Exploring Influences on the Psychological Wellbeing of Military Spouses in the United Kingdom: A Qualitative Systematic Review and Online Survey Study

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Date of Submission: March 2nd 2026

Word count (excluding appendices): 28,469

Candidate registration number: 100162405

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Thesis Portfolio Abstract

Background

It is well documented in the literature that military families face a multitude of challenges as part of military life. There is a lot of research around the wellbeing of military personnel, but much less around the wellbeing of their civilian partners. The US has been a global leader in beginning to conduct this research, with various studies looking at the impact of military challenges on military spouses' wellbeing, both generally and during times of increased stress, such as the perinatal period. Similar research has begun to be conducted in the UK assessing the wellbeing of military spouses. However, a systematic review of this literature has not been conducted. Furthermore, no empirical research has been conducted specifically on the perinatal mental health (PMH) of military spouses in the UK. This portfolio aims to explore the impact of being a military spouse on wellbeing in the UK, and what the factors are that influence wellbeing. It further aims to understand the challenges that spouses face more specifically during the perinatal period, what the rates of self-reported PMH difficulties are, and how the military challenges that they face are associated with the reported PMH difficulties.

Method

A qualitative systematic review of the research literature was conducted and identified 9 studies assessing the wellbeing of military spouses. The empirical paper utilised a cross-sectional survey design to understand the rated impact of military challenges on wellbeing and the self-reported PMH difficulties in a sample of 361 military spouses.

Results

The systematic review identified that spouses often feel they experience mental health difficulties as a result of the challenges that they face, but that there is a felt expectation to suppress these emotional responses. There was also a sense from spouses that the military do

not recognise their distress or difficulties. Furthermore, spouses described a change in their individual sense of self, with some reporting this to be positive albeit most describing negative impacts. Whether spouses live on base or off base appeared to influence their wellbeing, along with the expectations that they feel are placed upon them by the military culture that they live in. The empirical paper found a complex mix of challenges rated as impacting on spouses' wellbeing. The self-reported PMH rates were high, with over half of participants scoring above clinical cut off in most of the measures and difficulties with military accommodation were found to be significantly associated with small increases in depression, anxiety and stress scores.

Conclusions

The portfolio indicates that military spouses in the UK face a range of interconnected challenges as a result of military life, with a variety of outcomes on their wellbeing both generally and during the perinatal period. Further research is required to understand the mechanisms behind these challenges and their impact on wellbeing to help appropriately adapt policy and practice to better support the population of military spouses in the UK.

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Acknowledgments

Firstly, I would like to thank my supervisors Jo, Jodie and Kiki, who have all given me unwavering support throughout the thesis process. They were always at the end of an email providing advice, guidance and reassurance. I'd also like to thank my thesis partner, Ashley, for the support during our empirical projects that we collaborated on. No question was ever too silly, and she was always a text away.

Secondly, I would like to thank my family and friends, particularly my partner. They have all been there for me during the highs and lows of this process. The understanding, love, cups of tea and sweet treats have been invaluable. I will forever be grateful for their support and would not have made it to the end of the thesis without them.

Finally, I would like to thank Dandelion Military Families for their support throughout the project. From their invaluable insights at the initial research phase, and providing feedback on the survey draft, to sharing with their followers to help recruitment. This thesis would not be what it is without their input.

Chapter One

Introduction to the Thesis Portfolio

Word count: 1201

Introduction to the Thesis Portfolio

Wellbeing has been defined in many different ways and there is no agreed definition or way of measuring it that spans across disciplines. Many argue that this should be rectified, and some have attempted to create definitions that are both measurable and transferable (Simons & Baldwin, 2021). The Cambridge Dictionary definition simply defines wellbeing as "the state of feeling healthy and happy" (Cambridge University Press, n. d.). This simple definition proves difficult to measure, posing difficulties in the sphere of research. As an alternative, there are objective measures of wellbeing. These are largely tied to factors such as income, job opportunities and living standards which can more easily be measured (OECD, 2011). A significant limitation to this approach is cited as being unable to measure the preferences and priorities of individuals, which varies greatly. There are also subjective definitions of wellbeing, which largely fall into hedonic and eudaimonic perspectives. Hedonism reflects the view that wellbeing consists of pleasure attainment and pain avoidance, and eudaimonism defines wellbeing in terms of self-realisation and the degree to which a person is fully functioning (Ryan & Deci, 2001). A more recent way of attempting to define wellbeing is by combining hedonic and eudaimonic approaches. This provides a holistic definition of wellbeing, allowing insight into a person's individual experience.

The UK Faculty of Public Health (FPH) has utilised a combined hedonic and eudaimonic approach to defining wellbeing. It defines wellbeing as "the capacity of individuals to realise their abilities, live a life with purpose and meaning, make a positive contribution to communities, form positive relationships with others and feel connected and supported, experience peace of mind, contentment, happiness and joy, cope with life's ups and downs and be confident and resilient, and take responsibility for oneself and for others as appropriate" (UK FPH, n. d.). This definition is also used by the World Health Organisation (WHO) to define mental health, stating that mental health is a state of mental wellbeing that

enables the abilities described above, highlighting the intersectionality between wellbeing and mental health (WHO, 2025). As this definition is used by the UK FPH and WHO, this is the definition chosen to be used within this portfolio to measure and report on wellbeing and mental health. This definition also enables a more holistic approach to understanding an individual's experience. The systematic review in this portfolio focuses on the wellbeing of military spouses, whereas the empirical paper focuses on specific perinatal mental health difficulties of military spouses and not wellbeing.

One influential framework for understanding psychological wellbeing is Self-Determination Theory (SDT; Ryan & Deci, 2000). SDT proposes that wellbeing is dependent upon meeting three psychological needs: autonomy, feeling able to make meaningful choices; competence, feeling capable and effective; and relatedness, feeling connected and valued by others. When these needs are consistently supported, wellbeing is promoted. Conversely, environments that prevent these needs from being met are associated with psychological distress and poorer mental health. Military life presents several challenges that may threaten all three needs simultaneously.

Military spouses and partners face a range of challenges unique to being part of a military family. Research into the impact of these challenges on their wellbeing and mental health is limited in the United Kingdom (UK). However, a plethora of research has been conducted in the United States (US), which has shown increased rates of depression, anxiety and stress in military spouses compared to general population spouses (Orthner & Rose, 2006; Eaton et al., 2008; Padden, Connors & Agazio, 2011; Asbury & Martin, 2012; Gribble, Goodwin & Fear, 2019). Challenges such as deployment, when the serving partner is temporarily assigned away from home, and relocations, when the family unit move home for a military assignment, are key challenges that have been researched. Furthermore, literature from the US has shown that military challenges, such as deployment and decreased social

support, are key risk factors for increased PMH difficulties in military spouses, defined as mental health difficulties during the time from conception to 24 months postnatal. It is well documented that PMH difficulties in the general population are linked to an increased risk of maternal suicide, and 40% of all maternal deaths in the UK are due to mental health-related causes, with maternal suicide being the main cause of death (Knight et al., 2023). However, the PMH of military spouses and partners in the UK is another area that is currently under-researched, with no known published research articles exploring PMH in military spouses in the UK. This highlights a clear gap in the UK literature.

The plethora of research based in the US is helpful to indicate potential difficulties military spouses in the UK may be facing, however there are stark differences between the military and healthcare systems in the US and UK that make direct comparison difficult. A key difference is that military spouses in the US receive healthcare from the military itself as part of the package of care for military personnel and families. That means that service providers in the US have awareness of the challenges that military spouses face and can therefore provide the appropriate support to meet their needs. In contrast, the UK Armed Forces provide healthcare only to the serving personnel and so military spouses receive healthcare through the National Health Service (NHS), the same as civilian families. There is no mandatory training within the NHS to upskill professionals in the knowledge required to identify military specific risk factors for mental health difficulties and provide tailored support. This could be delaying care for military spouses for their mental health and wellbeing, both within and outside the perinatal period.

The systematic review within this portfolio aims to understand what the impact of being a military spouse is on wellbeing, and what factors impact the wellbeing of military spouses in the UK. This will begin to close the gap in the literature by being the first systematic review to investigate this topic based on samples exclusively from the UK.

The empirical project within this portfolio aims to follow on from the systematic review by investigating the mental health of military spouses in the UK specifically during the perinatal period. No research has been conducted in the UK specifically on the PMH of military spouses, and so this novel research will be the first of its kind and will provide recommendations for future research to begin to understand the experiences of this population at a key time in their lives. Data collection for the empirical project was shared as part of a larger project, however the research questions and associated analysis and write up was done separately.

The empirical project aims to explore the challenges that military spouses face during the perinatal period. This will help to gain an understanding of the perinatal risk factors that military spouses in the UK face. The study will also assess the self-reported PMH difficulties in the sample, giving an indication of how common these difficulties are. Finally, the study aims to understand if the military challenges are associated with poorer PMH.

For the purposes of this portfolio, military spouses and partners will be referred to as spouses and encompasses anyone in a relationship with serving military personnel.

