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Brief Report: Barriers to mental health treatment for military wives

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Abstract

Objective—This Internet-based survey provided information about barriers to mental health services for military wives.

Methods—Following qualitative work, an Internet-based program was created to identify military wives who may have major depressive disorder.

Results—Women (N = 569, ages 18 to 56) were recruited from 45 states and 8 foreign countries. Most participants (78%) reported notable depression. Many (44%) reported un-addressed mental health needs. Barriers included inability to attend daytime appointments (38%), inability to find a counselor who understands military spouse needs (35%), inability to find a counselor the participant could trust (29%), concerns about confidentiality (29%), and lack of knowledge about where to get services (25%). Barriers reported by the military wives differed markedly from those described by distressed women in the general population.

Conclusions—Military wives are an under-served population. Knowledge of military culture is essential for civilian mental health providers working with military wives.

Introduction

Wives of military service members cope with numerous stressors (1) including their husbands' dangerous deployments (2,3). Earlier studies found high prevalences of psychological distress and mental disorders in this population (4,5,6). Although some

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military wives make use of mental health services (5), previous research suggests these women face numerous barriers (7,8).

Because there are at least a million wives of active duty, Reserve, or Guard service members (9), this situation represents a major concern. While studies have examined barriers to mental health services for the general population (10) and for military personnel and veterans (11) there is little information on mental health barriers for military wives.

Further, service members' wives who do obtain mental health treatment may be served by civilian providers with few connections to military or veterans' health care systems and limited knowledge of military culture (12,13). Thus, it is important to gather nation-wide information about barriers to mental health treatment faced by military wives and to understand how these challenges may differ from those experienced by civilian women. The objectives of this Internet-based survey were (a) to describe barriers to mental health care perceived by wives of military service members and (b) to compare barriers for military wives versus those experienced by similar women in the general population.

Methods

Qualitative interview data from a convenience sample of 17 women currently or previously married to (or romantically involved with) male service members revealed unique concerns that informed questionnaire development. Details are in the on-line appendix.

Quantitative work involved 569 women (average age 29, range 18 to 56) who were chiefly (85%) white non-Hispanic and recruited primarily through social networking tools, including Facebook, Twitter, online forums, chat rooms, and web sites oriented toward military spouses. In addition, 56 Army Family Assistance Centers/Army Community Services facilities programs around the country were asked to distribute flyers describing the study which were also distributed at Oregon armories.

Social media were by far the most productive recruitment strategy. The project's web site quickly acquired over 4,000 Facebook "friends" located in more than 45 states and at least eight foreign countries (including Asia, Europe, and Latin America). Recruitment spanned May 2010 through July 2011.

Participants were asked to interact with a web site entitled Military Wives Matter that included screening questions and health status measures. Depression in the past week was measured with the 20-item Center for Epidemiological Studies - Depression (CES-D) scale (Chronbach alpha was .93 in this sample). Scores on CES-D of 16 to 26 are considered indicative of mild depression while scores of 27 or more suggest major depression.

Non-specific psychological distress in the previous month was measured with the six-item K6 instrument (Chronbach alpha was .89 in this sample). Scores above 12 on the K6 correspond to clinician-rated measures of serious mental illness.

Barriers to mental health services were measured by items from the National Survey on Drug Use and Health (NSDUH) (10). All participants were asked: "During the past 12

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months, was there any time when you needed mental health treatment or counseling for yourself but didn't get it?" Those answering in the affirmative were presented with 13 barriers (e.g. "couldn't afford the cost") and one open-ended item ("Some other reason, please specify"). Items included military-specific barriers suggested by participants in the qualitative interviews (e.g., "couldn't find a provider who understands the needs of military spouses," "couldn't find a provider you could trust").

Comparative data on the overall population of people married to military personnel were obtained from Department of Defense demographic reports (9). Numbers of deployments for service members were estimated from an Institute of Medicine report (2).

