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Barriers to and Facilitators of Military Spouses' Recovery from Perinatal Mental Health Disorders: A Qualitative Study

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Barriers to and facilitators of military spouses' recovery from perinatal mental health disorders: A qualitative study

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ABSTRACT

Introduction: Perinatal mental health disorders (PMHDs) are a common complication of child-bearing, affecting approximately 1 in 7 U.S. mothers. An expanding literature has examined how PMHDs affect military families; however, little is known about military spouses' experiences in accessing and engaging in treatment for PMHDs. The purpose of this qualitative study was to gain a better understanding of the barriers to and facilitators of accessing, engaging, and progressing in treatment and recovery among a sample of U.S. military spouses with PMHDs. **Methods:** Military spouses (N = 12) were recruited from a maternal mental health clinic at an academic medical centre in San Diego, California, United States. Five semi-structured focus groups were recorded, transcribed verbatim, and analyzed by research team members until consensus on themes was reached. **Results:** Eight themes emerged: five main barriers (stigma, impacts on service member's career, lack of support, accessibility, practical and logistical concerns) and three main facilitators (solid support structure, encouragement to seek help, practical and logistical facilitators). **Discussion:** Findings enhance and complement extant research examining barriers to mental health care treatment and recovery among military spouses and suggest barriers to and facilitators of PMHDs. Fear of harming the serving spouse's career can be mitigated through supportive military leadership advocating for serving spouses to support their partners' recovery. Education for military leaders in foundational knowledge of PMHDs, including screening, treatment, stigmas, and impact on families, is needed to create supportive and encouraging environments leading to open dialogue and non-punitive solutions that facilitate military spouses' recovery from PMHDs.

Key words: access to care, health care system, mental health care, military families, perinatal mood and anxiety disorders, postpartum, postpartum depression, qualitative, stigma, United States

RÉSUMÉ

Introduction : Les troubles mentaux en contexte périnatal (TMCP) sont une complication courante de la grossesse, qui affectent environ une mère sur sept aux États-Unis. Une littérature de plus en plus étendue s'intéresse à l'effet de ces troubles sur les familles des militaires ; cependant, on sait peu de choses sur les expériences des conjointes de militaires quant à l'accès et à la participation aux soins des TMCP. L'objectif de cette étude qualitative portant sur un échantillon étatsunien était de mieux comprendre ce qui empêche ou, au contraire, favorise l'accès et la participation aux soins, ainsi que le rétablissement progressif de conjointes de militaires atteintes d'un TMCP. **Méthodologie :** Des conjointes de militaires (n = 12) ont été recrutées à la clinique de santé mentale maternelle d'un centre médical universitaire de San Diego, en Californie, aux États-Unis. Cinq entretiens semi-structurés avec des groupes de discussion ont été enregistrés, transcrits mot pour mot, puis analysés par les membres de l'équipe de recherche jusqu'à ce qu'un consensus sur les thèmes ait été obtenu. **Résultats** : Huit thèmes ont ainsi été cernés : cinq obstacles principaux (préjugés, effets sur la carrière du personnel militaire, manque de soutien, accessibilité, préoccupations practico-logistiques) et trois éléments facilitateurs (solide structure de soutien, encouragement à obtenir de l'aide, éléments pratiques et logistiques facilitateurs). **Discussion :** Les résultats enrichissent et complètent d'anciens travaux sur les obstacles au traitement et à la guérison des problèmes de santé mentale chez les conjointes de militaires, et indiquent les obstacles et les éléments facilitateurs en matière de TMCP. La crainte de nuire à la carrière du personnel militaire pourrait être atténuée par le soutien explicite d'une hiérarchie encourageant les militaires à soutenir le rétablissement de leurs conjointes. L'éducation des chefs militaires en matière de TMCP, y compris le dépistage, le traitement, la stigmatisation et l'effet sur les familles, est

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essentielle à la création de milieux favorables et bienveillants qui, en permettant un dialogue ouvert et des solutions non punitives, faciliteront le rétablissement des conjointes de militaires atteintes d'un TMCP.