Chapter Two

Systematic Review

Prepared for Submission to Military Psychology Journal (Author Guidelines Found in Appendix A)

Word count (excluding references): 8561

Total page count: 36

The Impact of Being a Military Spouse or Partner on Psychological Wellbeing in the United Kingdom: A Thematic Synthesis

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The Impact of Being a Military Spouse or Partner on Psychological Wellbeing in the United Kingdom: A Thematic Synthesis

Abstract

Research into the wellbeing of military spouses and partners has primarily been completed with populations outside of the UK, with most in the US, which has different military and healthcare systems. Of the limited qualitative research conducted on the wellbeing of UK military spouses, a systematic review of this literature has not been completed. This systematic review aimed to identify the impact of being a military spouse on psychological wellbeing and the factors that impact the psychological wellbeing of military spouses in the UK. A systematic search of six online databases and snowball searches found nine studies that met the inclusion criteria. A quality assessment was completed, followed by a thematic synthesis. Two themes and two sub-themes were identified related to the first review aim: ‘emotional responses: hidden away and lack of recognition’ and ‘individual sense of self’. Two themes were identified related to the second review aim: ‘home as a help or a hindrance and ‘living by military expectations’. Spouses described mental health difficulties as a result of the challenges they faced, however also described expectations to suppress or minimise these emotions. Spouses spoke about differences in experiences depending on whether they lived on base or off base, with positives and negatives of each location described. Future research should further explore the wellbeing of military spouses to develop appropriate policies and practices to support this population in the UK.

The author has no conflict of interest to declare.

Keywords: military spouses; wellbeing; qualitative; thematic synthesis; United Kingdom.

Introduction/Background

The challenges of having a family within the military have long been recognised. Segal described the military and the family as "greedy institutions", both requiring extensive time and resource from individuals within them (1986). This poses challenges for all involved, however research into the impact on civilian partners is less extensive than that of the impact on military personnel. Currently, much of the research that has been conducted on this population is based on military partners and spouses based in the US, with very little having been conducted on samples from the UK.

Wellbeing and military spouses

The current literature highlights the potential negative impacts of being a military spouse on their wellbeing. One study found that when compared to spouses in the general population, military spouses had higher levels of perceived stress, with higher stress being negatively correlated with mental and physical wellbeing (Padden, Connors & Agazio, 2011). Another study found that military spouses were significantly more likely to meet the criteria for probable depression compared to women in the general population (Gribble, Goodwin & Fear, 2019). Being a military spouse has also been found to impact on marital satisfaction, with those with a spouse in the military reporting higher marital discord compared to those without a spouse in the military (Asbury & Martin, 2012).

Much of the research conducted on the mental health and wellbeing of military spouses focuses on the impact of deployment, with negative impacts seen on the rates of depression, anxiety, stress and marital satisfaction (Orthner & Rose, 2006; Eaton et al., 2008; Padden, Connors & Agazio, 2011; Asbury & Martin, 2012; Gribble, Goodwin & Fear, 2019). However, one study found that deployment was not a significant predictor of psychological distress in military spouses (Ribeiro, Renshaw & Allen, 2023). They also discovered that service-related moves, or relocations, were associated with greater psychological distress,

even when accounting for deployments. Relocations can impact spouses in various ways, particularly impacting on their employment, which has been found to have resulting impacts on wellbeing (Elliott, 2020). Being unable to gain the desired employment and contribute to the family financially has been found to impact on spouses' self-esteem, confidence and independence (Hosek & Wadsworth, 2013). Furthermore, underemployment of military spouses has been linked to lower psychological wellbeing and reduced quality of life (Trewick & Muller, 2014). This suggests that aiding military spouses to gain or maintain employment through their military life is important for maintaining their wellbeing.

Another common factor described in the literature to impact on spousal wellbeing is social support. Having a strong social support network has been found to increase positive adjustment in military spouses by 24% (Orthner & Rose, 2006). Additionally, support from the military and a strong sense of cohesion with the military community has been found to be predictive of adaptation (Pittman, Kerpelman & McFadyen, 2004). This suggests that social support is a key factor that can influence spouses' wellbeing.

A limitation of much of the research mentioned is the lack of data based on populations from the UK. Despite some systematic reviews being completed by researchers in the UK, they include very few, if any, studies conducted here (de Burgh et al., 2011; Blakely et al., 2012; Gribble et al., 2018). Much of the literature on this topic is conducted in the US, which has different military and healthcare systems, as described in the Introduction chapter, which may limit the applicability of these outcomes to UK populations. Whilst ideas may be drawn from the US data, there is a need for similar studies to be conducted on UK populations. Whilst this has begun in some cases, there is still a large gap in the literature in the UK.

Rationale

The experience of being a military spouse and its impact on wellbeing is well documented in the US. Whilst some research has been conducted into this area in the UK, a systematic review of the UK literature has not been completed. This systematic review aims to bridge the gap in the literature by evaluating the available qualitative research that explores the impact of being a military spouse or partner on psychological wellbeing in the UK. This approach fit with the holistic definition of wellbeing used and enabled in-depth insight into individual experiences.

The review questions are: 1) What is the impact of being a UK military spouse on psychological wellbeing? and 2) What are the factors that impact the psychological wellbeing of military spouses in the UK?

Methods

This review was completed using a social constructionist epistemological approach, which assumes that knowledge and reality are not objective truths but rather actively constructed through social and shared understanding. It further posits that researchers are part of the research process, and their position and interactions affect it (Charmaz, 2000; Clarke, 2005). Therefore, this review assumes that experiences of wellbeing are multiple, context-dependent and socially constructed rather than representing a single objective reality. The themes developed are interpreted as shared constructs across participants rather than universal truths. This position influenced the analytical process by prioritising participants' subjective meanings and recognising that the researchers also played a role in constructing the final thematic interpretation. The first author has professional interest in military spouse mental health, however no personal insight into the life of a military spouse. The review protocol has been published on PROSPERO (CRD420251077765).

Study inclusion criteria:

1. Studies in which at least one of the research questions describes focusing on the psychological wellbeing or mental health of military spouses or partners in the UK.
2. Studies in which the sample is of military spouses and partners whose partner is an active service member in any branch of the British Armed Forces and posted in the UK or abroad with or without the spouse or partner accompanying them.
3. Studies using a qualitative or mixed methods design, whereby only the qualitative aspects will be utilised.
4. Studies published in English.

Study exclusion criteria:

1) RCTs, systematic reviews, intervention studies.
2) Studies based on a sample of British Armed Forces Veterans.
3) Studies assessing partner wellbeing as a result of personnel injury/illness.

The inclusion criteria required studies to explicitly examine psychological wellbeing or mental health, rather than broader social determinants of health in isolation, such as employment, housing, financial stability or social support. This decision was made because the review sought to understand the overall lived experience of psychological wellbeing, rather than synthesising evidence relating to individual determinants independently. This increased the conceptual consistency across included studies and ensured that the findings directly addressed the review questions. However, it is acknowledged that many social determinants are closely intertwined with wellbeing and that studies examining these determinants without explicitly framing them in terms of wellbeing may have provided valuable insights. Consequently, this criterion may have reduced the number of eligible studies and limited the breadth of evidence informing the synthesis.

Search strategy

Peer reviewed studies and grey literature were included so a systematic search was completed of MEDLINE, PsycINFO, CINAHL, SCOPUS, OpenDissertations and ProQuest. MeSH terms related to the review title were used, as shown below:

- (XB military OR "armed forces" OR navy OR "air force" OR army OR naval)
- AND (XB spouse OR partner OR family OR wife OR husband OR spousal OR girlfriend OR boyfriend)
- AND (XB "psychological wellbeing" OR "mental health" OR "emotional wellbeing" OR well-being OR "psychological distress")

Snowballing searches were done by searching reference lists of included studies.

Thematic Synthesis

The first author conducted a thematic synthesis to summarise the findings from the included studies. This method was chosen as it was designed to address questions about people's experiences (Thomas & Harden, 2008). The thematic synthesis has three identified steps suggested by Thomas & Harden: 1) free coding, 2) development of descriptive themes, and 3) development of analytical themes (2008). The 'results' and 'discussion' sections of the papers were extracted and data related to the review questions were coded line by line for step one. Codes were then explored across the studies and grouped into descriptive themes. The descriptive themes were considered alongside the research questions to then develop them into analytical themes. Reflective discussions were had with the supervisory team as the themes were developed to ensure rigour.

Results

Study selection

The flowchart for study selection can be seen in Figure 1. 5728 studies were found through the initial searches, 4,934 of which were peer-reviewed studies and 794 were grey literature, and all were uploaded onto a reference management website. After duplicates were

removed, 2915 studies remained. The first author independently searched and screened the titles and abstracts of the studies retrieved during the searches for potentially eligible studies. The third author independently screened the titles and abstracts of 20% of the studies retrieved. There was 97% agreement between the first and third author at the screening stage. Disagreements were discussed and conclusions reached. 107 studies were deemed potentially eligible and taken forward to the full text screening. 20% of these were also screened by the third author. There was 83% agreement between the first and third author at the full screening stage. Disagreements were discussed and conclusions reached. This resulted in 8 studies included in the review. One further study was identified through snowballing (Verey & Fossey, 2013).

Data extraction

Data were extracted from the nine included studies. This can be seen in Table 1. The nine studies included 520 participants (studies one and five used the same sample), 514 females, 5 males and 1 who preferred not to disclose their gender. One study did not report the military domain the spouses were associated with. Of the ones that did, 55 participants were associated with the British Army, 50 with the Royal Navy, 8 with the Royal Marines, and 23 with the Royal Air Force.