General (civilian) population data were obtained from the 2011 NSDUH (N = 70,109; response rate 74%). Comparison respondents were married females ages 18 through 64 who satisfied diagnostic criteria for major depressive disorder at some time during the year prior to interview (*N* = 567 subjects).

Data analysis employed IBM SPSS Statistics version 20 and accounted for NSDUH complex sampling. The project was approved and overseen by the Institutional Review Board at Oregon Health & Science University. Informed consent was obtained for all participants.

Results

There were similarities and differences when study participants were compared to national data describing military spouses (9). For example, all study participants were women whereas females represented 91% of military spouses nation-wide (9). Participants (average age 29, range 18 through 56) were younger than military spouses overall (average age 33) and Whites were over-represented among participants compared with the service member population. Nearly all (91%) participants were married whereas by definition (9), all military spouses were married. Slightly less than two-thirds (61%) of participants were parents compared with slightly more than two-thirds (69%) of service personnel. Roughly forty percent of participants (37%) were employed which is similar to military spouses overall (42%). The vast majority (94%) of participants lived in the United States as did nearly all (91%) service members. Most participants rated their finances as comfortable or adequate, but 26% reported poor financial circumstances (data were not available for the overall military spouse population). Slightly over half the participants described their location as urban (data not available for military spouses overall).

Slightly over half the participants (58%) were married to Army personnel versus half the military wives overall. The vast majority (87%) of participants' husbands were on active duty versus about two-thirds (65%) for military wives generally. Most (83%) of the participants' husbands were enlisted (versus officers), which is close to the military spouse figure of 79%. Nearly half (46%) of participants said their husbands were deployed whereas overall military deployment was 6%. Participants' husbands averaged 1.9 deployments (standard deviation 1.3) versus 1.6 deployments (standard deviation 1.1) to Iraq or Afghanistan for military personnel generally (2). This difference is highly statistically

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significant ($p < 0.0001$ by Z-test). Half the participants lived more than 50 miles from their husbands' duty stations (data not available for military spouses overall).

Substantial numbers of participants endorsed moderate or severe mental health problems. On the CES-D scale most (51%) had scores over 26 which suggested major depression while another 27% displayed scores in the mild depression range of 16 through 26. The average CES-D score was 27. Looking at the NSDUH, 8% of married women reported past year major depressive disorder (complex standard error 0.5%).

On the K6 scale, 37% scored above 12, suggesting serious psychological distress. The comparable percentage for NSDUH subjects was 29% (complex standard error 2.68%). Thus, participants were more likely than national survey subjects to have had serious psychological distress within the past month ($p < 0.001$ by Z-test).

Table 1 describes barriers to mental health services experienced by participants and national survey respondents, respectively. Substantial percentages of both groups said they had needed but did not receive mental health treatment during the previous 12 months. More of the military wives described unmet treatment need (44%) than did national survey respondents (30%). This difference is highly statistically significant ($p < 0.0001$ by Z-test). Logistic regression models including variables common to both data sets showed that increases in age and K6 score were the most powerful predictors of unmet treatment need. In both populations, each unit increase in the K6 score elevated the chances of reporting unmet treatment need by 20% ($p < .001$).

There were substantial differences between the military wives and the national survey respondents in occurrence of barriers. Table 1 shows that the military wives reported being unable to get away during the day as the most common barrier (endorsed by 38% of participants) while this concern was less pertinent for the general population (24% of respondents). Conversely, over half (53%) of the general population described cost barriers whereas only 19% of military wives did so. These differences are highly statistically significant ($p < .01$ for both by Z-test).

About a quarter (26%) of military wives endorsed the item about confidentiality versus only 4% in the national survey ($p < 0.001$ by Z-test). In logistic regression models, the K6 score predicted confidentiality concerns for military wives ($p < .001$). Conversely, there were no statistically significant confidentiality concern predictors for national survey respondents.