Mots clés : accès aux soins, analyse qualitative, dépression postpartum, États-Unis, familles des militaires, postpartum, soins de santé mentale, stigmatisation, système de santé, troubles périnataux d'humeur et d'anxiété

LAY SUMMARY

Perinatal mental health disorders (PMHDs) are a common complication of child-bearing that affect about one in seven mothers in the United States. Military life often involves recurring separations from family as a result of deployments. Although much research has focused on how PMHDs affect military families, little is known about military spouses' experiences in recovering from PMHDs. This qualitative study centred on barriers to and facilitators of PMHD recovery among U.S. female military spouses. Semi-structured focus groups revealed five main barriers (stigma, impacts on service member's career, lack of support, accessibility, practical and logistical concerns) and three main facilitators (solid support structure, encouragement to seek help, practical and logistical facilitators). Identifying specific barriers to and facilitators of PMHD recovery among military spouses promotes military family psychological health and wellness.

INTRODUCTION

Perinatal mental health disorders (PMHDs) are a public health issue that have multiple and far-reaching deleterious effects on women, children, and communities.[1,2] Defined as mental illness that affects parents during pregnancy and up to one year postpartum, PMHDs encompass conditions including postpartum depression and childbirth-related posttraumatic stress disorder. In the United States, PMHDs are a common occurrence, affecting approximately one in seven pregnant or newly postpartum women.[3] When under-treated or untreated, PMHDs are associated with missed perinatal care visits,[4] premature delivery,[5,6] and impaired maternal-child attachment and bonding.[7] These illnesses also increase the risk of maternal suicide, a leading cause of maternal death during the first year after delivery in the United States.[8-10]

The impact of PMHDs on military families has been well established using quantitative methods. In a systematic review of literature focused on perinatal depression among military servicewomen and military spouses, Klaman and Turner found a prevalence ranging from 4.6% to 50.7%.[11] Andriotti et al. compared incidence rates of psychiatric disorders between the two groups and identified significantly higher rates among both pregnant and postpartum active duty servicewomen compared with military spouses.[12]

Risk factors for developing PMHDs are shared among civilian and military communities and include minoritized race,[12] marital discord and child care stress,[13] a familial or personal history of mental illness, medical complications during pregnancy,[14] and interpersonal partner violence.[15] In addition to the typical risk factors for developing PMHDs, military families encounter distinctive risk factors, including branch of service,[12] dual-military relationships, and active duty status.[13] Perhaps the most well-studied PMHD risk factors unique to military families are frequent moves and separation for training and deployment, which, in turn, decrease social support systems.[16] Prolonged separations also disrupt family structure and routines, which adversely affect stress levels.[17] A scoping review by Godier-McBard et al. identified deployment of the serving partner during the perinatal period as a significant risk factor for perinatal depression and increased psychological distress.[18]

Despite their pervasive nature, PMHDs are rarely treated to remission. Cox et al. conducted a systematic review to examine mean rates of diagnosis, treatment, adequate treatment, and remission across 32 studies.[19] They found that 30.8% of women with postpartum depression (PPD) are identified in clinical settings and that 15.8% of women with PPD receive treatment, 6.3% receive adequate treatment, and 3.2% achieve remission of symptoms. There are several barriers to tackling this treatment gap, and they occur at the individual, provider, and systemic levels.[20,21] At the individual level, perinatal women face the stigma of a mental illness diagnosis. Logistical barriers include lack of insurance, time, and child care. Additionally, women fear being labelled unfit parents.[20,22] At the provider level, barriers include lack of resources and lack of confidence in the skill level needed to diagnose and treat PMHDs. Health care system barriers consist of inaccessible or unaffordable mental health services and a shortage of specialized perinatal mental health clinicians.[20]

Extant quantitative research examining barriers to mental health care faced by military spouses also found that stigma and logistical concerns impede access to care.[23-25] These studies found that unique barriers exist for military spouses, including the inability to

find a mental health professional who understands the distinct challenges and needs of military spouses and the fear of jeopardizing a service member's career.[23] Although these studies examined barriers related to general mental health concerns, they were not specific to PMHDs. Additionally, these studies did not explore facilitators to mental health care treatment or recovery. Given the substantial impact of untreated PMHDs on women and their families, combined with the lack of qualitative data investigating barriers to and facilitators of access to and progress in PMHD recovery and treatment among military spouses, this study sought to examine the perceived barriers to and facilitators of access to and engagement and progress in PMHD treatment and recovery in a sample of military spouses.

