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A Case Study of Sexual Abuse and Psychological Correlates Among an HIV-Serodiscordant Couple

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Childhood sexual abuse (CSA), adult sexual abuse (ASA), and intimate partner violence (IVP) are documented risk factors for HIV infection and are often implicated in the presentation of mental health disorders in both males and females, including those who are vulnerable to HIV infection (African Americans; trauma survivors). As such, these issues may contribute to health-related challenges among couples, particularly if the individuals are impacted by histories of trauma and HIV. Presented here is a case study of one couple with self-reported histories of CSA and clinically significant symptoms of posttraumatic stress disorder (PTSD) and depression. This couple was selected from a larger National Institute of Mental Health (NIMH)-funded study of 535 African-American HIV-serodiscordant heterosexual couples (see El Bassel et al., 2010). The study couple completed eight sessions of an HIV sexual risk reduction intervention program to increase condom use. Although the couple reported an initial increase in condom use at the immediate post intervention assessment, condom use decreased to baseline assessment levels at the 12-month post intervention assessment. The decrease in HIV-transmission protective behaviors over time (i.e., condom use), in part, may be attributable to the clinically significant psychological distress symptoms of PTSD and depression that were maintained from baseline, throughout the trial, and at follow-up assessments. We propose that the success of sexual risk reduction interventions may be attenuated and compromised over time by the presence of sexual trauma histories and the residual mental health issues. We discuss clinical implications for health care professionals in their work with couples, especially those from racially diverse groups.

Keywords: HIV, sexual trauma, couples therapy

It has been well-documented across decades of study that ethnic minorities and low-income women continue to be disproportionately affected by HIV (Centers for Disease Control & Prevention, 2010). The high incidence of HIV/AIDS continues to be a public health crisis especially within African -American communities, who comprised 44% of all new HIV infections in 2009 but represented only 14% of the U.S. population (Centers for Disease Control & Prevention, 2011). Given this disparity, identifying potential contributors among African Americans that continue to propel this epidemic is critical.

Childhood sexual abuse (CSA), defined as forced or coerced incidents of non- and penetrative sexual contact with family or nonfamily members (Loeb, Gaines, Wyatt, Zhang, & Liu,

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2011), adult sexual abuse (ASA) involving attempted and completed acts of forced and coerced penetration (Loeb et al., 2011), and intimate partner violence (IVP), defined as physical, psychological, and sexual assaults and threats are gaining increased attention as HIV/AIDS-related risk factors for infection and disease transmission (Parsons, Grov, & Golub, 2012). The long-term psychosocial problems associated with sexual victimization and violence include negative psychological sequelae, sexual and physical revictimization, and interpersonal problems (Chartier, Walker, Naimark, 2009; DiLillo, Peugh, Walsh, Panuzio, Trask, et al., 2009; Glover, Loeb, Carmona, Sciolla, Zhang et al., 2010; Holmes, Foa, & Sammel, 2005; Loeb, Gaines, Wyatt, Zhang & Liu, 2011; Williams et al., 2011).

Other correlates of CSA include a variety of negative sexual health outcomes that impact both males and females years later in adulthood (Loeb et al., 2011) and are likely to influence how individuals function in relationships. While symptoms of posttraumatic stress disorder (PTSD) have been largely recognized as the hallmark residual effect of CSA, ASA and/or IPV (Caldwell, Swan & Woodbrown, 2012; Koenen & Wisdom, 2009; Tolin & Foa, 2006;), depression (Smith et al., 2012) and substance abuse (Testa, M, Hoffman, Livingston, 2010) are also noted. Some reports suggest that the experience of sexual abuse before age 18 (CSA), relative to incidents since age 18 (ASA), appear to be more predictive of severe symptoms of PTSD (Ullman, Najdowski & Filipas, 2009) and may contribute to sexual and/or physical revictimization (Loeb, Gaines, Wyatt, Zhang, & Liu, 2011). Regardless of which experiences appear to predict the worst psychological problems later in life, many survivors of CSA often have subsequent negative consensual sexual experiences (Loeb et al., 2011). These experiences may themselves be associated with an array of poor health behaviors and other negative outcomes among those at-risk for or living with HIV infection. For example, sexual-risk taking behaviors such as low rates of condom use (Johnson & Harlow, 1996) and multiple sexual partners (Merrill, Guimond, Thomsen & Miller, 2003) have also been noted as long-term correlates of CSA experiences and mental health outcomes. Continued patterns of these behaviors also increase the likelihood of sexually transmitted infections (STIs) among women with CSA (Mosack et al., 2010). Although these outcomes tend to impact both males and females (Senn, Carey, & Vanable, 2008), women appear to be at greatest risk for STIs and HIV infection, given that the prevalence of female sexual abuse before age 18 is higher than in males (Loeb, Williams, Carmona, Rivkin, Wyatt, Chin, & Asuan-O'Brien, 2002).

There is a confluence of life experiences that heighten risks for HIV. Women with CSA histories are significantly more likely to become HIV infected than those without such histories (Wyatt et al., 2002). The rate of HIV-infection in women with previous histories of CSA ranges from 32% to 59% (Mosack et al., 2010). Sexual risk taking behaviors are likely to be reported along with symptoms of depression, PTSD, and self-medicating coping behaviors such as substance abuse (Loeb, Williams, Carmona, Rivkin, Wyatt, Chin, Asuan-O'Brien, 2002; Testa, Hoffman, Livingston, 2010). Although studies of the pathways from trauma exposure, psychological adjustment problems, and substance abuse that can affect mental health are ongoing, taken together, these experiences contribute to the psychological impact resulting from sexual abuse early in life. If PTSD is noted, symptoms of numbing, reexperiencing, avoidance, and hyper arousal may compromise healthy sexual decision making and engender maladaptive coping behaviors (i.e., substance use and avoidance coping). Patterns of self-medication, denial, and avoidance tend to create of cycle of vulnerability that can result in revictimization. The trauma that can result is often accompanied by even more intense symptoms (Arata, 2000; Noll, Horowitz, Bonanno, Trickett & Putman, 2003; Fortier et al., 2009; Ullman, Najdowski & Filipas, 2009).