Figure 1. *PRISMA flow diagram detailing the study identification process (Reproduced from: Page et al., 2021).*

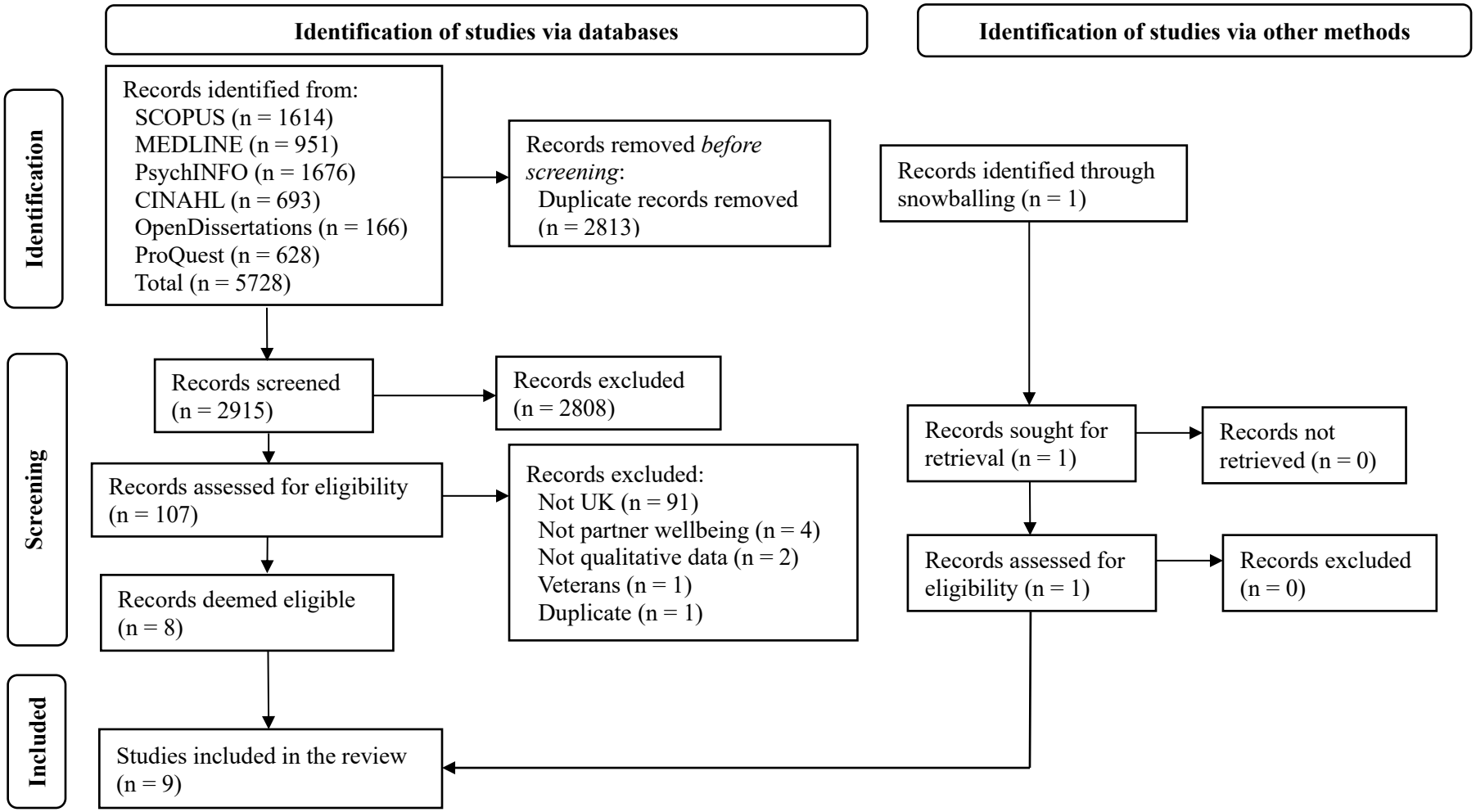


Table 1. *Characteristics and main themes for included studies.*

Study	Authors, year	Aims/research questions	Data collection method	Sample (including age, gender & military association)	Data analysis method	Themes (as described by authors)
1	Gribble, R., Goodwin, L., Oram, S., & Fear, N. (2019a)*	Exploring experiences of the relationship between UK military spouses and the military institution during relocation and the perceived influences on spouse wellbeing.	Interviews	19 female military spouses aged 30-60. 5 Royal Air Force, 14 British Army.	Framework analysis	1) Identity 2) Agency 3) Connectedness
2	Blakely, G., Hennessey, C., Chung., M. C., & Skirton, H. (2014a)**	1) What is the emotional, social and psychological impact on spouses of British military personally when relocated to a foreign country? 2) What methods are employed by spouses to adjust to a new environment? 3) What types of	Online forum	13 female military spouses aged 18 to 59. 5 Royal Navy, 2 British Army, 6 Royal Air Force.	Thematic analysis	1) The influence of location variables and individual situations 2) Personal coping mechanisms 3) The influence of personality and personal meaning-making

		emotional and social support are desired or used by spouses when living in a foreign community?				4) The availability of support and chosen support networks
3	Hassett, C. (2020)	1) How do military partners experience culture and deployment? 2) How do military partners perceive their mental health, wellbeing and identity during deployment? 3) How do military partners perceive coping with deployment?	Online survey	388 military spouses. 4 male, 383 female, 1 preferred not to say. No data on ages or military association.	Thematic analysis	1) Powerlessness 2) Tensions between multiple identities 3) Coping expectations and conflicting reality 4) Cycling through transitions
4	Osborne, A. (2020)	Explore the psycho-social impact of intermittent separation on dispersed military families.	Interviews	28 female military spouses aged 23-52. 9 Royal Navy, 2 Royal Marines, 11 British Army, 6 Royal Air Force.	Framework analysis	1) Identity 2) Loneliness 3) Well-Being 4) Familial relationships 5) Accessing support

5	Gribble, R., Goodwin, L., Oram, S., Fear, N. (2019b)*	Explore the employment experiences of UK military spouses with children during accompanied postings and how these are perceived to influence spouse wellbeing through the lens of self-determination theory.	Interviews	19 female military spouses aged 30-60. 5 Royal Air Force, 14 British Army.	Framework analysis	1) Identity 2) Agency 3) Self-worth 4) Connectedness
6	Gribble, R., Fear, N. (2022)	Explore how the experiences of spouses and partners and young people from UK naval families, living separately from personnel during the week, influence family functioning and dynamics and health and wellbeing.	Interviews	20 female military spouses aged 18-60. 6 Royal Marines, 14 Royal Navy.	Framework analysis	1) Family functioning and dynamics 2) Family health and wellbeing
7	Blakely, G., Hennessey, C., Chung.,	What is the emotional, social and psychological impact on spouses of British Military personnel when	Interviews and focus group	34 military spouses aged 18-60. 1 male, 33 female. 22 Royal	Thematic analysis	1) Marriage and relationships 2) Support 3) Change

	M. C., & Skirton, H. (2014b)**	relocated to a foreign country? What methods are employed by the spouses to adjust to a new environment and are these a reflection of individual coping strategies and location-specific factors? What types of emotional and social support are desired or used by spouses when living in a foreign community?		Navy, 6 British Army, 6 Royal Air Force		4) Individual differences and personal meaning-making 5) Family lifestyle and wellbeing 6) Acclimatising to new culture and social environment
8	Burkill, A. (2021)	Explore the lived experiences of army spouses who choose to reside outside of a military patch community and the implications of this on their sense of wellbeing.	Interviews	7 female military spouses aged 30-55. All British Army.	Interpretive Phenomenologi-cal Analysis (IPA)	1) Military vs civilian life 2) Separation vs stability 3) Disconnection 4) The military community: a place of several meanings 5) An opportunity to gain

9	Verey, A., & Fossey, M. (2013)	What role, if any, does accommodation plan in mediating the effects of the cycle deployment?	Interviews	11 female military spouses aged 18-45. All British Army	Thematic analysis	1) Family: structure, roles and relationships 2) A place called home: control, autonomy and choice 3) Community: inclusion and exclusion 4) Welfare provision (Army Welfare Service (AWS) and Unit Welfare Officers (UWO))

*- same overall study so same sample, different aims

**- same overall study so same aims, different sample

Quality assessment

The quality of each study selected for inclusion was assessed by the first author. 20% of the studies were also assessed independently by the second reviewer. This was done using the Critical Appraisal Skills Programme (CASP) checklist for qualitative research (2024). Despite limitations, such as the focus on methodological aspects of research and not assessing the theoretical standpoint, this tool was chosen as it is user-friendly for novice qualitative researchers and it being the most commonly used quality appraisal tool in Cochrane and WHO guideline processes (Noyes et al., 2020). Studies were rated on ten quality criteria, with each rated as 'zero' if not met, 'one' if partially met or where it is unclear or 'two' if definitely met. This resulted in a maximum score of 20, indicating a high-quality study. There was 85% agreement between the first author and second reviewer. Differences in opinion were resolved through discussion until a mutual decision was reached. Studies were numbered to allow ease of discussion throughout the rest of the review. The quality assessments for the studies can be seen in Table 2.

Of the nine identified studies for inclusion, five were peer-reviewed studies, three were non-peer-reviewed doctoral dissertations and one was a report conducted for the Army Families Federation (AFF) which included novel research data. The studies had quality assessment scores ranging between 16 (1) and 20 (8).