METHODS

Design

A qualitative descriptive study informed by a constructivist-naturalistic philosophy was designed to provide a vivid representation of participant experience with little interpretation.[26-28] This approach is used to describe an event or community perspective using data derived from focus groups or field notes.[29] Ethical approval was granted by the University of California San Diego Internal Review Board/Human Research Protections Program.

Procedure

A purposive sample was recruited and enrolled at a women's reproductive mental health outpatient clinic affiliated with the University of California San Diego Health Systems in San Diego, California, USA.[30] Clinicians at the clinic were instrumental in the recruitment process, informing clients undergoing PMHD treatment about the study and obtaining their permission to be contacted by researchers to consider participation. Eligibility criteria were as follows: English-speaking women with a diagnosis of a PMHD and married to an active duty service member. Those with a psychotic disorder and those unable to participate in a group setting were excluded. Informed written consent was obtained from all study participants.

Semi-structured focus groups were conducted with military spouses in varying stages of recovery from a PMHD. Semi-structured focus groups provide an interactive environment that enables an opportunity to compare and contrast experiences in PMHD recovery.[31] All focus groups were conducted in person, in one of the clinic's group psychotherapy rooms, by investigators (MHN, SS-A, AMR). Child care was provided by study staff in an adjoining playroom.

The focus group began with obtaining demographic information from participants to understand their varied backgrounds (Table 1).

Table 1. Detailed characteristics of participants

Participant	Age, y	Marital status	Race or ethnicity	Education level	Employed	No. of children	Rank	Pay grade	Annual household income, US$K	Branch of military
1	30	Married	White	College	No	2	PO2	E5	40-50	U.S. Navy
2*	30	Married	White	Postgraduate	Yes	4	Missing	E5	>100	U.S. Army
3	32	Married	White	High school	Yes	2	PO2	E5	60-70	U.S. Navy
4	30	Married	White	>High school	No	4	PO1	E6	30-40	U.S. Navy
5	28	Married	White	College	No	1	Missing	E5	80-90	U.S. Navy
6	27	Married	White	High school	Yes	1	AT2	E5	80-90	U.S. Navy
7	27	Married	White	>High school	Yes	2	Missing	E5	50-60	U.S. Navy
8	43	Married	White	College	Yes	2	Missing	E6	>100	U.S. Navy
9	31	Married	White	High school	No	2	Missing	E4	60-70	U.S. Navy
10	24	Married	White	Postgraduate	No	1	SGT	E5	20-30	USMC
11	35	Married	White	College	Yes	2	CAPT	O3	60-70	USMC
12	32	Married	White	Postgraduate	Yes	1	LT	O3	>100	U.S. Navy

Note: Mean age = 30.75 y (SD = 4.80).
*Denotes active duty participant.
PO2 = Petty Officer, Second Class; PO1 = Petty Officer, First Class; AT2 = Aviation Electronics Technician, Petty Officer Second Class; SGT = Sergeant; CAPT = Captain; LT = Lieutenant, USMC = U.S. Marine Corps.

The focus group was led using an interview guide developed by three of the investigators (SSA, AMR, MHTN). Researchers asked prepared questions. Probing questions were included to ensure complete and consistent information was obtained across groups.[32] Examples of questions are included in Table 2.