There is also evidence that mental health problems, including depression and PTSD, may compromise health behaviors for those living with HIV/AIDS. Major depression may be as high as 45% for those living with HIV (Basu, Chwastiak, & Bruce, 2005), and left untreated, is associated with poor adherence to highly active antiretroviral therapy (HAART), fewer medical care visits, increased risk of mortality, as well as poorer quality of life (Rabkin, 2008). Depression in HIV populations can contribute to an increase in risky sexual behaviors, especially in couples (Bradley, Remien & Dolezal,

2008). Others studies suggest that depression symptomology contributes to low libido (Rabkin, 2008). Similarly, PTSD rates are high among individuals living with HIV and are also associated with higher transmission risk behaviors and higher morbidity and mortality rates attributable to medication nonadherence and poorer health outcomes (Boarts et al., 2008; Sikkema, Hansen, Meade, Kochman, & Fox, 2009). HIV-positive people of color and women with trauma histories and comorbid psychological conditions appear to be considerably more vulnerable to illness progression because of the increased likelihood of poor medical adherence and outcomes in these groups (Centers for Disease Control, 2004).

We know more about negative sexual experiences for women because they appear to be at least twice as likely to develop PTSD and experience revictimization as to men (Koenen & Wisdom, 2009). However, male survivors of various forms of trauma continue to be understudied. This may be partly because of cultural and societal beliefs that men cannot be coerced or victimized and they should be strong enough to overcome unwanted attempts (Sorsoli, Kia-Keating, Grossman, 2008; Ullman & Filipas, 2005). These beliefs may contribute to an even greater reluctance to disclose abuse histories among men relative to women. Current research suggests that CSA ranges from 2% to 15% in males, whereas ASA has been reported in fewer than 10% of males (Aosved, Long & Voller, 2011). However, there are some indications that male survivors of sexual abuse before age 18 are significantly more likely to experience sexual abuse in adulthood compared with males without histories of CSA (Aosved, Long & Voller, 2011). Although CSA prevalence rates may be lower for males than females, male victims demonstrate more severe psychological problems, including higher rates of clinically significant PTSD, depression, and substance abuse, as well as self-harm, suicidal ideation, hostility, and anger after sexual abuse and/or revictimization (Aosved, Long & Voller, 2011; Coxell & King, 2010). There is also evidence that males who are victims of IPV, often noted to be more frequent in women (Archer, 2000), also experience residual psychological distress symptoms (Caldwell, Swan & Woodbrown, 2012; Garnefski & Arends, 1998). Although there is debate as to whether the risk of psychological adjustment problems differ by gender among survivors of lifetime sexual victimization and violence (Tolin & Foa, 2006), more research is needed to further clarify how sexual trauma impacts the well-being of male and female survivors in committed relationships.

Interpersonal problems, particularly relationship difficulties (i.e., maintaining healthy adult intimate relationships), have been widely reported in survivors of sexual victimization (DiLillo, 2001; Loeb et al., 2002; Watson & Halford, 2010) and in those who suffer from the residual mental health effects. For example, female survivors of CSA report lower levels of trust and intimacy, poorer sexual and relationship satisfaction, and communication problems with heterosexual partners compared to women without histories of CSA (DiLillo, 2001). In a study of adult intimate relationships, Watson and Halford (2010) reported that among female survivors of CSA, in particular, sexual abuse perpetrated by a family member, was associated with later relationship difficulties. There is also evidence that physical health problems such as chronic pelvic pain, vaginal tears, various gynecological problems, and generally poorer health is often experienced in women with sexual trauma histories (Campbell, Greenson, Bybee & Raja, 2008; Eadie, Runtz & Spencer-Rodgers, 2008). These health problems often contribute to sexual dysfunction, while co-occurring mental health effects of sexual trauma may contribute to sexual problems such as low libido, arousal problems, and/or less closeness to sexual partner (ter Kuile, Weijenborg & Spinhoven, 2010; Rosen, et.al., 2006). In effect, both physical and mental health issues may interact with a variety of relationship problems.

In contrast, little is known about the impact of sexual victimization on men's intimate relationships. We know that for many men, sexual traumatization and its psychosocial correlates may also contribute to physical health problems such as erectile dysfunction and subjective reports of sexual arousal problems (Turchik, 2011), which may also affect relationship satisfaction. A recent study indicates that both male and female survivors of CSA reported similar rates of poor relationship quality and the ability to assess relationship problems (Larsen, Sandberg, Harper & Bean, 2011). Further, the frequency of sexual abuse before age 18 along with histories of physical abuse has been re-

ported to be independently associated with decreased relationship quality among married couples (Larsen, Sandberg, Harper & Bean, 2011). Given that many survivors of sexual abuse and trauma often do not disclose these histories, even to their partners (Goldman-Brown, Edstein, Goodman et al., 2003), couples may not be readily aware of how each partner's past experiences contribute to the current relationship problems that they report. Consequentially, these issues are likely to influence how women and/or men with sexual abuse histories function in their intimate relationships and the kinds of problems that they may seek help for, especially those who are impacted by dual histories of HIV and sexual or physical trauma. Among couples seeking mental health services, including those seeking to address relationship conflicts, the presenting issues and/or symptoms may not reveal information regarding HIV status or past trauma.

This case study presents an HIV-serodiscordant couple with histories of trauma, sexual risk behaviors, and mental health challenges which may impinge on their attempts to maintain long-term HIV risk reduction efforts. Patterns of their sexual behaviors and psychological well-being are described to better understand how health providers, counselors, and other mental health professionals who work with individuals or couples can best provide services for a couple impacted by both histories of trauma and HIV. To protect their confidentiality, we use pseudonyms to describe the backgrounds and relationship challenges of Mr. and Mrs. Smith.

Methods

The Parent Study – Context of the Case Study

Recently, an NIMH-funded study of 535 African American HIV-serodiscordant heterosexual couples (El Bassel et al., 2010) was completed, and early reports indicate the success of this HIV/STI risk reduction program. The cluster randomized controlled trial (Eban) was conducted in four U.S. cities with high rates of HIV infection, including Atlanta, Georgia; Los Angeles, California; Philadelphia, Pennsylvania; and New York, New York. Couples were eligible if (1) both partners were at least 18 years old, (2) at least one partner was African American, (3) they reported unprotected intercourse in the previous 90 days, and (4) they were aware of each other's HIV serostatus. Disclosure of histories of abuse was not required. One thousand seventy participants were enrolled (mean age was 43 years; 40% of male participants were HIV-positive). Couples were randomized to one of two intervention conditions: a couples-focused Eban HIV/STI risk-reduction intervention or a similarly structured, attention-matched health promotion comparison group. Continuous IRB approval was maintained over the course of the study. If a participant displayed significant distress during assessment, the Data Collector stopped the assessment and provided brief counseling and referral for mental health services (NIMH Multisite HIV/STD Prevention Trial for African American Couples Group, 2008).

