

Living in the Face of Trauma (LIFT): An Intervention for Coping With HIV and Trauma

Living in the Face of Trauma (LIFT): An Intervention for Coping With HIV and Trauma is a group intervention that focuses on improving the coping abilities of individuals--women of any sexual orientation and men who have sex with men--who have HIV and a history of childhood sexual abuse. LIFT promotes better health protective decisionmaking with the goals of reducing the symptoms of traumatic stress and the risk of transmitting HIV, as well as the risk for substance abuse, a common experience among these populations.

LIFT therapists use a cognitive behavioral approach to help clients develop and maintain healthy relationships and protective health behaviors such as substance use reduction, protected sexual intercourse, increased patient-provider communication, and HIV treatment adherence. Since a key element of the intervention is to provide a supportive and safe treatment environment, LIFT groups are composed of same-gender clients, usually with a similar sexual orientation. Significant time in each session is devoted to sharing personal experiences of HIV infection and childhood trauma, allowing clients to offer each other support and feedback. LIFT therapists guide clients in identifying traumatic stress parallels (e.g., feeling powerless) between their HIV diagnosis and childhood sexual abuse. Past and present coping methods such as alcohol and drug use are discussed with the group, and healthy coping strategies are offered and then practiced during group role-plays and as homework. LIFT is manual driven and consists of 15 90-minute sessions delivered weekly by two cotherapists to groups of about 10 clients each.

Descriptive Information

Areas of Interest	Mental health treatment Substance abuse prevention Co-occurring disorders
Outcomes	Review Date: December 2010 1: Traumatic stress symptoms 2: HIV sexual risk behaviors 3: Substance use
Outcome Categories	Alcohol Drugs Mental health Trauma/injuries
Ages	26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	Outpatient
Geographic Locations	Urban Suburban
Implementation History	Since 2001, LIFT has been implemented with approximately 160 individuals in 3 sites in New York, Connecticut, and Illinois. Additional implementation sites in North Carolina and Illinois will serve up to 50 individuals.
NIH Funding/CER	Partially/fully funded by National Institutes of Health: Yes

Studies	Evaluated in comparative effectiveness research studies: Yes
Adaptations	No population- or culture-specific adaptations of the intervention were identified by the developer.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Indicated

Quality of Research

Review Date: December 2010

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

[Meade, C. S., Drabkin, A. S., Hansen, N. B., Wilson, P. A., Kochman, A., & Sikkema, K. J. \(2010\). Reductions in alcohol and cocaine use following a group coping intervention for HIV-positive adults with childhood sexual abuse histories. *Addiction*, 105\(11\), 1942-1951.](#) 

[Sikkema, K. J., Hansen, N. B., Kochman, A., Tarakeshwar, N., Neufeld, S., Meade, C. S., et al. \(2007\). Outcomes from a group intervention for coping with HIV/AIDS and childhood sexual abuse: Reductions in traumatic stress. *AIDS and Behavior*, 11\(1\), 49-60.](#) 

[Sikkema, K. J., Wilson, P. A., Hansen, N. B., Kochman, A., Neufeld, S., Ghebremichael, M. S., et al. \(2008\). Effects of a coping intervention on transmission risk behavior among people living with HIV/AIDS and a history of childhood sexual abuse. *Journal of Acquired Immune Deficiency Syndromes*, 47\(4\), 506-513.](#) 

Sikkema, K. J., Wilson, P. A., Hansen, N. B., Kochman, A., Neufeld, S., Ghebremichael, M. S., et al. (2010). Effects of a coping intervention on transmission risk behavior among people living with HIV/AIDS and a history of childhood sexual abuse: Erratum. *Journal of Acquired Immune Deficiency Syndromes*, 55(2), 286.

Supplementary Materials

[Gribble, J. N., Miller, H. G., Rogers, S. M., & Turner, C. F. \(1999\). Interview mode and measurement of sexual behaviors: Methodological issues. *Journal of Sex Research*, 36\(1\), 16-24.](#)

[Hansen, N., Kershaw, T., Kochman, A., & Sikkema, K. \(2007\). A classification and regression trees analysis predicting treatment outcome following a group intervention randomized controlled trial for HIV-positive adult survivors of childhood sexual abuse. *Psychotherapy Research*, 17\(4\), 404-415.](#)

[Harrison, L. D., Martin, S. S., Enev, T., & Harrington, D. \(2007\). Highlights. In *Comparing drug testing and self-report of drug use among youths and young adults in the general population* \(pp. 1-4, DHHS Publication No. SMA 07-4249, Methodology Series M-7\). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.](#)

[Schrimshaw, E. W., Rosario, M., Meyer-Bahlburg, H. F. L., & Scharf-Matlick, A. A. \(2006\). Test-retest reliability of self-reported sexual behavior, sexual orientation, and psychosexual milestones among gay, lesbian, and bisexual youths. *Archives of Sexual Behavior*, 35\(2\), 225-234.](#) 

