

**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**Should Patients Who Receive Postexposure Prophylaxis After Sexual Assault Be Considered for Preexposure Prophylaxis for HIV?**

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**Abstract**

Clinicians who encounter patients after sexual assault must offer competent, compassionate, trauma-informed care that fosters a patient's sense of safety and trust. In this case, a patient presents for HIV postexposure prophylaxis after a second sexual assault by the same perpetrator. This article considers how to balance providing a potentially beneficial intervention and avoiding retraumatization and stigmatization. Clinicians who facilitate patient-centered decision making about preexposure prophylaxis can respond to a patient's immediate needs and support her autonomy.

**Case**

Dr A routinely sees patients who have had possible exposures to HIV through consensual sex, exchange sex, sexual assault, health care work, or injection drug use. When a patient is potentially at risk for acquiring HIV, Dr A prescribes a 28-day prescription for postexposure prophylaxis (PEP) medications. Patients with ongoing risk for acquiring HIV are encouraged to begin preexposure prophylaxis (PrEP).

T is a new patient who comes to Dr A's clinic to be evaluated, for a second time, for PEP after a second sexual assault by an acquaintance who sometimes stays at the home T shares with a roommate. Dr A plans to prescribe PEP medications for T. Dr A discusses T's case with a colleague, Dr B, who encourages Dr A to recommend PrEP for T as well. Dr B remarks, "This is the second time this has happened with the same guy, and he's still coming by the house, so this could happen to T again. Besides, the data are better for preexposure than for postexposure prophylaxis. Next time, T might not come in soon enough."

PrEP could help T protect herself, but Dr A wants to carefully consider how to present PrEP to T so that T won't feel judged or blamed for her assaults. Dr A wonders how to help T.

**Commentary**

Sexual assault is common, with approximately 20% of women and 1% to 2% of men in the United States reporting a lifetime history of rape.<sup>1,2</sup> Survivors of sexual assault come

to medical care in a particularly vulnerable state and, unfortunately, often feel blamed, judged, and shamed for what has happened to them, even by health professionals.<sup>3</sup> Seeing patients who have recently experienced sexual assault can be a source of anxiety for the clinician who is trying not to say the wrong thing, imply blame, or make a comment that the patient could perceive as judgmental regardless of the clinician's intent. As the clinician caring for T, Dr A should make it the first priority to facilitate a **trusting and supportive relationship** with her. It is crucial that T's visit helps ease her suffering rather than compounding it. Dr A should begin the visit with clear and unequivocal statements that convey empathy, such as "I'm sorry this happened," "It's not your fault," and "I am here to listen or help in any way I can."<sup>4</sup> Without first creating a foundation of trust, any additional interaction might be futile.

The central ethical tension in this case is the potential conflict between Dr A's obligation to provide an intervention that could benefit the patient and the obligation to avoiding harming the patient through retraumatization or **stigmatization**. Will offering PrEP signal blame, imply acceptance of repeated assaults, or suggest that it is T's responsibility to protect herself from a harm inflicted upon her? We posit that it is ethically appropriate to offer PrEP in this context, and the principles of trauma-informed care provide guidance for doing so.

### **Not All About HIV or Pills**

Although T has come to Dr A for evaluation for HIV PEP, it is important to recognize that her risk of acquiring HIV is not the biggest issue at hand. The probability of acquiring HIV via one episode of receptive penile-vaginal intercourse or receptive anal intercourse is estimated to be 8 and 138 per 10 000 exposures, respectively.<sup>5</sup> To deliver care with a patient-centered approach, it is important to respond to the patient's request for PEP but also to consider issues beyond HIV risk and PEP, such as physical trauma, psychological trauma, pregnancy, and other sexually transmitted infections. Dr A should offer resources to help T obtain an evaluation from a sexual assault nurse examiner, if available in the community; attend counseling for her mental well-being; and report her assault to police if she wishes to do so. Intervening early with psychological support and providing resources for sexual assault survivors can diminish the long-term effect of trauma and increase the likelihood of ongoing engagement in services to support recovery.<sup>6,7</sup>

### **Trauma-Informed Care**

Recognition of the pervasiveness of trauma—including sexual assault—in the United States has inspired clinicians to strengthen their ability to provide **trauma-informed care** to all patients. There are 4 core principles of trauma-informed care: first, to acknowledge the widespread experience of trauma; second, to recognize the signs and symptoms of trauma; third, to minimize the potential for inadvertent retraumatization; and fourth, to respond with appropriate action and support.<sup>8</sup> Because at least part of this patient's trauma history is already known, Dr A can use the third and fourth principles to guide her approach with T.

