Military Culture and the Pregnant Female Soldier

Demere Kasper

Abstract

The military has developed a culture of its own, stemming from similar values and emphasis on qualities that the profession requires. Having long been a very masculine culture, the military struggles to keep the qualities that make it an effective fighting force while accommodating the growing population of soldier-mothers. The mission requires unique vaccinations that may pose a risk to developing fetuses, while mothers face a pregnancy and birth that may not have the traditional support system in place. There are possible risks of the vaccines, and there could be nursing interventions to aid in adaptation of military mothers and facilitate support.

The mission of the military is such that it requires its members to put the mission before self, and before family. This is a paradox when speaking to the childbearing family. Although looking to encourage positive family life, the soldier is subject to deployments regardless of their situation at home. Having long been a very masculine culture, the military struggles to keep the qualities that make it an effective fighting force while accommodating the growing population of soldier-mothers. Pregnant females are excused from deployment while pregnant and up to four months after childbirth (Ricks, 2007), but then are expected to meet their units downrange. Both the treatment and care for the female soldier should reflect recognition of the importance of female soldiers by addressing the unique needs posed when one becomes pregnant. Three areas, in particular, need attention: vaccinations, decreased resources available to pregnant women while in the military, and treatment while on duty.

A culture, as defined by Webster's New World College Dictionary (1999), is "the ideas, customs, skills, arts, etc. of a people or group that are transferred, communicated or passed along, as in or to succeeding generations." This broad definition can encompass many groups already established and recognized as a culture. However, it also allows for the inclusion of such groups that are not borne from locality, but instead collaborative entities that bring together persons from varying backgrounds and molding them into their own society. The United States military is one of these groups, and although each branch has its own unique flavor, there are fundamental commonalities between all the services. The military is also an institution that prides itself in high moral standards, with an emphasis on self sacrifice for both your fellow soldier, and your country. Within the military, there is a subculture of female soldiers, which will be the culture of focus. Current military studies that focus on female soldiers do not address pregnancy or motherhood and its effects on military readiness or on the soldier, but instead are highlighting the growing role of female soldiers and the effectiveness of the female soldier in combat (Putko, 2008).

Female soldiers are expected to deploy to support mission requirements and because of this, are required to have certain vaccinations. Because of the unique occupational hazards related to military service, women in the military, as are soldiers universally, are subject to different vaccinations that would not normally be administered in civilian settings, namely, the small pox and anthrax vaccinations (Ryan, 2008a, 2008b). Another problem is that mothers seldom have a traditional support system in place: a military wife is often far from her home and in many cases, her husband may be deployed (Schachman, 2004). The mother-soldier is also often far from home and if her spouse is also in the service they must find a way to balance the rigors of the job with raising a family. The third problem that pregnant mothers in the military face is how

they are treated while serving in the military. Current U.S. Army policy allows for a pregnant female to leave active-duty service, and it also has built in policies to protect the soldier from job requirements during active service that may be detrimental to the developing fetus's health (Ricks, 2007).

Vaccinations can pose a potential risk to soldiers that may not know that they are pregnant, exposing the festus to these unique vaccines, the effects of which are unknown. The two vaccines that have been studied are the smallpox and the anthrax vaccine. Two articles have been written on each respective vaccine and both analyses were conducted by the U.S. Department of Defense Center for Deployment Health Research at the Naval Health Research Center in San Diego, California. The smallpox analysis addressed health outcomes, specifically in preterm births and looked for associated birth defects among infants who have been exposed to maternal smallpox vaccination in utero (Ryan, 2008). This cohort study and the anthrax study, were conducted retrospectively; the anthrax study encompassed the years 1998 to 2004 while the smallpox study included infants born to active-duty military moms during 2003 to 2004 (Ryan, 2008a, 2008b). In the smallpox model, it was shown that maternal smallpox vaccination during pregnancy was not associated with preterm (28–36 weeks estimated gestational age) or extreme preterm delivery (≤28 weeks estimated gestational age). Also found was that maternal smallpox vaccination during the first trimester of pregnancy was not significantly associated with overall birth defects (Ryan, 2008).

The anthrax model demonstrated that birth defects were slightly more common in first trimester-exposed infants when compared with infants of women vaccinated outside of the first trimester (Ryan, 2008). However, the research purports that the statistically small association observed may be unlikely to represent a true causal relationship between vaccination in early pregnancy and birth defects (Ryan, 2008). Pregnant military women should be educated regarding this information, and healthcare providers should consider it prior to the administration of the anthrax vaccine.