[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 Sexual Behavior*, 38\(1\), 121-134.](#) 

[Sundin, E. C., & Horowitz, M. J. \(2002\). Impact of Event Scale: Psychometric properties. *British Journal of Psychiatry*, 180, 205-209.](#) 

Outcomes

Outcome 1: Traumatic stress symptoms

Description of Measures

Traumatic stress symptoms were assessed using the Impact of Event Scale (IES), a 15-item self-report scale that measures the frequency and severity of distress associated with a specific life event. The IES measures both the intrusion and avoidance of certain ideas, feelings, and situations

associated with the trauma. Each item presents a symptom that is measured for the prior 7-day period on a 4-point scale (0, 1, 3, and 5) that ranges from "not at all" to "often." The Intrusion subscale includes items such as "I thought about it when I didn't mean to" and "I had waves of strong feelings about it." The Avoidance subscale includes items such as "I stayed away from reminders of it" and "I tried not to think about it." Participants rated symptoms with reference to their traumatic childhood sexual experiences. The instrument was administered using a computer-assisted personal interview.

Key Findings	<p>In a randomized clinical trial, HIV-positive clients with a history of childhood sexual abuse were assigned to one of three conditions: LIFT, 15 weekly 90-minute sessions of an HIV support group, or a wait-list control. Traumatic stress symptoms were assessed at pretest and within 2 weeks posttreatment (posttest). Findings included the following:</p> <ul style="list-style-type: none"> • From pre- to posttest, LIFT participants had a decrease in the frequency and severity of intrusion symptoms compared with control group participants ($p = .007$). This difference was associated with a small effect size (Cohen's $d = 0.49$). Change in intrusion symptoms from pre- to posttest did not differ between HIV support group and control group participants. • From pre- to posttest, both LIFT and HIV support group participants had a decrease in the frequency and severity of intrusion symptoms ($p = .001$ for each group) and avoidance symptoms ($p = .004$ for each group). However, the improvement in avoidance symptoms was larger for LIFT than HIV support group participants ($p = .026$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.3 (0.0-4.0 scale)

Outcome 2: HIV sexual risk behaviors

Description of Measures	<p>HIV sexual risk behaviors were evaluated using an adapted version of the Sexual Risk Behavior Assessment Schedule, which measures the number of self-reported unprotected sex acts--with all partners and with partners whose HIV serostatus was negative or unknown to the participant--during a prior time period (past 4 months was used at all assessments in this study). An unprotected sex act was defined as any act of insertive or receptive anal or vaginal intercourse in which neither party used a condom. The instrument was administered using a computer-assisted personal interview.</p>
Key Findings	<p>In a randomized clinical trial, HIV-positive clients with a history of childhood sexual abuse were assigned to one of three conditions: LIFT, 15 weekly 90-minute sessions of an HIV support group, or a wait-list control (which was randomly assigned to LIFT or the HIV support group after 4 months). Assessments occurred at pretest, within 2 weeks posttreatment (posttest), and at 4-month intervals thereafter through 12 months posttreatment (follow-ups). Findings included the following:</p> <ul style="list-style-type: none"> • Across the posttest and follow-up assessments, both LIFT and HIV support group participants had a decrease in the frequency of unprotected sex with all partners ($p = .02$ for each group) and with partners who were HIV-negative or of unknown serostatus ($p < .001$ for each group). • LIFT participants had a greater decrease in the frequency of unprotected sex with all partners compared with HIV support group participants at the 4-, 8-, and 12-month follow-ups ($p < .001$). These group differences were associated with small effect sizes (Cohen's $d = 0.43, 0.41, \text{ and } 0.48$, respectively). • LIFT participants also had a greater decrease in the frequency of unprotected sex with partners who were HIV-negative or of unknown serostatus compared with HIV support group participants at the 4-, 8-, and 12-month follow-ups ($p < .001$). These group differences were associated with small effect sizes at the 4- and 8-month follow-ups (Cohen's $d = 0.48 \text{ and } 0.39$, respectively) and a very small effect size at the 12-month follow-up (Cohen's $d = 0.04$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.2 (0.0-4.0 scale)

