Prenatal and Mental Health Care Among Trauma-Exposed, HIV-Infected, Pregnant Women in the United States

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*Comprehensive prenatal care for HIV-infected women in the United States involves addressing mental health needs. Retrospective quantitative data are presented from HIV-infected pregnant women (*n *= 45) who reported childhood sexual or physical abuse (66%), abuse in adulthood by a sexual partner (25%), and abuse during pregnancy (10%). Depression and anxiety were the most commonly reported psychological symptoms; more than half of the sample reported symptoms of posttraumatic stress disorder (PTSD), including HIV-related PTSD (PTSD-HIV). There was a strong association between depression and PTSD as well as between anxiety and PTSD-HIV. The majority of infants received zidovudine at birth and continued the recommended regimen. All but one infant were determined to be noninfected. Women improved their $CD4^+$ T cell counts and HIV RNA viral loads while in prenatal care. Results support the need for targeted prenatal programs to address depression, anxiety, substance use, and trauma in HIV-infected women.*

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Often described as a special time in a woman's life, pregnancy is a uniquely individual experience. For women living with HIV infection, pregnancy is complicated by challenges, such as treatment changes and the emotional stress of preventing mother-to-child transmission of HIV. According to the Centers for Disease Control and Prevention (CDC, 2009), an estimated 75% of the women living with HIV in the United States are of childbearing age. Since the advent of maternal therapeutic interventions, the live birth rate for HIV-infected women is now estimated to be 150% higher than in the pre–antiretroviral therapy (ART) era (Sharma et al., 2007). Increased birth rates in HIV-infected women represent significant challenges for health care providers serving this population at a national level. Comprehensive prenatal care for HIV-infected women in the United States involves effectively addressing mental health needs, including depression and substance use (Leserman et al., 2007; Rosen, Seng, Tolman, & Mallinger, 2007; Sharps, Campbell, Baty, Walker, & Bair-Merritt, 2008).

Pregnant women, regardless of HIV serostatus, are particularly vulnerable to interpersonal violence (IPV) and psychological distress (Rosen et al., 2007). Research has consistently demonstrated that women living with HIV experience alarming rates of exposure to trauma (physical and sexual abuse) throughout their lives, placing them at serious risk for psychological distress (Simoni & Ng, 2000). HIV-infected women also are more likely to experience a traumatic event than are women in the general population. Kalichman, Sikkema, DiFonzo, Luke, and Austin (2002) reported a high rate of lifetime sexual assault (68%) in 110 HIV-infected women recruited from a variety of clinical settings. Similarly, Simoni and Ng (2000) interviewed 230 HIV-infected women living in New York City, who were primarily African American or Hispanic, and found that 43% had a history of childhood physical abuse, and 38% had a history of childhood sexual abuse (CSA).

Many women living with HIV who encountered abuse during childhood are likely to relive a pattern of repeated traumatization as adults. For example, in a racially and ethnically diverse sample of 490 women, Wyatt et al. (2002) found that HIV infection was associated with a "severe trauma history" involving exposure to multiple events (e.g., CSA, adult sexual assault, and/or physical violence or conflict). Furthermore, Kalichman et al. (2002) reported that HIV-infected women with a sexual assault history had a lifetime average of 7.5 sexual assault experiences, and many were likely to have experienced non–sexual relationship violence as well. Such evidence indicates that women living with HIV are likely to encounter not only a history of repeated traumatization but also exposure to more than one type of traumatic event. Further, Simoni and Ng (2000) found a significant correlation between childhood abuse and assault for adult HIV-infected women, suggesting that many HIV-infected women live in a context of IPV throughout their lives.

Traumatic experiences can often have serious and long-lasting consequences. Research has demonstrated that consequences of trauma, such as childhood physical and sexual abuse, include increased vulnerability to low self-esteem, anxiety, depression, suicide, sexual difficulties, and interpersonal problems (Johnsen & Harlow, 1996). Zlotnick, Warsaw, Shea, and Keller (1997) found that abused women reported more frequent and longer episodes of depression and anxiety compared to women without a history of trauma. Other evidence has suggested that low-income women may be particularly vulnerable to IPV as well as to depression, PTSD, and substance use as a result of the abuse (Martin, Mackie, Kupper, Buescher, & Moracco, 2001; Rosen et al., 2007; Tolman & Rosen, 2001). These consequences are especially serious in persons living with HIV, given that existing evidence suggests that psychiatric disorders may significantly worsen adherence to ART (Horberg et al., 2008; Mellins, Kang, Leu, Havens, & Chesney, 2003). Moreover, depressive symptoms were noted as an independent predictor of mortality in a survey of mortality trends for women with HIV infection from 1995 to 2004 (French et al., 2009).

IPV during pregnancy is particularly dangerous because of the potential risk to both the mother and fetus. Studies have estimated that 3% to 19% of