Focus groups were audio recorded and transcribed verbatim. The interviewing investigators (SSA, AMR, MHTN) debriefed after each group to ensure that the quotes used reflected a variety of participants and that individuals who spoke were correctly identified and to note nonverbal behaviour and other group dynamics not captured in the audio recording. Pertinent noted nonverbal behaviour and group dynamics were added to focus group transcripts as memoranda. The groups were one hour in length. Participation was voluntary and, upon focus group completion, each participant received a US$25 honorarium to acknowledge their time and travel.

Positionality affects the research process in its entirety.[33] The first author identifies as an Asian American woman. The remaining authors identify as white American women. The participants all identified as white American women. Additionally, the authors who conducted the interviews are licensed mental health clinicians with research experience. Two of the interviewers (MHTN and AMR) were employed as mental health clinicians at the clinic. These interviewers did not interview clients whom they were treating.

Data analysis

Kim et al.'s systematic review of qualitative descriptive research found the average number of interviews to be 11 to 20.[34] Data collection with analysis is an iterative process in qualitative description, and the number of interviews may increase as a researcher seeks to gain consensus with emerging themes. Transcribed materials were analyzed using thematic analysis that supports the constructionist approach to examine the meaning of an experience operating within societal influence.[35] Themes are represented through an inductive analysis dependent on the context of the woman. This analytic approach is a process in which the data are coded without trying to fit them into a pre-existing template or researcher preconception,[31,35] and it is consistent with the purpose of the study to identify and richly describe barriers to and facilitators of help seeking in a novel population, with a low level of abstracted interpretation. Initial codes were selected on the basis of their frequency in the discussion and relevance to the research questions. After line-by-line coding, the codes were clustered to form central categories and establish the initial code book. The research team met regularly to review coded excerpts and develop themes collaboratively. For this study, data saturation, evidenced when no new information was discovered in data analysis, signaling that data collection could cease, occurred with the fourth focus group.

RESULTS

Five focus groups, consisting of 12 participants, were interviewed for approximately 60 minutes each. Participants ranged in age from 18 to 35 years; all were married (9 to U.S. Navy service members, 2 to U.S. Marine Corps service members, and one to a U.S. Army service member) and self-identified as white. Annual family household incomes, but not pay grades, were reported. It should be noted that one participant was an active duty service member (Table 1).

Thematic findings

Eight themes emerged: five main barriers (stigma, impacts on service member's career, lack of support, accessibility, practical and logistical concerns) and three main facilitators (solid social support structure, encouragement to seek help, practical and logistical facilitators). Each theme is substantiated by direct quotes from participants. Themes are summarized in Figure 1.

Table 2. Example of focus group interview questions

Prepared questions	Probing questions or statements
What was your experience in getting care for your PMHD?	Tell me more about that experience.
What were some things that got in the way of accessing treatment?	What was the most difficult obstacle in accessing care?
What are some things that help you feel better?	What helped you most in your recovery?
How do you think being in the military community has affected your treatment and recovery?	How have deployments affected your family?

PMHD = perinatal mental health disorder.

Barriers

Stigma

Stigma was a salient barrier identified by this group of military spouses. Participants described perceived stigma related to two categories: 1) internalized or self-stigma and 2) public or external stigma. Statements and sentiments regarding stigma as a barrier to recovery are organized into these two sub-categories.

Internal stigma is the degree to which one accepts stigma from others and attaches that stigma to one's own identity.[36] Internal stigma is especially pertinent in this population because women are forging their identities as mothers while they recover from mental health conditions, such as depression, that are often characterized by feelings of helplessness, worthlessness, and excessive guilt. Participants felt that their mental health condition contributed to feelings of failing and inadequate mothering. One woman stated:

> The hardest thing I endured was the stigma. I suffered for a long time. I felt like I was failing my son, even though I was so busy doing everything. You are trying to be a really good mom and you feel like you are not a good mom.