All studies were assessed as having clear aims and appropriate qualitative methodology and research design to achieve the aims. Most clearly explained the recruitment strategy utilised, however one (6) gave limited information on the recruitment process. All studies gave clear explanations of data collection methods which were appropriate to the research aims. However, few of the studies mentioned data saturation, with only two (3, 7) discussing it. Only two studies (7, 8) explicitly discussed the relationship between the researchers and the participants, and potential for bias within the study. Four of the studies (1,

Table 2. *Quality assessment of the included studies using CASP for qualitative research.*

CASP Criteria Study number	1	2	3	4	5	6	7	8	9
Was there a clear statement of the aims of the research?	2	2	2	2	2	2	2	2	1
Is a qualitative methodology appropriate?	2	2	2	2	2	2	2	2	2
Was the research design appropriate to address the aims of the research?	2	2	2	2	2	2	2	2	2
Was the recruitment strategy appropriate to the aims of the research?	2	2	2	2	2	1	2	2	2
Was the data collected in a way that addressed the research issue?	2	2	2	2	2	2	2	2	2
Has the relationship between researcher and participants been adequately considered?	0	0	1	1	0	1	2	2	0
Have ethical issues been taken into consideration?	1	2	1	2	1	1	2	2	1
Was the data analysis sufficiently rigorous?	2	2	2	2	2	2	2	2	2
Is there a clear statement of findings?	2	2	2	2	2	2	2	2	2
How valuable is the research?	1	2	2	2	2	2	1	2	2
Total score (0-20)	16	18	18	19	17	17	19	20	16

2, 5, 9) failed to mention the relationship between the researchers and participants at all. All studies, apart from one (9), made at least brief mention of ethical considerations in the form of stating ethical approval from an ethics committee. Half of the studies included further

information regarding ethical issues, such as about participant consent. All studies demonstrated rigorous data analysis, all using a known method of analysis with detailed evidence for the themes developed. Additionally, they all provided clear statements of findings in relation to the research aims or questions. All studies referred to the usefulness of their research, however two (1, 7) included only a single sentence with limited detail.

Synthesis

The synthesis of the nine included papers produced two analytical themes and two subthemes related to review question one: 1) Emotional Responses: Hidden Away and Lack of Recognition, and 2) Individual Sense of Self. Two analytical themes were identified for review question two: 1) Home as a Help or a Hindrance and 2) Living by Military Expectations. Table 3 indicates which papers contributed to each theme. The following section outlines each theme, supported by evidence and quotations taken from the included studies.

What is the impact of being a military spouse on psychological wellbeing?

Emotional responses

Hidden away

The emotions expressed by military spouses in relation to military challenges varied, along with the responses to these emotions. Some found the military challenges, such as separation, to be too much and found themselves experiencing various mental health difficulties, such as anxiety, depression and stress: “Sometimes it feels like a kind of temporary depression.” (4) and “[I] started getting depression a few months ago.… It was mainly through lack of support because I was just getting … very tired and very stressed.” (6). Mental health difficulties were also described in relation to employment difficulties that spouses faced due to relocating: “I found myself in a real sort of trench of depression because I just couldn’t see where my life was going” (5). In contrast, a small proportion of spouses

Table 3. *Contribution of papers to each theme*

	Study number								
Analytical theme	1	2	3	4	5	6	7	8	9
Emotional Responses		●	●	●	●	●	●	●	
Individual Sense of Self	●	●	●	●		●	●		●
Home as a Help or a Hindrance	●			●			●	●	●
Living by Military Expectations	●	●	●	●	●			●	●

reported more positive outcomes from the challenges they faced: “sometimes you have to look outside the barriers … and work around it. So that can make you stronger.” (5). Others took on the “it is what it is” mindset to cope with the challenges they faced: “You just do don’t you. Well, that’s just the situation so we’ll just get on with it” (4). However, this response may also be linked to the expectation to conform to the military culture, particularly when living on base. This includes the expectation to “just get on with it” (3) and hide their emotions for the sake of their military partner: “I am told by the command to be careful what you do share because you don't want to add that added stress onto your service member because it may take his mind off of the job…which in turn could put him and other people in danger” (3). Whilst this spouse appeared to have been told to not share their emotions, another seemed to do so intrinsically, suggesting it is an unspoken expectation: “I would never tell my husband while he was deployed if I was struggling; it’s not fair on them when there's nothing they can do to help” (3). It appears spouses felt they must be seen as coping and resilient in response to the difficulties they faced and not express how they were really feeling.

Furthermore, spouses often spoke in an invalidating way of their own experiences, downplaying their emotions, giving further insight into the expectations of their coping

responses: “It was a normal reaction to an extraordinary situation so how can that be classed as depression” (3). Many described using avoidance as their way of coping with stressors, keeping with the expectation to hide or suppress emotions, with one spouse describing how they will avoid all reminders of their military partner when they are away: “Initially, I clean the house, and put all his stuff away” (3). This suggests that the expectation among military spouses may also be to suppress emotional responses, which is likely to impact on their wellbeing and their ability and willingness to seek help.

Another common emotional response from spouses across many of the studies was a feeling of resentment towards their partners and the military for the concessions they were required to make: “You just think “Oh, how is this fair that he gets to keep all of his leave, you know, and swan off around the world and not have to deal with any of this?” … [It’s] resentment to[ward] him that he can go and live a single man’s life while I’m juggling at home” (6). Further negative impacts were also seen on the relationship between spouses and their serving partner. Many spouses spoke of strain on the relationship due to having limited time together: “I feel that we don’t see each other or spend time together. … We just kind of facilitate the children” (6). Others spoke of feeling pressure to ensure time together was perfect: “There’s a pressure to make the time you’re together perfect. And sometimes when it doesn’t work out that way, you feel that you’ve failed at something” (6). The difficult emotion of resentment towards the military personnel seems to have an impact on the relationship between the spouse and their military partner, which is in turn impacting on the spouses’ wellbeing as it limits their ability to have positive relationships, a key factor in the definition of wellbeing.

Lack of recognition

The emotional impact of military spouse life was often described by spouses as not being recognised by the military institution. They described a lack of support available to

them during various challenging times, such as prior to deployment: “There isn't enough support for soldiers and families before they go as this is a very unsettling time” (3). Other spouses described feeling as though they are not a priority to the military and felt invisible: “The focus is on his deployment and even the leaflets handed out to supposedly offer helpful info were written to the person being deployed. I felt invisible to the RAF” (3). One spouse even felt as though the military did not respect them: “…there is no respect, there’s no respect for the spouses” (7). In particular, spouses living off base found their needs to be neglected and felt as though they are “left behind” (8) by the military: “I didn’t get much from kind of the Welfare side of the army in terms of how I was doing… I have always had a bit of an issue with the army’s attitude to family and how they kind of present this family life but actually don’t really fulfil that” (8). Spouses also spoke of reluctance to seek support from the military if needed: “I think wives are reluctant to seek official help as it does progress up thru chain of command.” (2). Additionally, some spouses spoke of organisations outside of the military not understanding their circumstances, creating the notion that they cannot help the spouses, rendering spouses powerless and unable to seek support. The perceived lack of understanding from the military and outside services appears to impact on spouses’ ability to access support for their wellbeing.

Military spouses described various emotional responses they experience as a result of the challenges of military life. However, many spouses described a need to conform to military culture and suppress or hide these emotions. Spouses described feeling unseen by the military and not understood by services, making access to support difficult. These factors are likely to impact on spouses' wellbeing as it impacts on their ability to feel supported, to feel contentment, happiness and joy, and to cope with life’s ups and downs, as described in the definition of wellbeing.

Individual sense of self

A common theme across the studies was the impact on spouses' individual sense of self as a result of military life. Some spouses described individual growth as a result of the challenges of military life. This was reported in relation to overcoming barriers to employment, managing the demands of separations from their military partner through deployments and living as a dispersed family, as well as managing relocations. One spouse described deployment as "enriching- you grow as an individual and everything is strengthened as a family" (3). Other spouses described improvements in their confidence and feeling psychologically stronger. One spouse described her responses to an overseas posting: "It definitely changed me. For the better I hope. It made me more independent and a much stronger person, more confident" (2). Spouses described separations and the increased demands on them as fostering increased independence: "I need to do a bit more for myself and I think that's like a really good thing. I think it's like made me more independent" (4).

However, some spouses viewed this increased independence as minimising of their individuality due to the increased demands and responsibilities resulting in them needing to turn their focus away from themselves. Spouses spoke of these demands being hard to manage and exacerbating stress. One spouse spoke of the impact of these demands on her: "it was really difficult to keep on top of everything, do everything I wanted to do and I just found I had no time for me at all" (4). Another spouse spoke of the impact this also had on her socialisation, further minimising her sense of self: "I don't have the chance to go out and do things for myself or maybe join a club or a running group or something where you would get that social interaction of your own" (4). This was particularly felt by spouses with children, who described having to assume a single parenting role at times of separation, enforcing that sense of unwelcome independence: "I no longer had a partnership at home. … [I was] in a way a single parent looking after a small child, and my partner was doing his own thing and he had …no family responsibilities" (6).

Other spouses found that the military challenges they faced limited their independence and made them more reliant on their partners, minimising their sense of self. This dependence on their partners made some spouses feel inadequate and as though their right to individualism was revoked, sometimes causing interpersonal conflicts in their relationships: “The very fact we are referred to as “dependents” is patronising and the fact that the serving spouse is the only one who can do anything official is very frustrating.” (2). This was often seen in relation to losing employment as a result of relocations, with one spouse describing “I had my own job but yeh coming out here I am just a wife and mother” (7). Others described this loss of independence as being part of the military culture. One spouse spoke of an interaction with a housing officer who refused to continue talking to her when she became upset about a problem with their service accommodation and would only speak to her husband: “I just thought “I can’t believe people speak to people like this!”. . . There is this attitude which permeates…really you’re not your own person. You’re “wife of”. . .” (1).

The increased demands and responsibilities that spouses face as part of a military family is sometimes welcomed as it increases their individual sense of self, however, was more often described as unwelcomed and viewed as minimising of their sense of self. This is seen through the need to do everything alone and therefore having little time for themselves. Other spouses felt an increased dependence on their partner and minimisation of their role and individualism. This impacts spouses’ wellbeing as it inhibits their ability to realise their abilities, live life with purpose and take responsibility for themselves.