Outcome 3: Substance use

Description of Measures	<p>Substance use was measured using items from the 2000 National Survey on Drug Use and Health. The frequency of past-month use of alcohol, cocaine (powder or crack), and marijuana was reported using the following rating scale: 0 = none, 1 = 1-2 days, 2 = 3-5 days, 3 = 6-10 days, 4 = 11-20 days, 5 = 21-28 days, and 6 = every day. For cocaine and marijuana, a dichotomous variable for any use (1) versus no use (0) was created. For alcohol, the number of drinks typically consumed on drinking days was reported using the following rating scale: 0 = none, 1 = one or fewer, 2 = two to three, 3 = four to five, and 4 = six or more. An estimate of past-month drinking quantity (i.e., number of drinks consumed in the month) was calculated by multiplying drinking frequency by number of drinks per drinking day. The instrument was administered using a computer-assisted personal interview.</p>
Key Findings	<p>In a randomized clinical trial, HIV-positive clients with a history of childhood sexual abuse were assigned to one of three conditions: LIFT, 15 weekly 90-minute sessions of an HIV support group, or a wait-list control (which was randomly assigned to LIFT or the HIV support group after 4 months). Assessments occurred at pretest, within 2 weeks posttreatment (posttest), and at 4-month intervals thereafter through 12 months posttreatment (follow-ups). Findings included the following:</p> <ul style="list-style-type: none"> • From pretest to the 12-month follow-up, both LIFT and HIV support group participants had a decrease in past-month drinking quantity ($p = .03$ for each group), with LIFT participants having greater improvement (a decrease of 5.1 vs. 1.6 drinks per month for LIFT and HIV support group participants, respectively; $p = .029$). • Across the posttest and follow-up assessments, both LIFT and HIV support group participants had decreases in any cocaine use ($p = .001$ for each group) and the frequency of cocaine use ($p = .006$ for each group). LIFT participants had greater improvement than HIV support group participants in any cocaine use over time ($p = .044$), such that fewer LIFT than support group participants reported any cocaine use at posttest (14% vs. 27%) and at the 12-month follow-up (11% vs. 24%).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.2 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	26-55 (Adult)	52.6% Female 47.4% Male	68% Black or African American 17% Hispanic or Latino 10% White 5% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see [Quality of Research](#).

	Reliability of	Validity of		Missing	Confounding	Data	Overall
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Outcome	Measures	Measures	Fidelity	Data/Attrition	Variables	Analysis	Rating
1: Traumatic stress symptoms	3.5	3.5	3.5	3.0	3.0	3.5	3.3
2: HIV sexual risk behaviors	3.0	3.0	3.5	3.0	3.0	3.5	3.2
3: Substance use	3.0	3.5	3.5	3.0	2.5	3.5	3.2

Study Strengths

Self-report instruments with strong psychometric properties served as the basis for the outcome measures. Prior research has documented the reliability of computer-assisted interviews for reporting behaviors of a sensitive nature. Implementation fidelity was strong overall in this study; systematic training was conducted using an intervention manual, and an adherence instrument was used to document that intervention delivery followed the manual. The study design included random assignment to conditions. Data analysis involved an intent-to-treat statistical approach with sophisticated data modeling that used all data collected from each participant and controlled for the correlation of repeated assessments over time on the same individual.

Study Weaknesses

Sample reliability and validity data for the HIV sexual risk behavior measure were not provided despite an adaptation of the original instrument. Exposure to the intervention was variable, and no fidelity instrument with established reliability and validity was identified. Attrition of intervention participants steadily increased across follow-ups, with the attrition rate being moderate (35%) at the 12-month follow-up. Statistical modeling of potential confounding variables was limited because of the diversity in the recruited sample relative to sample size and a severe skew in the percentage of participants (49%) reporting at pretest that they had not used substances in the previous 4 months.

Readiness for Dissemination

Review Date: December 2010

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Sikkema, K. J. (n.d.). Living in the Face of Trauma (LIFT): Coping with sexual trauma as a positive prevention approach [PowerPoint slides]. Durham, NC: Author.

Sikkema, K. J., Kochman, A., van den Berg, J. J., Hansen, N. B., & Watt, M. H. (2009). LIFT. Living in the Face of Trauma: An Intervention for Coping With HIV and Trauma. Durham, NC: Author.

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see [Readiness for Dissemination](#).

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.8	3.0	3.3	3.3

Dissemination Strengths

The manual is comprehensive and well organized and provides excellent step-by-step intervention guidance and clear instructions for group session delivery. The handouts for client homework are engaging and support generalization of the coping skills learned in group sessions. The training provides a useful rationale and background for the intervention and an overview of group sessions. Fidelity tools are straightforward and easy to use, and they focus on the key elements of program delivery. Guidance for measuring client treatment outcomes is provided.

Dissemination Weaknesses

Materials do not provide information for agency administrators on necessary supports for successful implementation. The training does not employ methods of adult learning, such as role-play, vignettes, or discussion. Training opportunities are very limited. Although this intervention addresses very sensitive issues with an often stigmatized population, neither training nor consultation is required for new

implementers. Fidelity checklists are meant to be completed by therapists and shared with supervisors, but no guidance is provided for supervisors on using this tool for quality assurance purposes.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
LIFT manual (includes fidelity and outcome measurement tools)	Free	Yes
2-day, off-site training available annually in New York or Connecticut	\$1,200 per participant (for 10-25 participants)	No
On-site consultation	\$200 per hour (or \$1,500 per day) per consultant, plus travel expenses	No
Phone and email support	Free	No

Replications

No replications were identified by the developer.

Contact Information

To learn more about implementation or research, contact:

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Consider these [Questions to Ask](#) (PDF, 54KB) as you explore the possible use of this intervention.