In addition to attaching mental health stigma to their identities as mothers, respondents attached stigma to their identities as military spouses. Notably, living with a PMHD detracted from their role as reliable and steadfast partners. One spouse was told, "You don't need [treatment]. You are a Navy Seal wife! You have to be strong with them, you have to be strong at home." On top of needing to be strong and reliable, participants felt their needs were not a priority. As military spouses, their husbands' careers came before their own welfare, and they felt they needed to sacrifice their mental well-being. One participant emphasized, "I am the mistress; he is married to the navy." Another added, "Family is second to work." Several women expressed the mantra, "If the navy wanted you to have a wife, they would have issued you one in your sea bag."

Public or external stigma refers to the belief that others view mental health conditions negatively.[36] Several participants reported what they perceived as invalidating statements from their health care providers. "My doctor was surprised to hear what I was going through because I seemed so 'normal.'" Others felt ashamed for accepting mental health treatment. "Everyone was judgmental. My parents said, 'You don't need medicine, you just need to be happy.' When you have so many people against it, it makes it hard to accept it." Finally, participants experienced isolation due to perceived public stigma from the military spouse community. "They think 'She's crazy. Don't hang out with her.' They don't invite me [out] anymore because I don't drink since I'm on meds."

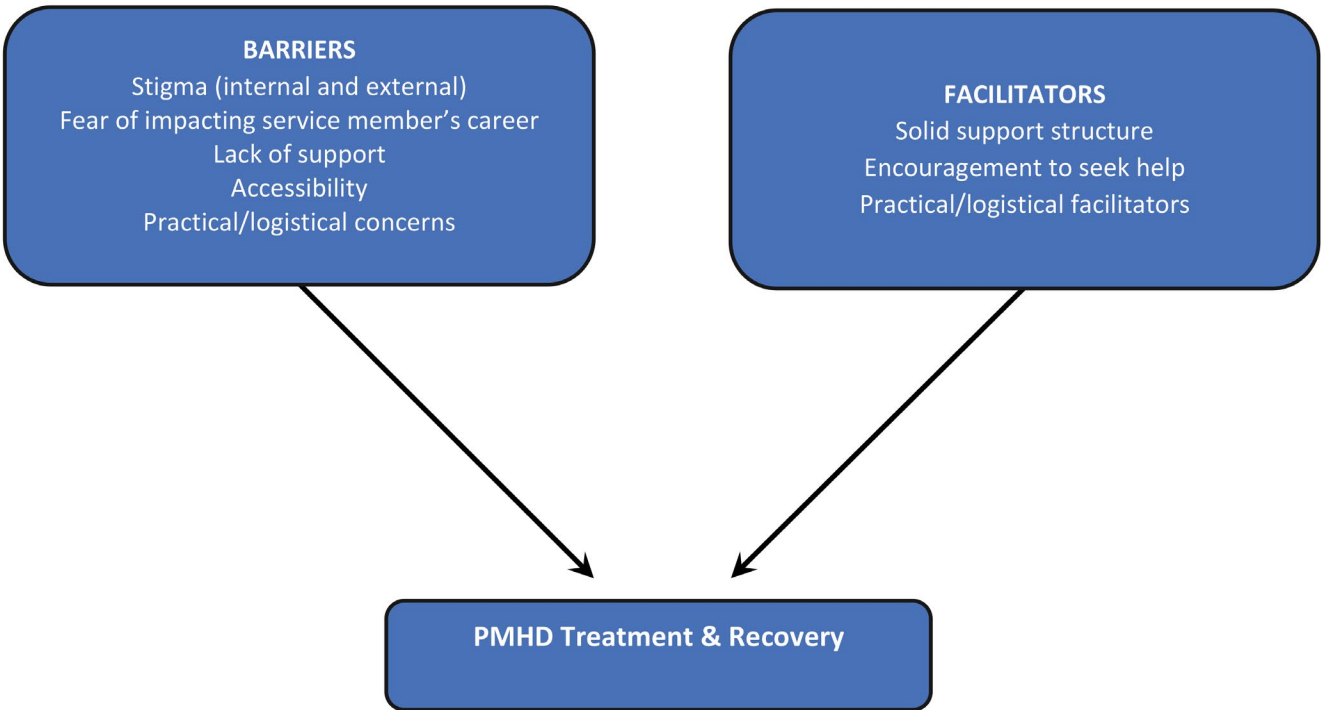

Figure 1. Thematic diagram of barriers and facilitators to perinatal mental health disorder (PMHD) treatment and recovery