What are the factors that impact the psychological wellbeing of military spouses in the United Kingdom?

Home as a Help or a Hindrance

The influences on spouses' wellbeing appeared to vary depending on whether spouses lived on base or off base. Living on base was described as limiting spouses' independence and individual control, which links clearly with the Individual Sense of Self theme. Spouses were often limited in relation to where they could live, for how long, as well as the decoration of the house, limiting their ability to reflect their identity in their home: ""Oh, by the way you're going to move to such-and-such an area" where you've got no control at all, being told where you're going to move to, and not having a choice." (1). This oftentimes also had an impact on employment opportunities due to the disruption of frequent relocations. Some spouses found that employers could be supportive and understanding: "I've been so lucky for where a work, just having really empathic managers, they just been really supportive" (4). However, this seemed to be a rare response from employers. This also then impacted on the spouses' 'employee' identity, at times leaving them restricted to the military wife identity: "I gave up um, quite a good job and stuff, to move there… It's just, I wanted my own life… You have to give up a lot of your own identity when you move, and I didn't like it." (9). This suggests that living on base may reduce their ability to live life with purpose and meaning and realise their abilities.

The relationships that spouses were able to build also appeared to be influenced by living on base or off base. Those living on base described a strong specialness of being around other spouses who they had a shared understanding with: "patch life can be remarkably special" (8). Many described these bonds as being integral to dealing with the challenges that they faced: "We've all been there and every-body out here has had that experience … so I think it is very supportive" (7). In contrast, others described difficulties in building relationships whilst living on base due to the frequency of relocations: "you still can't really make friends with people in the barracks… because you are going to move after 2 years" (8). Others described the relationships formed quickly to be "artificial" as a result of

the military life "forc[ing] an unrealistic situation where friendships were hastily formed" (7). Those that felt unable to build those relationships appeared to have a desire for the idealised patch life as portrayed in films: "I would love that community feeling you know when you watch the films about army wives" (8). Others also described military spouses forming "cliques" on base and thus making it difficult for other spouses to feel welcomed. This suggests that the relationships spouses are able to build on base can be variable, however there is a general agreement among spouses that they are important, and are also integral to the definition of wellbeing.

Alternatively, living off base provided spouses with more agency and control. They had the opportunity to own their home, allowing geographical stability and independence for themselves and their families, as well as creative freedom on their home: "I am going to be in charge of my own destiny for once, which was, yes, very exciting" (9). It also allowed them the opportunity to develop their career, increasing their financial independence: "It's nice to go to work… be able to earn some money…Because before it was just my husband who was the earner" (4). Many also described the freedom of not feeling watched by the military: "having your own space and not feeling that the military is watching you. We can do what we like here… freedom of there isn't any control other than as you say" (8). This sense of freedom allowed spouses to develop their own identities as they wished to: "I'm a [JOB TITLE], I'm a, a friend, a daughter, a sister and trying to understand academia and then I'm also with someone in the army rather than I imagine if I was a military wife living on camp" (4). Living off base appears to give spouses more freedom to be themselves, allowing them to realise their abilities and live life with purpose and meaning, potentially improving their wellbeing.

However, living off base often meant increased separations from their military partner, resulting in increased responsibility in maintaining the home and family life. Whilst

this was seen as increased independence, it was not always welcomed (see Individual Sense of Self). There was also a sense of being suspended between the military and civilian communities when living off base. They reported a sense of disconnection from the military community and the relationships that this provides. This was sometimes attributed to a lack of understanding from other military families of their situation as dispersed families: “I think a lot of people who don’t live in a kind of dispersed way don’t really understand…within the military community” (4). This was also sometimes attributed to the physical geography of living away from the military base, limiting access to the community: “not being on site, we’re left out of the loop, no letters, nothing” (9). As a result of having limited access to those going through similar experiences, spouses reported a negative impact on their wellbeing: “I think not being around people to discuss it with who are going through the same thing that did affect my wellbeing” (8). Spouses also reported a disconnect from their civilians counterparts due to a lack of understanding in the challenges associated with being a military spouse: “None of my friends from home really had any concept of it, you can’t really explain to them” (9), as well as a misconception within the civilian community that military spouses choose the lifestyle: “I don’t tend to share a lot with civilian friends because…there is almost a judgment in the fact that it’s a lifestyle choice erm, and actually it’s not a lifestyle choice” (4). Some spouses also reported feeling cautious about sharing their military identity with civilians due to the complexity of their situations and not knowing others’ opinions of the military: “in order to explain, I would have to explain quite a lot, and also the problem of course, is that I have no idea what people’s views of the military are” (8). This impacts the level of support spouses have available to them through friends and family: “I’d find it really difficult to talk to friends like I would do other friends in the military circle” (9). Living off base appears to have potentially negative impacts on the relationships that spouses can build, a key part of the wellbeing definition.

Living on base or off base both have positives and negatives. Both locations appeared to impact on spouses' ability to reach each of the different aspects of the wellbeing definition, particularly in relation to feeling connected and supported. This suggests that location is a key factor that impacts on spousal wellbeing, however the level of control that spouses have over their location is not clear, which may further impact on their wellbeing.

Living by Military Expectations

Spouses spoke about various expectations placed upon them, both by themselves and by the military. A commonly spoken about expectation was that spouses take on the military wife identity and the expectation to portray themselves in a certain way to fit this identity: "The wife has to have a true pioneering spirit and have the strength to adapt to a new place, culture, time zone, and everything that brings" (2). They spoke of the expectations to act a certain way to be in line with their husbands' career: "I feel constrained in what I can say and do because there are people of the mind-set in the military that if your wife doesn't behave and stay in line in the way they think they should, their husband's career will suffer" (1). This clearly links with the 'Emotional Responses' theme whereby spouses also felt the expectation to suppress or hide their emotions. They also spoke of their role being to support their husband: "I have a role to play, and that is primarily to support my husband as he does a difficult job" (3). Some spouses spoke of the expectation to assume their partners rank within the military spouse community, despite not always feeling comfortable in doing so: "because we were the Officers' wives they thought that we should be leading them . . . we didn't feel it was appropriate or why should we have to do it just because we're an officer's wife" (1).

For some, this expectation to take on the military wife identity was welcomed and spouses saw this identity as something to be embraced and to be proud of. Identifying as a military wife allowed spouses to feel a sense of community with other military wives, allowing a level of understanding not possible with those outside of the military sphere: "The

sense of camaraderie, that you get from all the wives because all your husbands, they are all in the same boat as you" (9). Furthermore, those who felt a disconnect from this identity, such as those living off base, expressed dissatisfaction: "I think living outside of SFA that part of my identity doesn't matter as much…I know when I am in SFA it does matter and its respected" (8). In contrast, others chose to reject the military wife identity, feeling it limited their independence and overall identity. One spouse spoke of having "lost a bit of my identity being married to someone in the military" (5). Many spouses taking this stance on the military wife identity sought to have identities outside of the military, often through employment and the social connections this provided: "you're your own person and you're not sort of classed with your husband as such … that's nice" (5). However, some spouses spoke about the expectation to give up or change their employment in response to military demands: "I think there is still a lot of people in military, perhaps the older guard who think that wives, families should just follow their husbands around … maybe someone may want a career" (4). Those who could not attain employment expressed frustration: "[I felt] bored! Frustrated … kinda a bit useless really. I just felt like that spouses on someone's arm" (5). This suggests that the expectation to take on the military wife identity has mixed responses, highlighting the potential impact on wellbeing.

The felt expectation that spouses give up or change parts of their identity to fit the expected military wife identity could have a negative impact on spouses' ability to experience contentment and live life with meaning and purpose, amongst other aspects of the wellbeing definition. This suggests that the expectations placed upon military spouses impacts on their wellbeing.

Discussion

This review aimed to understand the impact of being a military spouse on wellbeing, and what factors influence this through a thematic synthesis of nine studies identified through

a systematic search. This produced four analytical themes and two sub-themes, two for review question one with the two sub-themes and two for review question two. These themes highlighted the expectations placed upon military spouses to hide or suppress their emotions, as well as a lack of recognition of their emotions from the military. Furthermore, changes to their individual sense of self in both positive and negative ways were described. These impacts were described as influenced by whether spouses lived on base or off base, with positives and negatives of living in each location, as well as by the expectations that accompany the 'military wife' identity.

The themes identified relating to question one highlighted the areas where military spouses described impact on their wellbeing. Some spouses commented on the expectation to hide or downplay their emotions to protect their partner and their partner's career, and to live up to the military expectation to "get on with it". Whilst previous research may not highlight the felt expectation of this response, a similar response of hiding and avoiding emotions has been seen in the US (Cafferky & Shi, 2015). A small proportion of spouses' spoke of getting stronger due to the challenges they faced, such as increased independence, which is also in line with previous research from the US (Cole et al., 2024). However, spouses also described negative impacts on their independence and conflicts to their identity. Within this, the importance of employment was highlighted in order to maintain independence and individual identity, similar to previous findings (Hosek & Wadsworth, 2013; Trewick & Muller, 2014). The idea that others do not recognise or understand the challenges associated with military family life was reported by spouses in this review to be a factor that impacted their wellbeing and, along with the expectation to suppress their emotions, is likely to influence their help seeking. This has been documented previously, with this being stated as a perceived barrier to care for military spouses (Lewy, Oliver & McFarland, 2014).