Guided by an integrated ecological framework and the principles of Nguzu Saba, including unity, collective work and responsibility, self-determination, creativity, purpose, cooperative economics, and faith, the Eban intervention was an 8-week, standardized manualized intervention facilitated by a male–female team. The intervention included four sessions with individual couples and four with groups of couples. Specifically, in Session 1, the three to five couples met as a group for half the session and as single gender groups with the same-gender facilitator in the second half. In Sessions 2 to 4 and 8, each couple met separately with their cofacilitators, whereas in Sessions 5 to 7, the couples attended group sessions. The curriculum included strategies for addressing individual, interpersonal, social, and cultural factors that influence risk behavior among HIV-serodiscordant couples. The intervention used dyadic and group processes to focus on challenges confronting urban African-American couples, cultural, gender, and ethnic pride, and risk avoidance as an investment in the future of the couple and of the African American community and culture. Communication and cognitive problem-solving techniques were applied to increase empowerment, self-efficacy, and reframing strategies to assist in achieving risk reduction. In contrast, the health promotion intervention was designed to increase positive health behaviors and medication adherence. Sexual risk reduction was not a focus of the health promotion intervention.

Data were collected at baseline assessment, immediate post intervention assessment, and at 6- and 12-month post intervention assessments and analyzed for the 535 randomized couples: 260 in the intervention group and 275 in the comparison group; 81.9% were retained at the 12-month post intervention assessment. Results indicated significant reductions in HIV/STI risk behaviors among Eban African American HIV-serodiscordant couples (for more information, see El Bassel et al., 2010). Mr. and Mrs. Smith were selected for their shared histories, sexual, and/or physical victimization, as well as their commitment to their relationship and to each other.

Materials and Procedure

Data were collected individually through the use of audio computer assisted self -interview (ACASI) and face-to-face interviews. The CSA and ASA questions were collected through face-to-face interviews with questions adapted from the Wyatt Sex History Questionnaire (Wyatt, Lawrence, Vodounon, & Mickey, 1993).

The Brief Symptom Inventory (BSI) measures nine domains of psychological symptoms (Derogatis & Melisaratos, 1983; Derogatis, 1983). In this study, we used only items from the BSI depression subscale (Questions 9, 16, 17, 18, 35, and 50). Respondents were asked to rate their feelings on a five-point scale from 0 = *not at all* to 4 = *extremely*. A sample item is "Feeling no interest in things." Although there are many validated measures of depression, the BSI depression subscale was selected mainly for its brief length (i.e., six items) to reduce participant burden.

PTSD symptoms were assessed with the 17-item PTSD Checklist – Civilian Version (PCL-C) (Weathers & Litz, 1994). The couple was asked to rate the degree to which they were bothered by each PTSD symptom within the last month on a scale from *not at all* (1) to *extremely* (5). Scoring the PCL-C yields a sum score, with higher scores signifying a greater degree of PTSD symptomatology. A total score of 30 or above is reported as clinically significant for PTSD among general and military populations (Bliese, Wright, Adler, Cabrera, Castrol, et al., 2008).

Sexual functioning was assessed with three items from the original 17-item Watts Sexual Function Questionnaire (WSFQ), which assesses the major components of the sexual experience, including sexual desire, arousal, orgasm, and satisfaction (Watts, 1982). In the present study, one item was selected from each of the sexual desire, arousal, and orgasm components of the scale, as they are the more common symptoms of sexual dysfunction. Responses for each item were assessed on a five-point Likert scale, with higher scores signifying more positive sexual functioning.

Relationship satisfaction was assessed with the seven-item Relationship Assessment Scale (RAS) (Hendrick, 1988). The couple was asked questions that addressed relationship characteristics including the length of relationship, whether or not they were married to their study partner, and the quality of the relationship. They were also asked to rate items concerning how well their partner met their needs from *poorly* (1) to *extremely satisfied* (5). The RAS yields a score of relationship satisfaction ranging from 7 (*low satisfaction*) to 35 (*high satisfaction*).

A Reliability Change Index (RCI) was calculated for the health outcomes of depression, PTSD, sexual functioning, and relationship satisfaction in order to assess whether the change between pre- and post intervention scores were significant. RCI is equal to the individual's baseline score minus the post intervention score divided by the standard error of the difference of the tests being used (Jacobson, Roberts, Berns, McGlinchey, 1999). A reliable change score greater than 1.96 represents a significant change (Jacobson, Roberts, Berns, McGlinchey, 1999).

Condom use was assessed by the couple's reported proportion of condom-protected intercourse acts in the past 90 days. This was calculated as a weighted average of responses (see El-Bassel et al., 2012, for detailed description of these items).

Results

Background History of the Couple

Mr. Smith

Mr. Smith was a 44-year-old African-American male and the HIV-negative partner of Mrs. Smith. He did not complete high school, was currently unemployed, and reported a

monthly income of less than $400. He did not have any children. At the time of the interview, Mr. Smith had public health insurance. He reported being with Mrs. Smith for approximately 17 years and did not report having any concurrent partners.

For this study, CSA was defined as experiencing before the age of 18 any unwanted or forced sexual contact (ranging from touching and fondling to intercourse) and/or having sexual experiences with someone at least 5 years older. Mr. Smith had an extensive history of sexual abuse spanning from his childhood into his adulthood. He reported five time points before the age of 18 where he experienced CSA, and at these various ages he experienced multiple incidents of CSA.

His first experience of sexual abuse occurred at the age of 6 with his mother who was 28 years old and another person. He was forced to engage in vaginal intercourse. On a five-point Likert scale of how he felt at the time, ranging from *not at all* to *very afraid*, Mr. Smith expressed feeling very afraid. His second CSA experience occurred at the age of 12 and included oral-vaginal sex. However, during this time period, he experienced multiple incidences with several relatives who were at least 18 years of age. He expressed feeling somewhat afraid during these events. His third CSA experience was again at the age of 12 with multiple individuals, including his mother and one other relative who was at least 28 years of age. He was forced to engage in vaginal and oral sex. At that time, Mr. Smith expressed feeling neither afraid nor unafraid. His fourth CSA experience occurred at the age of 13 with a 30-year-old relative. Again, this involved multiple incidences where he experienced oral-vaginal sex, vaginal intercourse, and anal penetration with a finger or object. He expressed feeling very afraid when these events occurred. His fifth CSA experience occurred at the age of 16 with a 35-year-old male who raped him (i.e., anal penetration with his penis). Mr. Smith reported not feeling afraid. Since the age of 18, Mr. Smith reported additional experiences of being victimized, including anal penetration (i.e., being raped).