According to the third principle, to prevent retraumatization, Dr A should avoid asking unnecessary details about the assault and should keep in mind that every sexual assault survivor is unique and may respond differently during recovery. If a physical exam is indicated, Dr A should ask for consent beforehand and ask what would make the **exam more comfortable** for the patient. Relative to the fourth principle, Dr A must provide an empathetic response to T and verbally acknowledge her situation (eg, "I'm so

sorry this happened to you. My job is to support patients who have experienced sexual assault, and I hope to be a helpful resource for you”). A qualitative study of survivors of sexual assault demonstrated that survivors highly prioritized having a clinician who emphasized empathy, confidentiality, validation, and individual agency during their visits.<sup>9</sup> After expressing empathy, Dr A can focus on T’s current concerns and use those concerns to guide her recommendations (eg, “I am here to listen and help in any way I can. What would be most helpful for you today?”). Dr A can inquire about T’s perception of her vulnerability to future assaults by this or any other perpetrator. The answer to this question could both guide Dr A’s connecting her to resources for ensuring she has a safe place to stay and help gauge her interest in taking PrEP for ongoing exposure risk. Best practices for trauma-informed care enable the patient’s preferences and needs to guide the visit and permit the clinician to share resources and provide support.

### **PEP and PrEP**

After establishing a safe, trusting environment, Dr A can discuss with T the differences between PEP and PrEP for HIV. PEP is a medication strategy to help prevent HIV acquisition after possible exposure and is recommended for individuals after either sexual assault or consensual sex. The recommended regimen for PEP is a 28-day course of 3 antiretroviral medications typically used to treat HIV.<sup>5</sup> PEP must be initiated within 72 hours of the exposure; appropriate care includes initial and follow-up HIV testing. PEP has been shown to significantly decrease the risk of HIV seroconversion in observational studies and in animal models, although its precise effectiveness is difficult to quantify.<sup>5</sup> PrEP is an HIV prevention strategy initiated before exposure and is available for individuals with ongoing risk, including those who have received one or more courses of PEP within the past year.<sup>10</sup> Numerous studies have supported the efficacy of oral PrEP, reporting a 78% to 90% reduction in HIV infections in heterosexual cisgender women with sufficient adherence.<sup>11,12</sup> Patients prescribed PEP who have concern for potential ongoing exposure can be safely transitioned to PrEP after completion of their PEP course.<sup>5</sup> Taking PrEP does not need to be a lifelong commitment; recommended PrEP duration is based on how long the patient remains at risk for HIV acquisition and can be safely stopped when the patient is no longer at risk. While on PrEP, patients should be seen periodically in clinic for monitoring.<sup>5,10</sup> Both PEP and PrEP regimens are generally well tolerated, and development of drug resistance and serious side effects is rare.<sup>5</sup> These treatments are not mutually exclusive and can be combined for HIV prevention.<sup>5,10</sup>

Some clinicians might view offering PrEP to T as inappropriate because this option does not address the root cause of her predicament or diminish her risk for future sexual assault. The central flaw in this viewpoint is the assumption that T’s risk environment can be changed. Victims of sexual assault are often unable to simply remove themselves from risk; keeping herself safe is likely not entirely within T’s control. Clinicians are unable to control many elements of patients’ risk environments but can offer strategies to help patients protect themselves from dangerous or threatening circumstances. Common strategies for patients include connecting with groups that support rape survivors, reaching out to trusted family members and friends, seeing a mental health professional for counseling, and engaging in self-care activities. Offering resources as part of trauma-informed care can help Dr A provide holistic care and demonstrate awareness that PrEP does not address the root causes of T’s plight. Discussing both PEP and PrEP with T would empower her with options to decrease her risk of HIV acquisition, even if other aspects of her current situation might not be completely within her control. In our view, the best approach to determining whether T

will take PrEP in the future is for Dr A to offer the option and engage in a process of shared decision making with T. Some patients might view PrEP as a means to protect themselves that helps them regain some control in a risk environment, while others might consider it to be an unwelcome continual reminder of sexual assault. If T indicates that she is not prepared to discuss or make a decision about PrEP at the initial visit, Dr A should arrange a follow-up visit to discuss PrEP before the end of the PEP course.

### Barriers to PrEP Access

Dr A needs to be attuned to the practical considerations involved in starting PrEP in order to be honest and forthright with T about potential barriers to local resources for assistance. This approach is consistent with the principle of avoiding retraumatization that could occur if T is offered something that she cannot access due to external factors beyond her control. Unfortunately, even if T wants to take PrEP, she might be unable to obtain it due to cost (nearly \$2000 per month without insurance).<sup>13</sup> Particularly in states that opted out of Medicaid expansion, payment assistance can be difficult to access,<sup>13</sup> and out-of-pocket costs put PrEP out of reach for most individuals at risk. PrEP access in the United States is vastly inequitable in terms of not only geography but also race/ethnicity. It is underprescribed to Black and Latino men who have sex with men, who bear the highest burden of new HIV infections.<sup>10</sup> In many areas, PrEP navigators are available to help patients access payment assistance for PrEP.<sup>14</sup>

### Shared Decision Making

In summary, the overall goal is to provide competent, compassionate, trauma-informed care for T in the immediate aftermath of her sexual assault and to support her autonomy through shared decision making about HIV prevention in the future. By applying principles of trauma-informed care, Dr A can resolve the tension between offering a beneficial treatment and avoiding harm to the patient. Options like PEP and PrEP are important for T to consider as ways to regain agency. Our role as clinicians is to support patients holistically—their physical, mental, and emotional needs—while also empowering them with choice and providing the resources they need to make informed decisions for their own health.

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**Editor's Note**

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