Fear of, or experiences of, negative impacts on the service member's career

The second barrier to military spouse treatment and recovery from PMHDs involved fear of harming the service member's career. Others experienced detrimental effects. One participant shared, "My husband was kicked out of his platoon because I needed him at home." Participants described how these fears amplified their distress. Another explained, "Basically, all they care about is if it affects his work, or his ability to work; they don't really care about anything else."

Lack of support

Participants described shaky social support structures that usually consisted of family, friends, husbands, and neighbours. They felt their support structures were affected by the frequent moves characteristic of military life. "You lose some of the support system that you've built, and it's hard to find other people to fill that void." Others felt that deployments disrupted support they received from their husbands. These left participants feeling vulnerable, uncertain, and overwhelmed. One woman shared, "I feel bad because I'm complaining about 100,000 things and [he is] 10,000 miles away and there's nothing [he] can do about it." Another expressed, "There are no fallback support systems to catch me when I fall."

This disruption in support continued post-deployment as service members reintegrated into the family. "Everything changes when daddy is home. And you understand that, but, when you are feeling the way that you are feeling, and he does not quite understand what is going on ... That was the hardest part, you readjust and then the same thing would happen again months later."

Accessibility: Delays in accessing mental health care, few specialized providers

The fourth barrier identified involved access to timely mental health care. At least one military spouse in each group described perceived delays in finding a mental health clinician. Participants described long wait times or jumping through many hoops. One spouse described in detail how delays lead to desperation, stating:

> I know that, for me, with how severe my postpartum depression was, if I had to wait even a week or two, I think that would have just put me in a worse place, in such a bad place that I just don't see how I could've waited any longer.

Practical and logistical concerns

Logistical and practical barriers centred on difficulty finding child care, obtaining prescriptions, and financial concerns related to treatment. Participants were reluctant to have others provide child care because of trust issues. One noted, "Especially in the military, if you recently moved, you don't know anyone."

Participants also described difficulty accessing their medication. Women experienced long wait times at retail pharmacies, and others had issues with online pharmacies and pharmacy benefit managers. One mother noted, "They force you to get mail-in prescriptions, but they have my address from six years ago; they won't change it."

Concerns about mental health care costs were noted during each group. One spouse stated, "I had to pay $100 for a prescription and then to have to pay that every month. That's $100 that could clothe and feed my kids." Participants felt the costs were insurmountable and outweighed the risks of their untreated illnesses. Another mother said, "And when you are already feeling worthless, and then it's like am I worth the money?" Yet another responded to the cost of treatment by thinking, "I'll just stay depressed for another year."

Facilitators

Solid social support structure

A solid social support structure was a facilitator of the treatment and recovery process for participants. Husbands and other family members were identified as the primary pillars of participants' support structures. They described partners who were able to identify the participants' need for treatment. One wife noted, "My husband knew right away that I wasn't okay because I wanted nothing to do with my son and he said, 'I am calling your therapist because you are not okay.'"

Another important source of support came from the service members' commanders. Participants described flexible commanders: "Your family matters the most; take leave and we will make it work." Another participant described a unit culture that felt caring and inclusive: "They have events, and they make sure all of the families are involved."

Encouragement to seek help

Encouragement to seek help came from a range of health care professionals. Participants described these interactions as the push they needed to seek help and appreciated the sense of urgency they felt from health

care professionals. One pointed out, "Someone from the doctor's office called on a Sunday and told me 'I heard you were having a problem, so let's get this going.'" They also responded positively to frequent encouragement. For example, one noted, "For me it was my midwife. She kept telling me to go [to therapy] and following up on me online with emails."