Throughout his life, Mr. Smith indicated that he has spent 122 days in prison. He reported drinking alcohol "a few times" over the past month and to using marijuana 21 times over the past 3 months but no heroin/injection drugs or other illegal substance use. He indicated no interpersonal, medical, or physical health problems as a result of his marijuana use. Mr. Smith has never entered a drug treatment or residential program. He did not HIV-seroconvert over the course of the study and reported good general health.

Mrs. Smith

Mrs. Smith was a 48-year-old White female and the HIV-positive partner in the relationship. She did not complete high school and is currently unemployed, reporting an income of between $851–1650 per month. At the time of the interview, she had public health insurance. She has been with Mr. Smith for 17 years, which is consistent with the history provided by Mr. Smith, and has had no concurrent sexual partners. She has no children.

Mrs. Smith reported having one experience of child sexual abuse. At the age of 10, a 50-year-old stranger raped her (i.e., vaginal penetration with his penis). On a five-point Likert scale of how she felt at the time, ranging from *not at all* to *very afraid*, she expressed having been very afraid. She reported no subsequent sexual abuse or interpersonal violence, both before and after age 18 (i.e., no other CSA, ASA, or IPV experiences).

Mrs. Smith had no history of incarceration. She did not use any alcohol during the past month and no illicit substances during the past three months. She has never been in a substance abuse treatment or residential program. She reported good general health despite having knowledge of her HIV-status for the past 17 years. She was currently receiving medical care for HIV and was adherent to prescribed antiretroviral medications. The last time she reported missing a dose of her antiretroviral medication was 1 to 3 months before the interview.

Psychological Well-Being

Depressive symptoms. Mr. Smith reported significant depressive symptomatology at the beginning of the intervention (BSI = 13) that increased over the follow-up period. At the 12-month post intervention assessment, he reported a score of 19, representing a significant RCI of worsening symptoms. Specifically, he

indicated that he felt "extremely" hopeless and worthless over the past month. He also indicated feeling "extremely" bothered by feeling lonely even when he was with other people. Of great concern was his report of being extremely bothered by thoughts of ending his life during the past week (see Table 1 for health outcomes over time).

Mrs. Smith reported moderate symptoms of depression (BSI = 9) at the beginning of the intervention that increased over the course of the intervention sessions and at follow-up. At the 12-month post intervention assessment, Mrs. Smith reported a higher depressive score (BSI = 13) and indicated that she was "quite a bit" bothered by feeling hopeless, blue, and having no interest in things within the last month. She indicated that during the past week, she was "quite a bit" bothered by feeling lonely even when she was with people.

Post-traumatic stress symptoms (PTSD). Mr. and Mrs. Smith both endorsed clinically significant levels of PTSD symptoms, which remained elevated over the course of the intervention and the follow-up period.

At the initial interview, Mr. Smith had a reported a score of 53 on the PCL-C. Specifically, he reported that over the past month, he had been "extremely bothered" by repeated, disturbing memories, thoughts, or images, dreams, feelings that he was reliving and avoiding activities and situations because they reminded him of a stressful past experience. He also indicated he was "bothered" by feelings that his future would somehow be cut short and bothered "quite a bit" by an inability to fall or stay asleep over the past month. Although he reported less avoidance of activities or situations that reminded him of the past at the 6-month follow up (PCL-C = 51), each of the above symptoms remained elevated one year after the intervention sessions ended (PCL-C = 55). Mr. Smith indicated that he continued to be "moderately" to "extremely" bothered by each of these symptoms. The RCI from baseline to either post assessment was not significant.

Mrs. Smith also reported elevated levels of PTSD symptoms. At the baseline assessment, she indicated being "extremely bothered" by having physical reactions to being reminded of past stressful experiences such as heart pounding, trouble breathing, and sweating and reported a 41 on the PCL-C. She also reported

Table 1
Health Outcomes Over Time With Reliable Change Index (RCI)

Health outcome	Participant	Baseline assessment	Immediate post assessment	6-month post assessment	12-month post assessment	Baseline to immediate post RCI	Baseline to 6-month post RCI	Baseline to 12-month post RCI
Depression (BSI)	Mr. Smith	13	—	16	19	—	−1.38	−2.78*
	Mrs. Smith	9	—	12	13	—	−1.38	−1.85
PTSD (PCL-C)	Mr. Smith	53	—	51	55	—	0.46	−0.46
	Mrs. Smith	41	—	50	49	—	−2.09*	−1.86
Sexual functioning (WSFQ)	Mr. Smith	9	—	5	11	—	3.25*	−1.63
	Mrs. Smith	12	—	6	9	—	4.08*	2.04*
Relationship satisfaction (RAS)	Mr. Smith	31	33	27	32	−0.73	1.47	−0.37
	Mrs. Smith	34	29	30	28	1.83	1.47	2.20*

* A reliable change score greater than 1.96 represents a significant change (Jacobson, Roberts, Berns, & McGlinchey, 1996).

being "extremely bothered" by difficulty falling or staying asleep and concentrating. At 6-month post assessment, she reported a 50 on the PCL-C, indicating an increase in certain symptoms, as indicated by the RCI. Despite reporting a decrease in feeling "bothered" by experiencing physical reactions, she continued to feel "bothered" by these symptoms "moderately" to "quite a bit" at the 12-month post intervention assessment (PCL-C = 49). She also reported feeling significantly more distant from people, emotionally numb and irritable, being "super alert," having a sense that her life would somehow be cut short, and a loss of interest in activities she once enjoyed. Although her symptoms were still prevalent, the RCI from baseline to 12-month post assessment was no longer significant.

