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Consequences of Military Sexual Trauma for Perinatal Mental Health: How Do We Improve Care for Pregnant Veterans with a History of Sexual Trauma?

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Perinatal mood and anxiety disorders (PMADs), including depression and post-traumatic stress disorder (PTSD), are a growing concern for population health, effecting up to 14% of pregnant and postpartum people with a societal economic cost of ~$14.2 billion per year.[1] Cumulatively, research indicates that those with a history of sexual violence or trauma are at increased risk of PMADs.[2–5]

Rates of lifetime sexual violence among women veterans range from 40% to 60%, with the highest rates being reported among those seeking health care from the US Department of Veterans Affairs (VA).[6,7] These experiences include sexual violence occurring before, during, and after military service. Military sexual trauma (MST), which includes sexual harassment or assault occurring during military service, is a type of sexual violence unique to veteran and military populations. Approximately one-third of women veterans using VA health care have a self-reported history of MST.[7]

In their article entitled ''A Longitudinal Investigation of Military Sexual Trauma and Perinatal Depression,'' Dr. Gross and colleagues focus their analysis on the association of MST with perinatal depression.[8]

Consistent with prior literature on sexual violence and PMADs, MST was strongly associated with increased symptoms of perinatal depression. The authors indicate two important implications of these findings. First, the importance of asking pregnant veterans about MST and initiating discussions with those receiving mental health care for MST-related sequelae about pregnancy plans and how a history of sexual violence might influence their experience of pregnancy, labor and delivery, and parenting.

Second, the authors indicate the need for ensuring access to trauma-informed obstetric care. How might these recommendations look in practice? And what would be necessary to implement them?

Notably, in addition to their experience of MST, women veterans have more severe and higher prevalence of childhood sexual abuse and lifetime interpersonal violence as compared with civilian women.[9,10] These lifetime experiences of sexual violence may also impact mental health, pregnancy, and parenting. Within VA regular screening for MST is reinforced in primary care through a one-time clinical reminder in the electronic health record. However, broad screening for lifetime exposure to sexual violence is not mandated or systematic. Expanded initiatives are needed to fully address the specific pregnancy and parenting concerns of veterans with a history of experiencing sexual violence.

Fortunately, many of the foundational pieces necessary for such programs are already in place, including the growing availability of comprehensive women's health clinics with integrated primary and mental health care, and maternity care coordination at most VA medical centers. Offering parenting classes designed specifically for those with histories of sexual violence or trauma, links to online programs such as Survivor Moms,[11] patient-centered educational tools to inform decision making regarding use of psychotropic medications in pregnancy, ongoing education for all clinicians regarding how to solicit and respond to patient histories of sexual violence, and connections to appropriate resources/referrals would build on these existing strengths.

Ensuring access to trauma-informed obstetric care is equally important but may be more challenging. Goals of trauma-informed obstetric care include (1) detection of new or ongoing abuse or violence and provision of support or referrals, (2) prevention of new trauma during prenatal care or childbirth, (3) avoidance of retraumatization, and (4) regular screening for PTSD and depression with referral to trauma-focused treatment when appropriate.[12]

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Through their growing maternity care coordination program and extensive mental health programs, VA may be well positioned to meet goals 1 and 4. Maternity care coordinators within VA are trained to screen for trauma and mental health symptoms, and to provide support and referrals for women experiencing interpersonal violence. VA mental health providers are also being increasingly trained in understanding the nuances of managing mental health during pregnancy and postpartum. Given the unique stressors related to the postpartum period, detection and treatment of mental health conditions such as PTSD during pregnancy are vital to ensure that individuals have the skills they need to cope during this sensitive and potentially stressful transition.

However, the prevention of new trauma during prenatal care or childbirth and preventing retraumatization presents a greater challenge. VA either pays for pregnant veterans to receive maternity care in the community or through contracts with nearby Department of Defense medical facilities. As such VA has limited control over the care pregnant veterans receive given the relatively small number of pregnant veterans in any given location.

Nevertheless, there are ways in which VA may be able to augment the maternity care pregnant veterans receive to empower and facilitate more trauma-informed approaches to obstetric care. These include investing in programs to ensure peer support, possibly through use of mobile health technology; facilitating collaboration with maternity care providers through provision of handheld/electronic maternity records (''pregnancy passports''); support for trauma-informed birth planning; and provision of doula support to empower veterans and build awareness of their unique cultural and gender issues.[12]

Sexual violence, including MST, has a range of health consequences for pregnant veterans and their families. As demand for VA maternity care continues to increase, investing in programs and policies designed to empower pregnant veterans and address the specific concerns of those with a history of sexual violence are needed. More broadly, in the era of #MeToo we need to consider as a nation how we can prevent sexual violence, including MST.

Disclaimer

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References

1. Luca D, Garlow N, Staatz C, Margiotta C, Zivin K. Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in California. Ann Arbor, MI2019.
2. Littleton H. Sexual victimization and somatic complaints in pregnancy: Examination of depression as a mediator. Womens Health Issues 2015;25:696–702.
3. Wosu AC, Gelaye B, Williams MA. History of childhood sexual abuse and risk of prenatal and postpartum depression or depressive symptoms: An epidemiologic review. Arch Womens Mental Health 2015;18:659–671.
4. Wosu AC, Gelaye B, Williams MA. Childhood sexual abuse and posttraumatic stress disorder among pregnant and postpartum women: Review of the literature. Arch Womens Mental Health 2015;18:61–72.
5. Rich-Edwards JW, James-Todd T, Mohllajee A, et al. Lifetime maternal experiences of abuse and risk of prenatal depression in two demographically distinct populations in Boston. Int J Epidemiol 2011;40:375–384.
6. Katon JG, Zephyrin L, Meoli A, et al. Reproductive health of women veterans: A systematic review of the literature from 2008 to 2017. Semin Reprod Med 2018;36:315–322.
7. Sadler AG, Mengeling MA, Syrop CH, Torner JC, Booth BM. Lifetime sexual assault and cervical cytologic abnormalities among military women. J Womens Health (Larchmt) 2011;20:1693–1701.
8. Gross G, Kroll-Desrosiers A, Mattocks K. A longitudinal investigation of military sexual trauma and perinatal depression. J Womens Health 2019 [Epub ahead of print]; DOI: 10.1089/jwh.2018.7628.
9. Blosnich JR, Dichter ME, Cerulli C, Batten SV, Bossarte RM. Disparities in adverse childhood experiences among individuals with a history of military service. JAMA Psychiatry 2014;71:1041–1048.
10. Katon JG, Lehavot K, Simpson TL, et al. Adverse childhood experiences, military service, and adult health. Am J Prev Med 2015;49:573–582.
11. Survivor Moms Companion. Available at: https://survivormoms.org/ Accessed September 19, 2019.
12. Gerber MR. Trauma-informed maternity care. In: Gerber MR, ed. Trauma-informed healthcare approaches. Cham, Switzerland: Springer Nature, 2019:145–155.

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