Practical and logistical facilitators

These final facilitators of PMHD recovery mirrored those identified as barriers. Participants noted that any kind of hands-on help was especially useful in feeling less overwhelmed. The top logistical and practical facilitators were in-home cleaning, child care, meal planning, and laundry services. A poignant group dynamic occurred in one group wherein the participants gathered after the formal focus group ended. Participants started a group text message chain among themselves so they could provide child care for each other. One participant stated, "This will help the mom who needs the babysitter, but also the mom who is babysitting [will] feel she is helping others. I know that would make me feel good about myself."

Ultimately, facilitators identified in this study pointed to a need to have all hands on deck to aid in their recovery from PMHDs. They realized the value of support and encouragement from their husbands, families, friends, health care professionals, and military leadership. This support and encouragement, in addition to practical help, tempered feelings of loneliness, anxiety, being overwhelmed, and hopelessness that often occur among people with PMHDs.

DISCUSSION

Five barriers to and three facilitators of PMHD treatment and recovery were identified. This study's findings enhance and complement extant research examining barriers to mental health care treatment and recovery among both the general and the military spouse perinatal population.[20-23,25,27] Stigma associated with mental illness is a well-established barrier to help seeking in both the general perinatal and the military spouse populations.[20,22-24] A novel finding of this study was the identification of internalized stigma that participants contended with in their dual roles as mothers and military spouses. For women living with PMHDs, stigma influences concerns of being viewed as a bad or unfit parent, social services involvement, and losing parental rights.[20,37] Additionally, military spouses internalize stigma that conflicts with pressure to be strong and the need to prioritize a service member's needs and career over their own wellness and comfort.[38] Internalized stigma was identified by using quantitative research methods with military spouses seeking general mental health care and primary health care.[23,25] Furthermore, in a mixed-methods analysis examining barriers to health behaviours (e.g., physical activity and stress management),[38] focus group participants felt pressure to put others' needs first.

Fear of harming spouses' careers does not appear in the general perinatal mental health literature. This barrier was identified by Eaton et al. when they surveyed military spouses seeking primary care at medical clinics on a large military base in the United States.[23] They found that 20.5% of the spouses who met the criteria for major depressive disorder, generalized anxiety disorder, or alcohol use disorder did not seek mental health treatment because of fear of harming a service member's career. The current study is the first to identify this fear using qualitative methods. Furthermore, analysis elucidated how this fear increased spouses' stress levels.

Solid and weak social support structures were identified as facilitators of and barriers to, respectively, PMHD treatment and recovery. Abundant extant research illustrates a positive correlation between social support and mental well-being in the perinatal period.[39] Schachman and Lindsey compared social support among military spouses who did and did not meet screening criteria for postpartum depression during an infant's eight-week health maintenance and immunization visit.[40] They found that spouses who screened positive for postpartum depression had a lower perception of social support than women who did not screen positive. Findings of this study complemented the existing literature by revealing how frequent moves and deployments aggravated shaky support structures. This study also highlights the importance of peer support in PMHD recovery. In a systematic review and meta-analysis conducted by Huang et al., formal peer support interventions have been found to prevent and reduce harm from postpartum depression.[41] The current analysis indicates that peer support may have mutual benefit for the person giving support, as well as for the person receiving it.

Another distinctive finding of this study involves military command. Support from a service member's leadership team as a facilitator of recovery, coupled with fear of hindering a service member's career as a barrier to recovery,[20,21] indicates the importance of military leadership's role in maintaining family mental health. These findings parallel research examining the degree

of acceptance of mental health treatment by military units and leadership as predictors of active duty service members' treatment-seeking behaviour. A systematic review of help seeking and mental health service utilization among military service members conducted by Hom et al. identified military leadership as an instrumental impetus to treatment engagement.[42] Researchers reported that positive leadership behaviours, including communication from senior leadership that seeking mental health treatment would not harm one's military career, reminders of the importance of care, and guaranteed time off to receive care without negative impacts on career, are associated with lower barriers to mental health care.[43,44] Additionally, greater perceived family support from the military has been associated with better behavioural health outcomes among military spouses.[45] To address these distinct study findings, the authors suggest educating military leaders and commanders about PMHDs and their potential impacts on the military if left untreated.[46] Presentation of educational content, grounded in a foundational knowledge of PMHDs, including screening, treatment, stigmas, and impacts on the family, is warranted. This education can help leaders create supportive and encouraging environments, lending to open dialogue and non-punitive solutions that facilitate access to, and recovery from, PMHDs.