Sexual Functioning

At baseline, Mr. Smith reported "almost always" having a desire for sex. He said that he was always able to achieve an erection and "ejaculated" too soon about half of the time during intercourse. At baseline, 6-month, and 12-month post assessments, he reported a score of 9, 5, and 11 on the WSFQ, respectively. The RCI between baseline and 6-month post assessment was significant with Mr. Smith reporting increased problems achieving an erection and premature ejaculation. However, the RCI was not significant between baseline and the 12-month post intervention assessment. At baseline, Mrs. Smith reported "always" having a desire for sex. She said that she never experienced vaginal dryness and was able to reach an orgasm every time she engaged in sex. However, at the 6-month post intervention assessment, she reported a decrease in desire and the ability to climax and more experiences with vaginal dryness. While these symptoms improved at the 12-month post assessment, they continued to be problematic. On the WSFQ, she reported a score of 12, 6, and 9 at baseline, 6-month, and 12-month post assessments, respectively. The RCI was significant between baseline and both post assessments.

Relationship Satisfaction

Mr. and Mrs. Smith both reported that they loved each other "very much" throughout their enrollment in the Eban Project. At baseline, Mr. Smith indicated that he "rarely" wished that he had not developed a relationship with Mrs. Smith. His RAS baseline score was 31. However, from the immediate post intervention assessment on through the 6- and 12-month post intervention assessments, he indicated that he "sometimes" or "often" wished he had not developed the relationship. Nevertheless, his RAS score at the 12-month post intervention assessment was essentially unchanged (RAS = 32), with the RCI not being significant between baseline and any post assessments. Despite Mr. Smith reporting that there were an "average" number of problems in the relationship at baseline, thereafter his responses ranged from "very few" to "many" problems. Overall, Mr. Smith indicated that he was "satisfied" to "extremely satisfied" with the relationship throughout the course of the intervention and at the follow-up assessments.

In contrast, Mrs. Smith reported being "extremely satisfied" with her relationship with Mr. Smith, both at baseline and at the 12-month post intervention assessment. She reported that she "never" regretted the relationship with Mr. Smith. However, her RAS scores did reflect a change over time. While at baseline Mrs. Smith indicated that there were "very few" problems in their relationship, she described having an "average" number of problems at all subsequent assessment points. Importantly, her RAS score decreased from 34 to 28 and the RCI was significant from baseline to 12-month post assessment.

Sexual Risks

Neither Mr. nor Mrs. Smith reported having a sexually transmitted infection at any of the assessment points. Both reported no condom use at baseline, using condoms 77% of the time at immediate post intervention assessment, 17% at the 6-month post intervention assessment, and no condom use at the 12-month post intervention assessment (See Figure 1 for condom use percent over time).

Discussion

In the present case study, we presented a married, low income, long time unemployed, HIV-serodiscordant couple comprising an Eu-

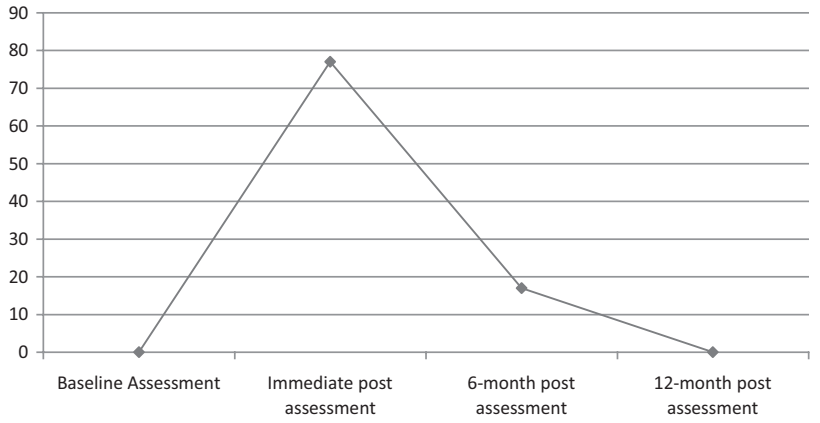


Figure 1. Sexual risks (condom use percent over time).

ropean-American HIV-positive female and an African-American HIV-negative male. Both reported histories of CSA and clinically significant symptoms of depression and PTSD at baseline. The couple completed eight sessions of an HIV/STI risk reduction intervention program and reported an initial increase in condom use. However, condom use decreased to baseline level (e.g., no condom use) by the 12-month post intervention assessment. While much research points to difficulties in maintaining increases in condom use over time, we do know that this couple was trying to make this behavioral change while contending with significant psychological distress and histories of trauma. These are factors that have been correlated with HIV-transmission behaviors (Wyatt et al., 2002; Basu et al., 2005). While causal inferences clearly cannot be determined from data on one couple, and a myriad of factors could potentially have attenuated their initial success, it is possible that significant changes in their psychological well-being after treatment ended (Mrs. Smith's increase in symptoms of PTSD at 6-month follow-up and Mr. Smith's significant increase in depressive symptoms at 12-month follow-up) could have allowed old barriers to condom use to reemerge. Accordingly, we hypothesize that in sexual risk reduction interventions, short-term successful outcomes may potentially be compromised by both the sexual histories of each partner and the residual correlates, including mental health issues. Understanding the potential contribution of past traumatic experiences to current psychosocial functioning may be critical to conceptualizing the emotional, sexual, and physical health status of individuals, as sexual trauma victims tend to use health care services at high rates (Grossman et al., 2009).

Clinical Implications for Couples Work

Given that Mr. and Mrs. Smith's sexual risks were reticent to change over time, combined with changes in their perceptions of problems and satisfaction with their relationship, including the significant diminishing satisfaction of one partner, it is important for health professionals to ask in-depth questions about consensual and nonconsensual sexual histories, experiences with physical abuse, and the periods of time in which these events occurred and with whom. Similarly, both partners in this relationship experienced an increase in sexual dysfunction post treatment. If individuals report sexual and/or relationship problems, it is important to invite both partners to attend a session together to determine how personal histories may influence their health and mental status and that of their partner, as well as the couple's social, emotional, and sexual satisfaction.

Not all health professionals recognize the need to broaden their approach to the assessment of these health related problems. During the formative phase and piloting of the Eban intervention, couples often reported that their health care providers had never asked if they were in a relationship, inquired about the couple's serostatus, or whether the uninfected part-

ner knew about the HIV status of the infected partner (NIMH Multisite HIV/STD Prevention Trials for African American Couples Group, 2008).

