Perinatal Mental Health in the Military: Health Systems and Policy Considerations

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Screams wake you up at random intervals throughout the night. You cannot sleep more than a couple hours at a time. You are bleeding from an internal wound that will take weeks to heal and you have external stitches. Your ribs and abdominal muscles have separated. Your organs have spread and shifted within your body. You feel grateful that you have a healthy baby but can't help but grieve the birth you didn't have. You were induced early and moved at a pace you didn't feel comfortable with. You said, "yes" to everything the doctors recommended, even though you didn't understand most of it, because you were overwhelmed and scared. You didn't have time to physically prepare for the birth because your work schedule and other responsibilities left little time for self-care. Life flows around you still: dishes need to be done, bills paid, and appointments made. You don't have time to grieve or even take a shower. You have limited help and you're feeling too depressed to do more than what is necessary. There's no family member within hundreds of miles. You're taking unpaid leave and cannot afford to pay for help. Your spouse offers support where they can but does not really get it and then must return to work before you are healed. The pediatrician says your baby has lost too much weight since birth and you're not producing enough milk. These conditions would challenge any person's mental health.

This story shows a common set of circumstances that may or may not eventually lead to a label of "disorder," such as post-partum depression. You might relate to this postpartum story or only some elements of it—issues of sleep deprivation, lack of social support, and physical recovery after pregnancy. As a health services field, we must balance applying clinical labels to individuals (e.g., postpartum depression) and a broad public health lens that highlights pathogenic environmental and social conditions. The former leads to individual analysis and intervention and the latter may lead to universal policy interventions that uplift individuals and communities. In this vein, some experts suggest reframing our perinatal mental health services to focus on psychological well-being rather than illness and considering what promotes well-being (Alerdice, 2020). This article focuses on environmental and policy circumstances that may relate to psychological well-being during the perinatal period for military families.

What is perinatal mental health?

Military Health System (MHS) providers need to be aware of perinatal healthcare needs and mental health to provide comprehensive care to our Service members and civilian family members. Individuals enter and remain in the Service during primary reproductive years, so perinatal mental health is especially relevant for this community. The term *perinatal mental health* refers to the spectrum of mental health wellbeing, struggles, and tensions that occur throughout pregnancy and after birth (Howard & Khalifeh, 2020). Hormone changes do not explain all clinical symptoms and many individuals have symptoms that do not rise to a clinical threshold, i.e., symptoms don't cause a level of impairment that requires medical intervention (Dagher et al., 2021) as described in the example above. Personal, generational, social, and environmental factors influence the level of stress and experience of mental health concerns through the perinatal period. According to a Government Accountability Office (GAO) report on data from 2017-2019, 36% of Tricare beneficiaries who were pregnant or postpartum within one year had a mental health diagnosis (US GAO, 2022) indicating that perinatal health is an important area for practice and progress within the military.

Military Health System outcomes, obstetric violence, and medical trauma

According to mortality and morbidity statistics, the United States is the most dangerous industrialized nation in which to give birth (Tikkanen et al., 2020). The Military Health System (MHS) fares similarly to civilian medical facilities, showing similar rates of mortality, morbidity, and worse outcomes among childbearing people of color (Hall et al., 2021). In terms of infant health and outcomes, compared to the civilian sector, infant mortality in military treatment facilities is lower, though racial inequities for infants of color persist (Vereen et al., 2023). These outcomes suggest that the Military Health System creates similar outcomes and propensity for harm, particularly towards racially marginalized families. Experts identify that a complex interaction of patient, provider, and healthcare system factors drive these unsettling mortality and morbidity numbers (Noursi et al., 2021). There is more research needed regarding other marginalized groups, such as transgender men and other queer individuals, though a review of experiences of civilian transgender men described general perceptions of alienation and loneliness within the perinatal healthcare environment (MacLean, 2021). These outcomes demonstrate that, birthing people, marginalized folks in particular, must also contend with significant risk of birth-related medical trauma in addition to normative personal hormonal and physical changes (Kukura, 2017).