The analytical themes identified relating to question two highlighted the main factors that influenced the wellbeing of military spouses. Spouses spoke of their location largely influencing their wellbeing, with various positives and negatives to living on base and off base. Very limited research has been conducted on the experiences on base versus off base, other than those included within this review, suggesting this insight into the different experiences of spouses when living on base or off base is novel to the UK. A common factor described as influencing wellbeing both on base and off base was the relationships that spouses were able to build. This is well documented in previous research, with data showing that social support predicts adaptation to military challenges (Pittman, Kerpelman & McFadyen, 2004; Orthner & Rose, 2006). Finally, spouses spoke of the sacrifices they are expected to make as a factor influencing their wellbeing. The expectations placed upon military spouses, usually resulting in some level of sacrifice, has long been recognised and the military often criticised for (Harrell, 2001; Ohlsson, Nilsson & Larsson, 2023).

The findings of this review are mostly in line with previous research from the US. However, this review also produced some findings which have not been regularly documented in the literature, such as the various difficulties of living on base or off base, and the felt expectation to hide or suppress their emotions. This may be due to these findings being unique factors to the UK military population, or that these areas are still under researched.

The findings of this review may be understood through the lens of self-determination theory (Ryan & Deci, 2000). Across the themes identified, military spouses described experiences that appeared to both support and frustrate the needs posited as key to wellbeing within the theory. Autonomy may be challenged through limited control over relocations, accommodation and employment opportunities, alongside expectations associated with the military spouse role. Competence may be affected through disruptions to employment,

changes in family responsibilities and difficulties maintaining valued roles outside of military life. Relatedness may be influenced by experiences of separation from partners, difficulties accessing support, and feeling misunderstood by both military and civilian communities. Whilst some spouses described personal growth, increased independence and stronger social connections, many reported experiences suggestive of chronic psychological need frustration. From an SDT perspective, these experiences may help explain the negative impacts on wellbeing described across the included studies.

Limitations

A potential limitation of this review is the small number of studies included. Whilst this could mean that key experiences of military spouses may be missed, the rigorous searches involved in a systematic review strongly suggest that this limited number of studies is due to the relevant research not yet existing. Additionally, the large number of studies excluded due to not being based on a UK sample indicates the extent of research completed in this area in other countries. This strongly suggests that the UK needs to increase their level of understanding of the experiences of this population. Further research into this area may produce more insightful information into the difficulties that military spouses experience in the UK.

A further limitation relates to the inclusion criteria, which required studies to explicitly investigate wellbeing or mental health. Although this increased conceptual coherence within the review, it may have excluded studies exploring broader social determinants of health, such as employment, housing, or access to social support, where wellbeing was not the primary focus. These determinants emerged as important influences within the included studies, suggesting that a broader review may have generated a richer understanding of the mechanisms through which military life affects spouses' wellbeing.

Future systematic reviews could therefore consider adopting broader eligibility criteria to synthesise evidence relating to social determinants alongside explicit wellbeing research.

Many of the studies included in this review focused on specific challenges that military spouses face, such as relocations and living off base. This may have skewed the results of the systematic review, as more data was provided on these specific aspects in comparison to other aspects of military life. Any adaptations to the systematic review to account for this would have resulted in fewer studies being included and risked missing vital information for understanding military spouses' wellbeing. Instead, this limitation highlights the lack of literature on the subject, further showing the need for new research to be conducted on the wellbeing of this population in the UK.

A final limitation of this review is the subjective quality of the interpretive synthesis of the data into analytical themes. Whilst every attempt was made to reduce subjective researcher bias throughout the review, such as by having a second reviewer for a sample of the study selection phase, and similarly during the quality assessment, time and resource restrictions prevented such a process during the synthesis of the data itself. The themes constructed by the author were discussed with the research supervisors, however initially developed independently, owing to an increased chance of researcher bias.

Recommendations

This review highlighted some of the factors that appear to influence military spouses' wellbeing, such as where spouses live and the expectations placed upon them within the military culture. Having awareness of the factors likely to influence spouses' wellbeing is key to being able to support them effectively. It is recommended that the military and civilian services that spouses may access receive detailed information or training on these factors and their impact to ensure they are taken into consideration when providing care to people in this population.

Further research into the wellbeing of military spouses in the UK is required. Much of the current literature available focuses on specific aspects of being a military spouse, meaning important factors influencing their wellbeing may be missed. Further understanding is also needed of the barriers and facilitators to help seeking within this population. Finally, further understanding is needed of the different appraisals in response to the challenges, such as understanding of why some spouses thrive during relocations and others find them very challenging. If the mechanisms behind these differences can be understood, more targeted support can be put in place to support those who need it most. Having a clearer understanding of the impact of being a military spouse on their wellbeing is vital to develop and appropriately adapt support within the military and the NHS, and influence how these two institutions work together.

Conclusion

Military spouses in the UK experience a wide range of challenges that can impact on their wellbeing. Spouses report impacts on their emotional responses and individual sense of self, with few spouses reporting these impacts to be positive. Factors such as whether they live on base or off base, and the expectations placed upon them as military spouses appear to influence their wellbeing. This is the first systematic review of the literature based on UK samples and highlights the need for further research into this population in the UK in order to inform practice and policy to more effectively support this population.

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Chapter Three

Bridging Chapter

Word count: 409

Bridging Chapter

The systematic review synthesised data from nine studies reporting the wellbeing of military spouses in the UK. The review showed that the unique challenges that military spouses face can have an impact on their wellbeing. Spouses described experiencing mental health difficulties, such as depression, along with the felt expectation to hide or suppress these emotional responses. Furthermore, spouses described feeling their wellbeing was not recognised by the military institution and the challenges they faced not understood by services outside of the military. Spouses spoke of impacts on their individual sense of self, with some welcoming a sense of independence, some feeling this independence was a hindrance to their individuality, and some feeling their independence was reduced, reporting increased dependence on their serving spouse. The expectations placed upon military spouses by themselves and the military, along with whether they live on base or off base, appear to be key factors influencing their experience and wellbeing.

As described by WHO, mental health is a state of mental wellbeing, suggesting that those who experience impacts on their wellbeing in turn experience impacts on their mental health. The outcomes of the systematic review indicate that military spouses may be at increased risk of experiencing difficulties with their wellbeing as a result of their unique challenges, with themes consistently reflected threats to autonomy, competence and relatedness. This suggested that military stressors may influence wellbeing through common psychological mechanisms rather than acting independently. Consequently, the empirical study was designed to investigate whether military challenges associated with housing, relocations, deployments and support were associated with poorer perinatal mental health. Systematic reviews based on US military spouses have found that factors such as deployment, relocations and lack of social support are linked to PMH difficulties (Godier-McBard et al., 2019; Spencer et al., 2025). Furthermore, there is some evidence from the US

to suggest that military spouses experience high rates of perinatal depression, with suggestions of prevalence rates up to 50% (Klaman & Turner, 2016). At the current time, there is no research based on samples from the UK and therefore, the empirical paper aims to begin filling this gap in the literature. The empirical paper sought to understand what the challenges are that military spouses face, what the self-reported levels of PMH difficulties are, and whether these challenges are associated with poorer PMH. This will enable understanding of whether some of the challenges described in the systematic review are also relevant to military spouses PMH.

Chapter Four

Empirical Paper

Prepared for Submission to Military Psychology Journal (Author Guidelines Found in Appendix A)

Word count (excluding references): 7780

Total page count: 37

The Challenges of Being a Military Spouse or Partner in the Perinatal Period

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The Challenges of Being a Military Spouse or Partner in the Perinatal Period

Abstract

The experiences of military spouses in the perinatal period in the UK are currently unknown, and the only source of information is from studies based on samples from the US, who have different military and healthcare systems. This study aimed to understand the main challenges that military spouses face, the frequency of PMH difficulties in this sample, and if the identified challenges are associated with poorer PMH. A self-selecting sample of military spouses from across the UK completed an online survey, resulting in a sample of 361 participants. The results indicate that the self-reported rates of PMH are high, with over 50% of participants scoring above clinical cut off in most of the mental health screenings. There was limited difference in the impact ratings of the military challenges, with spouses mostly rating the challenges as having at least some negative impact on their wellbeing. Hierarchical regression models indicated that having past mental health diagnoses, a younger maternal age and lower education level was associated with poorer PMH. After controlling for these factors, rating military accommodation as being more impactful on wellbeing was found to be associated with worse perinatal depression, anxiety and stress. Additionally, rating difficulties with military spouses own employment as more impactful on wellbeing was found to be associated with worse perinatal trauma, however causal relationships could not be concluded. The mechanisms of these predictor variables remain unknown and are a recommended focus for future research. Strengths and limitations of the study are discussed, as well as implications of the findings.

The author has no conflict of interest to declare.

Keywords: military spouses; perinatal mental health; United Kingdom.

Introduction

Perinatal Mental Health in the General Population

During the perinatal period, women are at increased risk of developing mental health difficulties, with estimates of up to 27% of people experiencing PMH difficulties (Howard et al., 2018). In the UK, specialist PMH services have been recommended by the National Institute of Health and Care Excellence (NICE) since 2014, with services beginning to grow from then. Within the NHS long-term plan, services were extended to 24 months post-birth, from 12-months, to be in line with the cross-government ambition highlighting the first 1001 days of a child's life as critical (NHS England, 2019).

PMH difficulties are associated with significant risks for both parents and children. Poor PMH can impact on maternal self-esteem, partner and family relationships, and the mental health and social adjustment of the child (Stein et al., 2014). "The Best Start for Life" report makes it clear that good mental health for parents is a critical factor in good parenting, child health, development, and bonding, making the identification of population-specific risk factors particularly important (HM Government; 2021).