When individuals or couples seek services, health care providers may be unaware of the potential underlying issues of each partner. This lack of information can result in neglecting possible factors which serve to maintain and/or exacerbate current difficulties. In their standard assessment of patients, conducted in individual sessions, clinicians should routinely assess for HIV-status, sexual and physical trauma histories, as well as sexual risk behaviors within and outside of the main partnership. It is possible that some components of personal histories like HIV status or abuse and trauma may need to be discussed in a couples session, but partners may also need individual sessions to prepare them for the disclosure of personal events that they may have never previously shared or for the impact that disclosure has on the other individual and the relationship.

Despite the need for comprehensive assessments, health care professionals, including mental health counselors and therapists, may not be adequately trained to assess for histories of sexual or physical victimization or HIV-status. For instance, noting these deficits, Donohoe (2010) reported that after mental health professionals completed an educational program concerning violence and abuse prevention, they not only changed their attitudes about the importance of assessing for abuse histories but increased their competence and practice of sexual abuse assessments within their professional practices. Others have recommended the incorporation of routine screening for CSA in females (Seng & Patersen, 1995) and males (Lab, Feigenbaum & Silva, 2000). Similarly, increasing competence to conduct preventive HIV screenings, HIV-related education (Khalsa, 2006), and to provide psychotherapy for HIV/AIDS patients who present with comorbid mental health concerns has been emphasized for health professionals (Schmeller-Berger, Handel, Searight & Katz, 1998). Despite the importance of screening for and addressing these factors, it is unclear whether training in sexual victimization, HIV status, and mental health is a national priority and whether providers should be required to obtain this training for licensure. Without consistent policy, the delivery of informed services will be varied across different states, service organizations, and providers.

Limitations

We recognize limitations of this study. First, although social desirability was reported as relatively low (El Bassel et al. 2010), this case study may have been influenced by the retrospective recall of histories of sexual and physical abuse (Loeb et al., 2011). This study measured outcomes longitudinally. Although we were able to detect change over time for each outcome, we were unable to statistically determine whether this couples' histories of trauma, psychological distress, condom use, relationship satisfaction, and sexual functioning related, predicted, and/or interacted with each other. Similarly, we do not know the extent to which these issues were factors for other couples in the EBAN study. Better understanding these relationships will potentially allow HIV sexual risk reduction treatments to be more effective.

Future Directions

It is important for research to understand how psychological status and change over time as well as histories of sexual and interpersonal trauma may interact with treatment and intervention efficacy. Although some providers will ask screening questions and determine the need for additional services, it is important to realize that screening questions may simply identify what events occurred (Wyatt et al., 1988). The referral of individuals or couples with abuse and trauma histories and who are HIV infected to an appropriately trained professional is especially important if they are to benefit from more in-depth treatment. Assessments that determine at what age, with whom, where, what happened, and how the survivor felt regarding the behaviors and experiences are important to psychological, sexual, and physical health (Wyatt et al., 1988). This basic information may also influence policy regarding whether the sexual and physical abuse reporting requirements that differ by state apply to the disclosure and/or the kind of referral that would be appropriate to provide care, if needed.

Clinicians who provide treatment need to explore the meaning of these experiences in their patient's lives. While the focus may be on collecting information to assess risk of HIV infection and transmission, or discussing relationship or sexual problems with couples, there needs to be an integration of these topics when couples like Mr. and Mrs. Smith seek care. A deeper understanding of the impact and appraisal of these experiences will better help to identify what influences and motivates sexual and general health behaviors by taking an in-depth sexual history. Importantly, patients may not know how to change their risk behaviors or to identify the triggers that may be related to unhealthy coping strategies like substance abuse or to those that heighten symptoms of trauma or depression.

Providing couples with insight about how each individual may affect the psychological well-being of the other may be another area for which health providers may need additional training. Specifically, training to clarify how past experiences can contribute to relationship conflicts and sexual functioning. Teaching skills that emphasize providing support to each other can strengthen the couple's emotional bond and ameliorate psychological distress. Health care providers also need to determine in what other areas couples may be at risk including cigarette smoking, the use/abuse of alcohol, the use of other legal and illicit drugs, and whether regimens for HIV antiretroviral drugs are adhered to or misused, including being sold for income. Clinicians need to assess the meaning of substance use for their patients as drugs may be used as a self medicating strategy to cope with difficult life events such as past trauma, symptoms of PTSD (Ullman, Najdowski & Filipas, 2009), or living with the diagnosis of HIV. The need to address these factors and the resulting psychological sequelae may be critical to the success of therapy with HIV infected couples.

Our case study with Mr. and Mrs. Smith underscores the importance of providing additional booster sessions to current, structured interventions such as Eban, even though both individuals rated it as being highly useful in their relationship. Neither partner had received any prior individual therapy to discuss their personal histories of trauma or to make decisions about what aspects, if any, of their past histories they wanted to share with each other. Mr. Smith and Mrs. Smith, the HIV-positive partner, are likely to continue to report incidents of unprotected sex and a decrease in their sexual functioning as a couple unless he receives treatment for his ongoing symptoms of PTSD, depression, and growing distress about daily coping, and she receives attention for her psychological distress, as well. Their involvement in mental health related services with regular monitoring about their progress and setbacks could increase the chances that their shared positive perceptions of relationship satisfaction could be retained. Renewed attention to following Mrs. Smith for HIV medical adherence and condom use with her partner, and acknowledging both individual and dyadic level needs, could ensure that they maintain their health and well-being as individuals and as a loving couple.

References

Aosved, A. C., Long, P. J., & Voller, E. K. (2011). Sexual revictimization and adjustment in college men. *Psychology of Men & Masculinity, 12,* 285–296.

Arata, C. M. (2000). From child victim to adult victim: A model for predicting sexual revictimization. *Child Maltreatment, 5,* 28–38.

Archer, J. (2000). Sex difference in aggression between heterosexual partners: A meta-analytic review. *Psychological Bulletin, 126,* 651–680.

Basu, S., Chwastiak, L. A., & Bruce, R. D. (2005). Clinical management of depression and anxiety in HIV infected adults. *AIDS, 19,* 2057–2067.

Bliese, P. D., Wright, K. M., Adler, A. B., Cabrera, O., Castrol, C. A., & Hoge, C. W. (2008). Validating the primary care posttraumatic stress disorder screen and the posttraumatic stress disorder checklist with soldiers returning from combat. *Journal of Consulting and Clinical Psychology, 76,* 272–281.