In addition to vaccines, a second problem for pregnant military women is that the transient nature of the military profession requires the military woman to adapt to new surroundings. Although no research has specifically targeted the female soldier, it would be logical to affirm that external support systems may need to be considered and introduced to support those that wanted to become mothers as they often are far from home. There have, however, been some studies conducted regarding military wives. Research has suggested that these mothers may experience difficulty during the transition to motherhood because of the stress of military life and inability to access traditional support systems such as the mother's family (Schachman, 2004). Schachman, Lee and Lederma's study (2004) tested the effectiveness of the nurse's interventions on creating a positive prenatal and postpartum role adaptation among military wives, primarily through an intensive Baby Boot Camp. The Baby Boot Camp was a four week childbirth-parenting preparation program based on a military-derived resilience paradigm where the mother identified non-traditional resources, and engaged her in the development of internal resources to facilitate maternal role adaptation (Schachman, 2004). The program met once a week for four hours and received all the content of the traditional childbirth education program in addition to interventions which required an additional hour and focused on the identification, development, and use of the internal and external resources unique to military wives. This cohort was then compared to a cohort that only received the traditional childbirth education program which was a three hour class that met once a week and the content included childbirth-parenting preparation topics such as breathing and relaxation techniques, prenatal health, obstetric procedures, and newborn appearance and care. The study suggests that the methods used in the Baby Boot Camp succeeded in facilitating maternal role adaptation immediately after the intervention; however, these differences were not sustained at six weeks postpartum

(Schachman, 2004). I would assert that the mother-soldier would benefit from such interventions, and that they be continued longer than just six weeks.

Fortunately, it has been shown that the common and required small pox and hepatitis B vaccines have no significant effect on the childbearing soldier, but care should be used in the administration of anthrax vaccine (Ryan, 2008). Military installations differ in their health care policies, but most now require a pregnancy test before the administration of certain vaccines. Nursing care should reinforce educating the patient on what is safe and healthy for their developing fetus. This interaction should perhaps continue throughout the duration of the soldier's pregnancy to then allow for the introduction of Baby Boot Camp upon delivery. Nursing support should not discontinue after the first six weeks post-partum, as after this brief time period the mother-soldier is expected to return to duty and could be subject to deployment a mere three months after delivery. This could be an emotional stressor that requires one to heavily lean on external support systems, and currently there is no model for continued nursing support.

A third concern is that the nurse has a unique role to also identify if the pregnant soldier is being treated appropriately while on duty. Again, standard operating procedures differ from one institution to another, and even between branches, but U.S. Army Center for Health Promotion and Preventative Medicine (USACHPPM) Technical Guide (TG) 281 outlines the basic mission limitations of the pregnant soldier (Ricks, 2007). Although specific to U.S. Army, this guide is easily an example of the policies in other military branches. The other services have particulars that are unique to their primary mission: the Navy guide outlines how the pregnant servicewoman may not stay on a ship past their 20th gestational week, and specific guidelines for those women serving in aviator roles (Hoewing, 2003). The Air Force is not as clear as the aforementioned, but still details certain exceptions to training a pregnant airwoman would have, such as declining to participate in Chemical Warfare Defense Ensemble and mask confidence training (Roadman, 1998).

Designed not to be punitive in nature, the pregnant soldier in the U.S. Army is required to receive pregnancy counseling from her commander. During the course of this counseling, the soldier is informed about her right to leave active duty, her maternity care including doctor's appointments she should make and keep. She is told of resources available to her, details of her postpartum leave and her limited physical training program and requirements. As her pregnancy progresses, the soldier's duties become more limited. She can no longer work on vehicles in the motorpool and her duty day cannot be more than eight hours. The soldier is also non-deployable. All this seems to be in the best interest of the mother and child. However the normal-birth mother can be deployed a mere four months after giving birth, and this is universal across the services (Ricks, 2007; Hoewing, 2003; Roadman, 1998). This presents a unique challenge to healthcare providers, as the American Academy of Family Physicians Association recommends and encourages breast feeding until one year of age. If the military mother is deployed immediately, she is not even allowed the time to complete the minimum six month recommendation (American Academy of Family Physicians, 2007).

Practices have vastly improved from when women were first allowed into military service, and were required to leave active duty if they became pregnant, but there is still a hesitancy to fully embrace the pregnant female, especially as most commanders are male and tend to tip-toe around the subject. Of note, two of the three authors of USACHPPM TG 218, the Army guide for pregnant soldiers, are male, the lone female author a much lower rank than her male co-authors. The male domination of the military culture could be a barrier in advocating for longer non-deployment spells in the interest of the infants' health, and also contributes to the "hands-off" approach to the female soldier during her pregnancy. Thankfully military health systems are cognizant of the unique hazards the pregnant soldier is subject to, and have taken appropriate action, but there could be a more continuous method in nursing to support the mother not only through her pregnancy but through the first year postpartum. More studies need to be

conducted on this unique culture; especially on the emotional toll service may have on the military mother.

Nurses can be at the forefront in helping many of these soldier-mothers. Most major military bases have a dedicated hospitals associated with them. With that hospital are nurses, many of which are also serving alongside their patients in their branch of choice. This is a unique opportunity for the nurse to reach out and also have an empathetic relationship with the pregnant-soldiers regarding their needs and fears, as well as being their advocate with regard to vaccines. The nurse should also serve as an educator. The pregnant soldier received information regarding their rights and what health care measures they should take from their commanding officer during their pregnancy counseling. However, this is information being given by someone outranking the soldier, and who may intimidate the soldier, preventing true absorption of all the information presented. The nurse should ensure the female-soldier is aware of everything she has access to, and help be her advocate in enforcing other limitations in duty – such as the eight hour work day. The camaraderie of service as well as the basic nursing duties provides a perfect environment to address the unique needs of the pregnant soldier.

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