Risk Factors in Military Spouses

A variety of risk factors have been identified that increase a person's risk of developing PMH difficulties in the general population. These include lower education level, history of mental health difficulties and multiparity (Yang, Wu & Chen, 2022). Military spouses have a unique set of circumstances which may increase their risk of experiencing mental health difficulties, however the prevalence of PMH difficulties in this population is largely unknown. Klaman & Turner (2016) found that the prevalence of postnatal depression in military spouses in the US is somewhere between 4 and 50%. This wide range of prevalence highlights the lack of clear understanding of perinatal depression in this population. Research from the US has found that deployment, relocations, lack of social and

emotional support and increased family stressors as influencers of military spouses PMH (Drummet, Coleman & Cable, 2003; Spencer, et al., 2025). Deployment and relocation may be seen to reduce spouses' autonomy, whilst lack of social and emotional support may reduce their relatedness, which could be understood to impact on their wellbeing using self-determination theory. During the perinatal period, frustration of these psychological needs may increase vulnerability to depression, anxiety, stress and other perinatal mental health difficulties. Whilst the aforementioned studies and the theoretical framework from which they can be understood strongly suggest that military spouses may be at increased risk of PMH difficulties due to their unique circumstances, they are all based on samples from the US. Due to the differing military and healthcare systems, it cannot be assumed that the same findings would be present in a sample from the UK.

UK Military Spouses and Partners

The Family Continuous Attitudes Survey (FamCAS; Ministry of Defence (MOD), 2023) shows that, in the UK, 90% of military spouses are female, and just over 60% are under the age of 40, suggesting that this is a large population of people who may be at risk of developing PMH difficulties. Research into this population suggests that UK military spouses have higher rates of depression than the general population outside of the perinatal period, with 7.2% of the military spouse sample scoring as moderate depression or above, compared to 3.2% in the general population sample (Gribble, Goodwin & Fear, 2019). Along with FamCAS showing that 25% of military families who required access to mental health treatment felt they could not access it, the military spouse population appear in great need of further support to access services for their mental health, both inside and outside of the perinatal period (MOD, 2023).

The Current Study

Much of the current research into PMH difficulties in military spouses and partners is conducted in the US. At the time of writing, there appears to be no research into PMH difficulties in military spouses in the UK, nor the challenges of being a military spouse that may influence PMH. A recent systematic review concluded that the current research is limited in generalisability outside of the US and that research in the UK context is essential for developing military-informed perinatal care in the UK (Spencer et al., 2025). In order to effectively support this population, we must first understand their experiences of being military spouses and how this may influence their experiences of PMH difficulties.

Research Questions

Research question one: What are the main challenges faced by military spouses and partners in the perinatal period in the UK?

Research question two: What are the self-reported levels of perinatal mental health difficulties in a sample of military spouses and partners?

Research question three: Are military challenges associated with poorer perinatal mental health in military spouses and partners in the UK?

Method

Design

The study used a cross-sectional design utilising an online survey. A survey design was chosen as this aligns with previous research into PMH in military spouses and partners (Haas & Pazdernik, 2006; 2007). This design was also useful for collecting data from many participants at one time, improving the generalisability of the findings (Langdridge & Hagger-Johnson, 2009). Given the lack of research on military spouses in the UK, this design provided useful descriptive statistics and insights into this population.

This study formed part of a larger study investigating various aspects related to PMH in military spouses. JiscOnline was used to develop and distribute an online survey for the

larger study. Data relevant to the present study was extracted from the survey, including quantitative data on demographic information, severity of specific mental health difficulties, and self-rated impact of specific military challenges on mental health at the time of completion.

Participants

Participants were a self-selecting non-clinical sample of military spouses associated with the British Armed Forces who were pregnant and/or up to 24 months postnatal. Inclusion criteria included being over the age of 18, having sufficient understanding of English to respond to the questions and included spouses from across all military domains. The study excluded active service members of the military due to them receiving care and support from the MOD, as well as spouses of veterans.

A G*Power analysis for multiple regression analyses with 10 potential predictor variables (6 predictors, 4 controls) to detect a moderate effect size ($f^2 = 0.14$) with good power (0.8) and an alpha level of .05 resulted in a required sample size of 126 (Faul et al., 2009; see appendix B).

Measures

The survey can be seen in appendix C. This formed part of a larger study, and therefore not all questions within the survey were relevant for this study. Relevant questions are highlighted in the appendix.

Demographic Information

The survey collected demographic information from participants, including age, ethnicity, highest level of education, employment, location, current and historic perinatal information, number of children, mental health history, and military characteristics.

Military Spouse Challenges

Participants were asked to rate the negative impact of specified military challenges on their mental health and wellbeing during the present perinatal period on a 5-point Likert scale from 0 (No impact) to 4 (Big impact). There was also an option for participants to report that these challenges were not applicable to them (e.g. if their spouse had never been deployed.) These challenges were identified by the first author from previous literature and reflective discussions were held with members of Dandelion Military Families, a military parental mental health organisation, to ensure they were representative of the challenges spouses are likely to face. The challenges were spousal deployment (Runge et al., 2014; Godier-McBard et al., 2019; Clearinghouse for Military Family Readiness (CMFR), 2021; Morris, 2023; Dandelion Military Families, 2023), own employment (Runge et al., 2014; CMFR 2021; Dandelion Military Families, 2023; MOD, 2023), relocation (Runge et al., 2014; CMFR, 2021; MOD, 2023), lack of social support (Godier-McBard et al., 2019; Dandelion Military Families, 2023), military accommodation (Dandelion Military Families, 2023; MOD, 2023), and military control (CMFR, 2021).

Mental Health Questionnaires

The survey asked respondents about their experiences of depression, anxiety, stress, adjustment, post-traumatic stress disorder (PTSD), and psychotic-like experiences. These difficulties were chosen due to them being the PMH difficulties that are estimated statistically in the UK (Kulakiewicz, Parkin & Baker, 2021). The questionnaires were chosen for their brevity and applicability to answering the research questions.

Depression, Anxiety and Stress Scale (DASS-21). The DASS-21 is a shorter version of the Depression Anxiety Stress Scale developed by Lovibond and Lovibond (1995). Each item on the scale is associated with one of the three subscales (depression, anxiety, stress), with seven items per subscale. Scores above 14 on the depression scale, above 10 on the anxiety scale and above 19 on the stress scale indicate moderate or above severity in these

domains (Lovibond & Lovibond, 1995). The DASS-21 has 'very good' internal consistency (Cronbach's alpha 0.92) when used with perinatal populations (Xavier et al., 2016).

Adjustment Disorder – New Module (Brief; ADMN-8). The ADNM-8 is an 8-item measure assessing the levels of adjustment disorder in the respondent based on ICD-11 criteria, developed from the full, 20-item version by Kazlauskas et al. (2018). Ben-Ezra et al. (2018) established a cut off score of 18.5 or above being suggestive of adjustment disorder. For the purpose of this study, participants were asked to respond to these questions in relation to adjusting to being pregnant and/or giving birth within the current perinatal period. Ben-Ezra et al. (2018) found excellent internal consistency, with a Cronbach's alpha of 0.91.

Prodromal Questionnaire (16 Version; PQ-16). The PQ-16 is a shortened version of the 92-item Prodromal Questionnaire developed by Loewy et al. (2005), containing 16 items, developed by Ising et al. (2012). Nine items assess perceptual abnormalities, five assess unusual thought content and paranoia, and two assess negative symptoms. A cut off of 6 or more symptom items has been identified as sufficient to suggest a 'high risk of psychosis' in postpartum participants (Levey et al., 2018). However, it has been identified that item 16 is over-represented in postpartum participants due to the conceptual overlap with perinatal experiences, and so item 16 was removed from the data analysis in this study (Foreman et al., 2025). Ising et al. (2012) found the PQ-16 to have good internal consistency, with a Cronbach's alpha of .77.

PTSD Checklist (Brief; PCL-6). The PCL-6 is a 6-item version of the PCL, a 17-item questionnaire assessing PTSD symptoms developed by Weathers et al. (1993). The 6-item version was developed by Lang and Stein (2005). A score of 14 and above may indicate possible PTSD (Lang & Stein, 2005). Lang et al. (2012) assessed the internal consistency of the PCL-6 to be good, with a Cronbach's alpha of .78.

Procedure

The flowchart showing the procedure can be seen in appendix D. Recruitment was conducted primarily through advertising on social media using a poster (see appendix E). This included approaching appropriate charities and organisations, such as the Dandelion Military Families. The study also invited snowball sampling. Participants accessed the survey directly from advertisements. They were presented with the information sheet and consent form (appendix F). Participants were then presented with the survey content as detailed above. Participants could withdraw from the study up until responses were submitted. Following completion of the study, participants were presented with debrief information (appendix G). Participants were given the opportunity to follow another link to enter their email address to be entered into the prize draw for one of two £20 Amazon vouchers. This was optional, and it was made clear that this would not impact on their anonymity as email addresses were stored separately from the survey responses. The survey took an average of 24 minutes to complete.

Ethical Considerations

Approval

Ethical approval was provided by the UEA Faculty of Medicine and Health Sciences for the larger study, number ETH2425-0008 (appendix H). The Ministry of Defence Ethics Research Committee (MODREC) provided a written opinion stating that this project did not require MODREC ethical approval (see appendix I).

Consent

Participants were provided with the information sheet and consent form upon accessing the survey from advertisements and advised to close the browser if they did not consent to taking part. This is in line with the Health Research Authority guidance in seeking consent using online surveys (HRA, 2024). These were tested using the Gunning Fog Index to ensure appropriate wording and language, with an index of 10.39.