Boarts, J. M., Bogart, L. M., Tabak, M. A., Armelie, A. P., & Delahanty, D. L. (2008). Relationship of race-, sexual orientation-, and HIV-related discrimination with adherence to HIV treatment: A pilot study. *Journal of Behavioral Medicine, 31,* 445–451.

Bradley, M., Remien, R., & Dolezal, C. (2008). Depression symptoms and sexual HIV risk behavior among serodiscordant couples. *Psychosomatic Medicine, 70,* 186–191.

Caldwell, J. E., Swan, S. C., & Woodbrown, V. D. (2012). Gender differences in intimate partner violence outcomes. *Psychology of Violence, 2,* 42–57.

Campbell, R., Greenson, M. R., Bybee, D., & Raja, S. (2008). The co-occurrence of childhood sexual abuse, adult sexual assault, intimate partner violence, and sexual harassment: A meditational model of posttraumatic stress disorder and psychical health outcomes. *Journal of Consulting and Counseling Psychology, 76,* 194–207.

Centers for Disease Control and Prevention. (2004). *HIV/AIDS Surveillance Report.* Available: Http://www.cdc.gov/

Centers for Disease Control and Prevention. (2010). *HIV in the United States.* Available: Http://www.cdc.gov/

Centers for Disease Control and Prevention. (2011). *HIV/AIDS among African Americans: CDC HIV/AIDS fact sheet.* Available at http://www.cdc.gov/hiv/topics/aa/PDF/aa.pdf. Accessed February 23, 2012.

Chartier, M. J., Walker, J. R., & Naimark, B. (2009). Health risk behaviors and mental health problems as mediators of the relationship between childhood abuse and adult health. *American Journal of Public Health, 99,* 847–854.

Coxell, A. W., & King, M. B. (2010). Adult male rape and sexual assault: Prevalence, revictimization and the tonic immobility response. *Sexual & Relationship Therapy, 25,* 372–379.

Derogatis, L. R., & Melisaratos, N. (1983). The brief symptom inventory: An introductory report. *Psychological Medicine, 13,* 595–605.

Derogatis, L. R. (1983). *SCL-90-R.* Towson, MD: Clinical Psychometric Research.

DiLillo, D., Peugh, J., Walsh, K., Panuzio, J., Trask, E., & Evans, S. (2009). Child maltreatment history among newlywed couples: A longitudinal study of marital outcomes and mediating pathways. *Journal of Consulting and Clinical Psychology, 77,* 680–692.

DiLillo, D. (2001). Interpersonal functioning among women reporting a history of childhood sexual abuse: Empirical findings and methodological issues. *Clinical Psychology Review, 21,* 553–576.

Donohoe, J. (2010). Uncovering sexual abuse: Evaluation of the effectiveness of the victims of violence and abuse prevention programme. *Journal of Psychiatric and Mental Health Nursing, 17,* 9–18.

Eadie, E. M., Runts, M. G., & Spencer-Rodgers, J. (2008). Posttraumatic stress symptoms as a mediator between sexual assault and adverse health outcomes in undergraduate women. *Journal of Traumatic Stress, 21,* 540–547.

El-Bassel, N., Jemmott, J. B., Landis, J. R., Pequegnat, W., Wingood, G. M., Wyatt, G. E., Bellamy, S. L., & NIMH Multisite HIV/STD Prevention Trial for African American Couples Group. (2010). National Institute of Mental Health Multisite Eban HIV/STD Prevention Intervention for African American HIV Serodiscordant Couples: A cluster randomized trial. *Archives in Internal Medicine, 27,* 1594–601.

Fortier, M. A., DiLillo, D., Messman-Moore, T. L., Peugh, J., DeNardi, K. A., & Gaffey, K. J. (2009). Severity of child sexual abuse and revictimization: The mediating role of coping and trauma symptoms. *Psychology of Women Quarterly, 33,* 308–320.

Garnefski, N., & Arends, E. (1998). Sexual abuse and adolescent maladjustment: Differences between male and female victims. *Journal of Adolescence, 21,* 99–107.

Glover, D. A., Loeb, T. B., Carmona, J. V., Sciolla, A., Zhang, M., Myers, H., & Wyatt, G. E. (2010). Child sexual abuse severity and disclosure predict PTSD symptoms and biomarkers in ethnic minority women. *Journal of Trauma Dissociation, 11,* 152–173.

Goldman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P., & Gordan, D. S. (2003). Why children tell: A model of children's disclosure of sexual abuse. *Child Abuse and Neglect, 27,* 525–540.

Grossman, S. F., Lundy, M., Bertrand, C., Ortiz, C., Tomas-Tolentino, G., Ritzema, K., & Matson, J. (2009). Service patterns of adult survivors of childhood versus adult sexual assault/abuse. *Journal of Child Sexual Abuse, 18,* 655–672.

Hendrick, S. S. (1988). A generic measure of relationship satisfaction. *Journal of Marriage and the Family, 50,* 93–98.

Holmes, W. C., Foa, E. B., & Sammel, M. D. (2005). Men's pathways to risky sexual behavior: Role of co-occurring childhood sexual abuse, posttraumatic stress disorder, and depression histories. *Journal of Urban Health, 82,* i89–i99.

Jacobson, N. S., Roberts, L. J., Berns, S. B., & McGlinchey, J. B. (1999). Methods for defining and determining the clinical significance of treatment effects. *Journal of Consulting and Clinical Psychology, 67*(3), 300–307.

Johnson, L. W., & Harlow, L. L. (1996). Childhood sexual abuse linked with adult substance use, victimization, and AIDS-risk. *AIDS Education and Prevention, 8,* 44–57.

Khalsa, A. M. (2006). Preventive counseling, screening, and therapy for the patient with newly diagnosed HIV infection. *American Family Physician, 73,* 271–280.

Koenen, K. C., & Widom, C. S. (2009). A prospective study of sex differences in the lifetime risk of posttraumatic stress disorder among abused and neglected children grown up. *Journal of Traumatic Stress, 22,* 566–574.

Lab, D. D., Feigenbaum, J. D., & Silva, P. (2000). Mental health professionals attitudes and practices towards male childhood sexual abuse. *Child Abuse & Neglect, 24,* 391–409.

Larsen, C. D., Sandberg, J. G., Harper, J. M., & Bean, R. (2011). The effects of childhood abuse on relationship quality: Gender differences and clinical implications. *Family Relations: An Interdisciplinary Journal of Applied Family Studies, 60,* 435–445.

