidents that did not involve penetration.

Relationship between problem drug use and CSA severity. Women with problem drug use were not significantly more likely than women without problem drug use to report a history of CSA that involved penetration.

Discussion

The literature has amply documented disparities in health care and substance use patterns for minority women.⁶¹ Early traumatic experiences, including CSA, may

Table 1.**REGULAR USE OF SUBSTANCES AMONG HIV-POSITIVE, BLACK WOMEN WITH SEXUAL ABUSE HISTORIES (N=75)**

	Yes
Regular use of substance?	n=62 (83%)
Regular use of	
marijuana or hashish	n=55 (73%)
crack cocaine	n=46 (61%)
noncrack cocaine	n=30 (40%)
PCP or angel dust	n=20 (27%)
heroin	n=17 (23%)
downers (i.e., reds, rainbows, quaaludes)	n=15 (20%)
amphetamines (i.e., crystal, methadrine, methamphetamines)	n=12 (16%)
hallucinogens (i.e., LSD, mescaline, peyote)	n=12 (16%)
tranquilizers (i.e., valium, Librium)	n=6 (8%)
inhalants (i.e., glue, spray cans, gasoline)	n=6 (8%)
other opiates (i.e., methadone, morphine, codeine, demerol, dilauded, percodan, opium)	n=6 (8%)
Regular injection drug use	n=21 (28%)
heroin	n=13 (17%)
cocaine	n=10 (13%)
speedball	n=10 (13%)
amphetamines	n=3 (4%)
opiates	n=2 (3%)
other drugs	n=2 (3%)

exacerbate the problems faced by vulnerable populations, including HIV-positive Black women. This study describes substance use patterns, health care barriers, and revictimization histories in HIV-positive Black women with histories of CSA, a population of which we have little scientific knowledge. Women in this study coped with a host of traumatic life events including HIV infection, a history of substance abuse and childhood sexual abuse. The majority of the Black women in this sample reported CSA incidents that involved penetration; however, penetrative CSA was not significantly associated with problem drug use. These women with CSA histories reported high rates of lifetime substance use, regardless of whether the abuse involved penetration. This highlights the importance for health care providers of making thorough assessments of abuse in childhood, given the negative effect such events can have on already compromised health.

Another finding with health implications is the alarming prevalence of lifetime regular drug use. The majority of the HIV-positive Black women studied here reported an age at which they used drugs on a regular basis. High prevalence rates were found for marijuana, crack cocaine, PCP, and heroin. More than one quarter of

Table 2.

PERCEIVED BARRIERS TO HEALTH CARE IN THE PAST THREE MONTHS AMONG HIV-POSITIVE BLACK WOMEN WITH SEXUAL ABUSE HISTORIES (N=75)

Perceived Barriers	
Confidentiality	n=26 (35%)
Finances	n=15 (20%)
Have to wait too long	n=14 (18%)
Have to care for others	n=11 (15%)
Getting an appointment	n=10 (13%)
Feeling nervous or afraid	n=9 (12%)
Embarrassment	n=8 (10%)
Difficulty communicating	n=7 (9%)
Discrimination	n=7 (9%)
Was refused care	n=5 (6%)
Too much paperwork	n=2 (3%)
Discomfort with English	n=1 (1%)
Other barriers	n=3 (4%)

the women reported the regular use of injection drugs at some point in their lives. This is considerably higher than the prevalence rate for U.S. women in general and for Black women in particular.⁶²⁻⁶³ Further, given that the mean age of regular drug use was during adolescence, the need to intervene early with these CSA survivors is critical. While over a quarter of the women reported problem drug use in the past year, only one in ten reported having or having had a drinking problem. Further, over half of the Black women in the study had received treatment for their drug or alcohol problems. Clearly, substance use remained a critical issue in the lives of HIV-positive Black women who have experienced CSA.

Regarding barriers to health care, confidentiality was considered a problem by over one in three of these women (35%), while almost a quarter reported cost of health care as a problem. While one in five Black women reported that their doctors did not answer questions, women in this study overall communicated positively and proactively with their health care providers. This is in contrast to what has been reported in the literature citing a perceived dissatisfaction with health care providers among Black women.⁶⁴ Both positive and negative characteristics of doctor-patient relationships must be more carefully explored. We must better understand how the patient-provider relationship may discourage Black women from seeking further care.

There is a need to examine the substance abuse histories of Black women, as a mediator of earlier traumatic experiences and not simply as an HIV risky behavior itself. If sexual violence, HIV risks, and substance abuse are integrated into HIV interventions for HIV-positive and HIV-negative women, the chances are greater

Table 3.
HIV-POSITIVE BLACK WOMEN WITH SEXUAL ABUSE HISTORY AND THEIR COMMUNICATION WITH HEALTH CARE PROVIDERS (N=75)

	Never/Rarely	Sometimes	Mostly/Always
Doctors and other health care professionals sometimes ignore what I tell them	n=54 (72%)	n=18 (24%)	n=3 (4%)
Doctors and other health care professionals listen carefully to what I say	n=6 (8%)	n=11 (15%)	n=58 (77%)
Doctors and other health care professionals answer all my questions	n=4 (5%)	n=11 (15%)	n=60 (80%)
Sometimes doctors and other health care professionals use medical terms without explaining what they mean	n=51 (68%)	n=16 (21%)	n=8 (11%)
When I have concerns about my medical condition, I tell the doctor and other health care professionals about them	n=1 (1%)	n=3 (4%)	n=71 (95%)
When I see a doctor, I make sure I understand his/her decisions	n=2 (3%)	n=2 (3%)	n=71 (95%)
When I see the doctor, I make sure I know how to follow my treatment plan	n=0	n=4 (5%)	n=71 (95%)
I make sure doctors listen carefully to what I say	n=1 (1%)	n=3 (4%)	n=71 (95%)
When the doctor uses terms I don't understand, I ask what they mean	n=0	n=5 (7%)	n=70 (93%)

Note: Numbers may not add up to 100% due to rounding.

that women who are at risk for HIV will learn specific coping strategies that help minimize risky sexual and drug-related behaviors.

Future directions of research should include a search for consensus concerning culturally-related terms in research and how they should be measured and included in prevention and risk reduction programs. Guidelines for randomized clinical trials that ensure ethnic minorities are included in adequate numbers are necessary. This will allow for the assessment of within group ethnic and cultural differences in how factors affect HIV prevention and risk reduction interventions.

In the future, more emphasis should be placed on developing culturally congruent interventions that address histories of childhood sexual abuse, substance use/abuse, and HIV risk-taking behaviors for Black women. The rationale for behavior change may be to optimize public health. Finding strengths in cultural values and beliefs among Black women can ensure that reasons to change conform to beliefs about the importance of minimizing personal risks for the benefit of relationships, family, and community.⁵⁰

Limitations to this study should be considered. First, the relatively small sample of Black participants at baseline and cross-sectional sample limit the analytic power and generalizability of the frequencies reported here. The descriptive statistics reported here must be replicated with a larger sample of Black women to detail patterns of substance use among HIV-positive survivors of CSA.

Women reported that their current drug use was less than it was earlier in their lives. It is possible that with time, the effects of CSA were less likely to be associated with substance use and abuse for the majority of the sample. It is also likely that interventions that overlook the association between substance abuse and early CSA may not identify salient factors that must be addressed early in treatment efforts. There must be core training for health providers in substance use/abuse, histories of sexual violence, and HIV risks, or a good opportunity for early detection of the HIV-infected will be missed. The value of a culturally congruent intervention should be underscored. Such interventions will constructively link cultural beliefs and values to the health skills and attitudes being promoted.

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