Strengths and limitations

Limitations of this study include a small sample size that was racially homogeneous and limited by representation of military branches, with all but one participant speaking to the experience of U.S. Navy and Marine Corps spouses located in San Diego. Despite these limitations, holding the focus groups at a facility not associated with the military was a study strength, because it allowed participants to share their thoughts about military-related content more freely. Findings provide initial data and important information on the experiences and perceptions of a sample of military spouses receiving treatment for perinatal mental health issues.

Conclusion

Military spouses are the cornerstone of military family well-being and, thus, their psychological health should be prioritized, especially during the perinatal period. Promoting the mental health of military families also strengthens the well-being, readiness, and resilience of service members.[47] This study bolsters the literature pertaining to military spouse psychological well-being by identifying nuanced mechanisms by which military lifestyle and culture facilitate or impede treatment and recovery from PMHDs. These mechanisms include internalized stigma, fear of harming the service member's career, and support structures destabilized by frequent moves and deployment but strengthened by peer and military leadership. Additional inquiry should focus on evaluating systems aimed at identifying military families in non-military health care settings, reducing their risk with education and preventive interventions, and finding ways to accelerate access to specialized care.

AUTHOR INFORMATION

My Hanh (Theresa) Nguyen, PhD, PMHNP-BC, is a postdoctoral fellow at the National Clinician Scholars Program at the University of California at Los Angeles. Her clinical and research interests are focused on women's mental health and health inequities.

Semira Semino-Asaro, PhD, PMHCNS-BC, PMHNP-BC, is in private practice as a psychiatric nurse practitioner, focusing on perinatal mood and anxiety mental health conditions. She received training in parent-child dyadic therapy at the Newton Center for Affect Regulation in San Diego and completed a postgraduate fellowship in infant-parent mental health at the University of Massachusetts Boston's Department of Clinical Psychology. Her research interests focus on maternal-infant interaction in the context of perinatal mood and anxiety disorders.

Alison M. Reminick, MD, is a board-certified psychiatrist who specializes in women's mental health care. She directs the Women's Reproductive Mental Health Program at the University of California San Diego Health Systems, which helps women manage and recover from anxiety, depression, or other emotional concerns during infertility, pregnancy, or the postpartum period.

Amber T. Rukaj, MA, is a licensed marriage and family therapist, early childhood therapist, and postpartum doula. Rukaj co-founded and currently serves as the Co-Director of the Women's Reproductive Mental Health Program at the University of California San Diego Health Systems. She also operates a private practice and recently launched a local business, Spark Mamas, whose mission is to care for women the same way they care for others.

Cynthia D. Connelly, PhD, RN, is a professor at the Hahn School of Nursing and Health Science, Beyster Institute for Nursing Research, University of San Diego. An internationally recognized expert in health services research, she offers expertise in conducting research studies that focus on behavioural and social functioning at the level of the individual, small group, institution, or community, with translation into effective intervention strategies to facilitate more effective health service delivery in real-world settings.

COMPETING INTERESTS

The authors have nothing to disclose.

CONTRIBUTORS

Conceptualization: MH Nguyen, S Semino-Asaro, AM Reminick, AT Rukaj, and CD Connelly

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Supervision: MH Nguyen and CD Connelly

Project Administration: MH Nguyen

Funding Acquisition: S Semino-Asaro

ETHICS APPROVAL

This study was approved by the University of California San Diego Human Research Protections Program, San Diego, California, United States, on Mar 17, 2016.

INFORMED CONSENT

Informed consent was obtained from all patients.

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PEER REVIEW

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