One form of medical trauma is termed *obstetric violence*, which describes the experience of being treated as an object rather than an agent during birth (Perrotte et al., 2020). Obstetric violence captures both the provider factors and the ways in which the healthcare system influ-

ences the patient-provider dynamic that results in objectification. Obstetric violence encompasses the range of harm, including intentional abuse, forced medical procedures (e.g., cesarean, episiotomy), unconsented medical procedures, sexual violation, coercion, and disrespect (Kukura, 2017). In one survey of 2,781 doulas and labor and delivery nurses regarding witnessing disrespectful care, almost two-thirds of respondents stated they witnessed providers occasionally or often doing medical procedures without giving the birthing person time to consider or consent to it (Morton et al., 2018). About one-fifth of respondents stated they witnessed providers complete medical procedures explicitly against the consent of the patient. When birthing people lack the awareness of these structural issues and the concept of obstetric violence, they may feel that their mourning, grief, and depressed mood come from simply the process of giving birth. They may underestimate the impact of medical trauma and dehumanization on how they feel afterwards (Shabot & Korem, 2018). Practitioners and scholars within the field conceptualize obstetric violence as resulting against a larger backdrop of gender-based violence and patriarchal institutions that tend to dehumanize women (Perrotte et al., 2020; Garcia, 2020).

Lactation policies and support

The practice of lactation or breastfeeding represents an intersection of birthing parent and infant health. For example, nursing can reduce the risk of post-partum hemorrhage and ovarian cancer later in life, among other benefits (Bitbit et al., 2022). Some, but not many, Military Treatment Facilities (MTFs) have sought Baby-Friendly Hospital status, which is a years-long accreditation process to reach a standard of practices and policies that support nursing and recovery after birth (World Health Organization, 2017). Such baby-friendly hospitals establish skin-to-skin contact directly after birth between baby and parent, offer lactation consultation, and provide education on breastfeeding generally, among other practices. A scoping review identified military policies that promoted psychological well-being among birth-giving military community members included delayed separation of parent and infant, support lactation space in the workplace, and the employment of lactation consultants (Trego et al., 2021). Despite the helpfulness of these policies, specific branches may deviate from the policy according to mission requirements and there are gaps in policy adherence on the local level (Trego et al., 2021).

Other structural factors

Structural factors (e.g., financial well-being, change of duty stations) can increase stress and exacerbate mental health concerns for the individual who just gave birth and their family. Mental health challenges in general (i.e., not only related to the perinatal period) result from or are heavily influenced by environmental and social inequities (Allen et al., 2014). Food insecurity, a general marker for poverty, is as prevalent in active duty families as the civilian population and increased during the COVID-19 pandemic quarantine (Rabbitt et al., 2022). This trend conveys an overall financial precariousness of the average military family. The ability to take leave also interacts with financial pressure. Many military spouses work to make financial ends meet and yet most civilian companies in the United States do not offer paid family leave, as 23% of workers have access to paid family leave (US Bureau of Labor Statistics, 2022). In recognition of the negative impact of limited family and parental leave policies, Congress integrated and expanded parental, and caregiver leave into the 2022 National Defense Authorization Act. Now, according to Directive-type Memorandum 23-001 "Expansion of Military Parental Leave Program," the military standard for paid parental and caregiver leave is 12 weeks (Under Secretary of Defense for Personnel & Readiness, 2023). Military spouses may experience professional precariousness as frequent changes in duty stations and other military trainings and deployments disrupt their ability to sustain a job (Kamarck et al., 2020). Deployment and trainings create additional stress and demands on military families and the birthing parent. For example, a scoping review of 13 studies regarding impact of military deployments on perinatal mental health that identified themes of lack of social support and family-related stress as negatively impacting mental health (Godier-McBard et al., 2019). Altogether, military birthing parents, whether they are the spouse or active duty service member, experience significant competing demands related to financial stability, professional demands, general dislocation and isolation from family of origin.

Clinical practice

As a Military Health System provider, knowing the structural forces and potential for medical trauma is tantamount to providing responsive care to military families. The example described above offers a potential picture of a post-partum transition and the experience of caring for a newborn after the physical ordeal of childbirth. Building on this understanding, providers may consider assessing gaps in care (e.g., checking in with perinatal individuals prior to the six-week post-partum appointment) and connecting service members to resources (i.e., lactation consultants, Childcare Aware program that subsidizes childcare for Service members). As occupational medicine practitioners and assets to units, Military Health System providers may also help commanders interpret and adhere to DOD policies regarding lactation support, caregiver leave, and general support of caregivers.

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