Loeb, T. B., Gaines, T., Wyatt, G. E., Zhang, M., & Liu. H. (2011). Associations between child sexual abuse and negative sexual experiences and revictimization among women: Does measuring severity matter? *Child Abuse Neglect, 35,* 946–955.

Loeb, T. B., Williams, J., Carmona, J., Rivkin, I., Wyatt, G. E., Chin, D., & Asuan-O'Brien, A. (2002). Child sexual abuse: Associations with the sexual functioning of adolescents and adults. *Annual Review of Sex Research, 13,* 207–345.

Merrill, L. L., Guimond, J. M., Thomsen, C. J., & Milner, J. S. (2003). Child abuse and number of sexual partners in young women: The role of abuse severity, coping style, and sexual functioning. *Journal of Consulting and Clinical Psychology, 71,* 987–996.

Mosack, K. E., Randolph, M. E., Dickson-Gomez, J., Abbott, M., Smith, E., & Weeks, M. R. (2010). Sexual risk-taking among high-risk urban women with and without histories of childhood sexual abuse: Mediating effects of contextual factors. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders, 19,* 43–61.

NIMH Multisite HIV/STD Prevention Trials for African American Couples Group. (2008). Formative study to develop the Eban treatment and comparison interventions for couples. *Journal of Acquired Immune Deficiency Syndrome, 49,* S42–S51.

Noll, J. G., Horowitz, L. A., Bonanno, G. A., Trickett, P. K., & Putnam, F. W. (2003). Revictimization and self-harm in females who experienced childhood sexual abuse. Results of prospective study. *Journal of Interpersonal Violence, 18,* 1452–1471.

Parsons, J. T., Grov, C., & Golub, S. A. (2012). Sexual compulsivity, co-occurring psychosocial health problems, and HIV-risk among gay and bisexual men: Further evidence of a syndemic. *American Journal of Public Health, 102,* 156–162.

Rabkin, J. (2008). HIV and depression: 2008 review and update. *Current HIV/AIDS Reports, 5,* 163–171.

Rosen, R., Janssen, E., Wiegel, M., Bancroft, J., Althof, S., Wincze, J., . . . Barlow, D. (2006). Psychological and interpersonal correlates in men with erectile dysfunction and their partners: A pilot study of treatment outcomes with sildenafil. *Journal of Sex and Marital Therapy, 32,* 215–234.

Schmeller-Berger, L., Handal, P. J., Searight, H. R., & Katz, B. (1998). A survey of psychologists' education, knowledge and experience treating clients with HIV/AIDS. *Professional Psychology: Research and Practice, 29,* 160–162.

Seng, J. S., & Peterson, B. A. (1995). Incorporating routine screening for history of childhood sexual abuse into well-women and maternity care. *Journal of Nurse-Midwifery, 40,* 26–30.

Senn, T. E., Carey, M. P., & Vanable, P. A. (2008). Childhood and adolescent sexual abuse and subsequent sexual risk behavior: Evidence from controlled studies, methodological critique, and suggestions for research. *Clinical Psychology Review, 28,* 711–735.

Sikkema, K. J., Hansen, N. B., Meade, C. S., Kochman, A., & Fox, A. M. (2009). Psychosocial predictors of sexual HIV transmission risk behavior among HIV-positive adults with a sexual abuse history in childhood. *Archives of Sex Behavior, 38,* 121–134.

Smith, P. N., Gamble, S. A., & Cort, N. A. (2012). Attachment and alliance in the treatment of depressed sexually abused women. *Depression & Anxiety, 29,* 123–130.

Sorsoli, L., Kia-Keating, M., & Grossman, F. K. (2008). "I keep that hush-hush": Male survivors of sexual abuse and the challenges of disclosure. *Journal of Counseling Psychology, 55,* 333–345.

ter Kuile, M. M., Weijenborg, P. T. M., & Spinhoven, P. (2010). Sexual functioning in women with chronic pelvic pain: The role of anxiety and depression. *Journal of Sexual Medicine, 7,* 1901–1910.

Testa, M., Hoffman, J. H., & Livingston, J. A. (2010). Alcohol and sexual risk behaviors as mediators of the sexual victimization–revictimization relationship. *Journal of Consulting and Clinical Psychology, 78,* 249–259.

Tolin, D. F., & Foa, E. B., (2006). Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. *Psychological Bulletin, 132,* 959–992.

Turchik, J. A. (2011). Sexual victimization among male college students: Assault severity, sexual functioning, and health risk behaviors. *Psychology of Men & Masculinity.*

Ullman, S. E., & Filipas, H. H. (2005). Gender differences in social reactions to abuse disclosure, post-abuse coping and PTSD of child sexual abuse survivors. *Child Abuse & Neglect, 29,* 767–782.

Ullman, S. E., Najdowski, C. J., & Filipas, H. H. (2009). Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders, 18,* 367–385.

Watson, B., & Halford, W. K. (2010). Classes of childhood sexual abuse and women's adult couple relationships. *Violence and Victims, 25,* 518–535.

Watts, R. J. (1982). Sexual functioning, health beliefs, and compliance with high blood pressure medications. *Nursing Research, 31,* 278–283.

Weathers, F. W., & Litz, B. T. (1994). Psychometric properties of the clinician administered PTSD scale. *PTSD Research Quarterly, 5,* 2–6.

Williams, J. K., Kisler, K. A., Glover, D., & Sciolla, A. (2011). Exploring childhood sexual experiences and vulnerability to intimate partner violence among African American MSMW: Was that abuse or love? In L. E. Hynes (Ed.), *Sexual abuse: Types, signs and treatments.* Hauppauge: Nova Science Publishers.

Wyatt, G. E., Lawrence, J., Vodounon, A., & Mickey, M. R. (1993). The Wyatt Sex History Questionnaire: A structured interview for female sexual history taking. *Journal of Child Sexual Abuse, 1,* 51–68.

Wyatt, G. E., Myers, H. F., Williams, J. K., Kitchen, C. R., Loeb, T., Carmona, J. V., . . . Presley, N. (2002). Does a history of trauma contribute to HIV risk for women of color? Implications for prevention and policy. *American Journal of Public Health, 92,* 660–665.

Wyatt, G. E., & Powell, G. J. (1988). *Lasting effects of child sexual abuse.* Thousand Oaks, CA: Sage.

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