Analogously, the military wives had concerns about negative opinion in the community (19% of military wives) and about being committed or forced to take medication (17% of military wives) which were not shared by general population of women (5% and 8%, respectively, $p < .01$ by Z-test for both items). In addition, large percentages of military wives expressed concern that mental health providers would not understand military spouses (35%) and-or said they could not find a counselor they could trust (29% of military wives). A quarter of military wives said they did not know where to go for mental health services versus only 13% of general population respondents ($p < .002$ by Z-test).

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Among the military wives participating in the study, endorsement of the "needed … but didn't get" item did not vary by the participant's rural versus urban location, branch of service, or active versus reserve status

Discussion

Key findings were two-fold. First, military wives with mental health concerns face numerous barriers to treatment. Second, reported barriers differ substantially from those experienced by women in the general population.

Importantly, the project had representation of military wives from throughout the United States as well as overseas, comparison of participants with the overall military spouse population, and comparison to women in the general population. The methods were developed in collaboration with military wives and the project achieved its goal of recruiting a sample with substantial psychological distress.

On the other hand, the study relied on the Internet for access to potential participants. Military wives lacking Internet access were not eligible. Another limitation is that the study recruited few minority military wives. Military husbands (i.e., male service members) were intentionally not included. The recruitment methods and survey mode were designed to increase participation of women with depressive symptoms. Thus, the estimated symptom levels for participants presumably exceed those of military wives overall.

Some participants began but declined to complete the survey. It was not possible to compare those with complete versus missing data. Also, the questionnaire was intentionally brief. Thus, some topics could not be explored in detail such as the use of specific mental health services (e.g., inpatient care). Moreover, military spouses have stressors and needs in several non-clinical areas such as financial management (1). It is likely that the questionnaire design may have led to over-representation of military wives concerned about clinical needs. Conceivably, there could have been under-representation of military wives with needs in non-clinical areas.

Conclusions

These limitations notwithstanding, several conclusions follow from this work. Beyond "typical" barriers such as logistical challenges (e.g., lack of childcare), participants encountered military-specific barriers such as not finding a provider who understands military culture. This latter point is especially pertinent. While there are several military programs focused on spouse mental health (14), many military wives seek services from civilian providers (12,13,14). Participants felt that few civilian providers understand concerns of military families.

Thus, it is important to educate civilian clinicians about these concerns including the possible impact of care on service members' careers, trust issues, and confidentiality. For example, the federal government has supported pilot projects pairing military or veteran programs with civilian agencies (13). And military programs such as Respect-Mil (15) include training that could be adapted for civilian providers.

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One approach might be to expand the educational offerings aimed at civilian providers by the military's TRICARE program and its contractors. The online appendix includes examples of pertinent resources. Such strategies may facilitate access to mental health services for military wives.

Internet-based services may be particularly helpful for military wives. Strategies employing social media (such as Facebook) might also be used to inform military wives about availability of mental health services tailored to their needs and could facilitate provision of respectful services to a worldwide population.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Barriers

	Military wives [a]			National survey [b]			p-value [c]
Item	**N**	**Percent**	**Std Error**	**N**	**Percent**	**Std Error**	
Needed treatment past year didn't get	162	44	2.6	201	30	3.3	0.001
Can't get away during day	61	38	3.8	51	24	4.9	0.007
Information might not be kept confidential	42	26	3.4	11	4	1.8	0.001
Don't know where to go	41	25	3.4	28	13	3.3	0.002
Couldn't afford cost	31	19	3.1	103	53	5.4	0.001
Community negative opinion	31	19	3.1	17	5	1.6	0.001
Might be committed or have to take medicine	27	17	2.9	26	8	2.3	0.007
Insurance not pay enough	20	12	2.6	31	18	3.6	Not Sig
Negative effect on job.	17	10	2.4	23	8	2.6	Not Sig
No transportation.	15	9	2.3	11	5	2.7	Not Sig
Provider not understand military spouses	57	35					
Not find counselor could trust	47	29					
No services available	13	8					

[a] N = 369 respondents

[b] National Survey on Drug Use and Health 2011 married females ages 18 through 64 with past year major depressive disorder

N = 567 respondents

Weighted percents with complex sample standard errors

[c] Z-test