Confidentiality and data storage

Confidentiality laws and regulations were adhered to during the study. The anonymous data was stored in line with General Data Protection Regulations (GDPR) and the UEA Confidentiality Code of Practice. Following completion of the study, data was stored in accordance with the Good Clinical Practice Guidelines. The dataset will be retained by the primary supervisor for 10 years in line with university policy. Email addresses for the prize draw were destroyed after the prize draw was completed.

Distress and Debriefing

There was a risk that the content of the survey may have caused distress. Participants were provided with debrief information at the end of the survey detailing information on support available for their mental health should they have felt that they required it.

Analysis Plan

Data were analysed using IBM SPSS Statistics Version 31. Statistical analyses were completed using two-tailed analyses and $p < .05$ alpha level.

Data cleaning

The survey data was checked to identify incomplete and bot responses, identified through patterned responses. One suspected bot response was identified and removed due to the responses being the same for almost all questions. Where there was one missing item within a multi-item scale, mean scores from the rest of that individual's scale were inputted for the missing item ($n = 16$). This method is deemed acceptable when there is a low rate of missing data and there is high correlation between items (Scheffer, 2002; Little & Rubin, 2020). One participant was removed due to missing data in a whole scale.

Research questions one and two

The military challenges ratings were ordinal data and were described as such, however, were statistically assessed using parametric tests as these are more robust analyses

which are appropriate given the sample size (Norman, 2010; Sullivan & Artino, 2013). Frequencies and percentages were reported as descriptive statistics for categorical variables and mean and standard deviation for continuous variables.

Research question three

Data were screened for parametric requirements and assumptions were tested, indicating no violations. Correlation analyses and t-test analyses were used to identify significant correlations or associations between the variables and each mental health questionnaire, indicating which variables were then included in the hierarchical regression analyses. Multiple hierarchical regression analyses for the mental health screenings were performed to assess whether the impact of the military challenges was associated with poorer PMH when accounting for control variables.

Results

Sample

A total of 366 participants completed the survey. Three of these responses were removed due to being ineligible for the study as they did not currently live in the UK, one was removed due to having not completed the survey in full, and one removed due to patterned responses, leaving a total of 361 included responses. Participants were all female, aged between 20 and 43, with a mean age of 31 and 95% were white. The sample was made up of 55% associated with the British Army, 23% the Royal Navy and 22% the Royal Air Force. The demographic information, perinatal information and military characteristics for the participants can be seen in Tables 1, 2 and 3.

What are the main challenges faced by military spouses and partners in the perinatal period?

Table 3 presents the military characteristics of the sample and Table 4 presents the rated impact of military challenges on participants wellbeing during the current perinatal

Table 1. *Participant demographic information. (N = 361)*

	N (%)
Age	
20-25	58 (16.07)
26-30	89 (24.65)
31-35	146 (40.44)
36+	68 (18.84)
Ethnicity	
White	344 (95.29)
Mixed or multiple	5 (1.39)
Asian or Asian British	5 (1.39)
Other ethnic group	5 (1.39)
Black, Black British, Caribbean or African	2 (0.55)
Education level	
GCSE/BTEC Levels 1-2/NVQ Levels 1-2 or equivalent	35 (9.70)
A Levels/BTEC Level 3/NVQ Level 3 or equivalent	51 (14.13)
Certificate of Higher Education/BTEC Professional	33 (9.14)
Diplomas/NVQ Level 4	
Foundation Degree/Diploma of Higher Education/HND	25 (6.93)
Bachelors Degree/PGCE	127 (35.18)
Master's Degree/Postgraduate Certificate or Diploma	78 (21.61)
Doctoral Degree	8 (2.22)
Other	4 (1.11)
Employment status	
Full-time employed	132 (36.57)
Part-time employed	105 (29.09)
Self-employed	11 (3.05)

Student	6 (1.66)
Stay at home parent	89 (24.65)
Unemployed	12 (3.32)
Other	6 (1.66)
Country	
England	314 (86.98)
Scotland	33 (9.14)
Wales	10 (2.77)
Northern Ireland	4 (1.11)
Region	
South East	90 (24.93)
South West	95 (26.32)
East of England	43 (11.91)
West Midlands	15 (4.16)
East Midlands	20 (5.54)
Yorkshire & the Humber	18 (4.99)
North West	6 (1.66)
North East	4 (1.11)
Scotland	30 (8.31)
Wales	8 (2.22)
Northern Ireland	3 (0.83)
Other/Missing	29 (8.03)

Table 2. *Participants perinatal information (N = 361)*

	N (%)
Currently on maternity leave	
Yes	131 (36.29)

No	230 (63.71)
Currently pregnant	
Yes	82 (22.71)
No	279 (77.29)
If pregnant, how many weeks	
4-20	38 (46.34)
21-30	21 (25.61)
31-40	23 (28.05)
Birth in past 24 months	
Yes	312 (86.43)
No	49 (13.57)
Number of children	
0 (this is first child)	150 (41.55)
1	162 (44.88)
2	41 (11.36)
3+	8 (2.22)
Past perinatal mental health difficulties	
Yes	164 (45.43)
No	158 (43.77)
Not sure	39 (10.80)
Past mental health diagnoses since becoming a military spouse	
Never diagnosed	170 (47.09)
At least one diagnosis	191 (52.91)
Depression	116 (32.13)
Anxiety	156 (43.21)
Stress	53 (14.69)

PTSD	36 (9.97)
Psychosis	6 (1.66)
Other	20 (5.54)

Table 3. *Participants military characteristics (N = 361)*

	N (%)
Branch of military	
Royal Navy	83 (22.99)
Army	197 (54.57)
Royal Air Force	81 (22.44)
Military rank	
Other	251 (69.53)
Officer	110 (30.47)
Living in Service Family Accommodation	
Yes	256 (70.91)
No	105 (29.09)
Number of relocations ever	
Never	77 (21.33)
Once	71 (19.67)
Twice	81 (22.44)
Three times	55 (15.24)
Four times	34 (9.42)
Fives times or more	43 (11.91)
When relocated	
During a pregnancy	110 (38.71)
Within 24 months after a pregnancy	147 (51.76)
Not during a perinatal period	100 (35.21)

Other	4 (1.41)
At least one perinatal relocation	
Yes	195 (68.66)
No	89 (31.33)
Number of deployments ever	
Never	36 (9.97)
Once	51 (14.13)
Twice	49 (13.57)
Three times	62 (17.17)
Four times	29 (8.03)
Five times or more	134 (37.12)
When deployed	
During a pregnancy	181 (55.69)
Within 24 months after a pregnancy	191 (58.77)
Not during a perinatal period	96 (29.54)
Other	2 (0.62)
At least one perinatal deployment	
Yes	245 (75.38)
No	80 (24.62)

Table 4. *The rated negative impact of military challenges on wellbeing in the current perinatal period (N = 361).*

	N (%)						
Military challenge	Not applicable	No Impact (0)	Minimal Impact (1)	Some Impact (2)	Quite a lot of Impact (3)	Big Impact (4)	Median
Spousal deployment	21 (5.82)	3 (0.83)	10 (2.77)	39 (10.80)	115 (31.86)	173 (47.92)	4.00
Own employment	29 (8.03)	12 (3.32)	17 (4.71)	68 (18.84)	84 (23.27)	151 (41.83)	3.00

Relocations	54 (14.96)	15 (4.16)	31 (8.59)	95 (26.32)	77 (21.33)	89 (24.65)	3.00
Social support	30 (8.31)	7 (1.94)	20 (5.54)	56 (15.51)	94 (26.04)	154 (42.66)	3.00
Military accommodation	69 (19.11)	7 (1.94)	49 (13.57)	91 (25.21)	67 (18.56)	78 (21.61)	2.00
Military control	3 (0.83)	0 (0.00)	15 (4.16)	60 (16.62)	124 (34.35)	159 (44.04)	3.00

period. The median scores show that variation between the ratings for each challenge is limited. Very few participants rated any of the challenges as having no impact on their wellbeing, with relocations having the highest percentage of participants scoring it as 'no impact' at 4%. Of the participants that felt the challenges were applicable to them, 96% felt that the military challenges had at least minimal impact on their wellbeing during the perinatal period. Spousal deployments were most commonly rated as having a 'big impact' on spouses' wellbeing during the perinatal period; however this was similar to own employment, social support and military control. Relocations and military accommodation had much lower 'big impact' ratings, with the modal response for these challenges being 'some impact'. This suggests that, of the participants that viewed these challenges as being applicable to them, relocations and military accommodation had slightly lesser impact on wellbeing than the other challenges, albeit were still viewed as having some negative impact on wellbeing.

Most participants rated at least one challenge as having a 'big impact' on their wellbeing (82.5%), however most commonly rated two challenges this way, whereas 17.5% of participants did not rate any of the challenges as having a 'big impact' on their wellbeing. Only one participant rated all of the challenges as having no impact on their wellbeing. Further exploratory analysis of this data can be seen in the Additional Results chapter.

What are the self-reported levels of perinatal mental health difficulties in a sample of military spouses and partners?

The mean total scores on the mental health screening questionnaires and the frequency of participants scoring above the clinical cut-offs can be seen in Table 5. Over half of the participants scored above the clinical cut- off on most of the screened mental health difficulties, suggesting a high level of PMH difficulties in the population. This frequency is higher than the number of participants who reported they had previous PMH difficulties (45%) and the number of participants who reported general mental health diagnoses since becoming a military spouse (53%) but outside of the perinatal period. Furthermore, almost two third of participants (65%) scored above clinical cut-off in two or more of the mental health screening questionnaires.

Are military challenges associated with poorer perinatal mental health in military spouses and partners in the UK?

Correlation coefficients between potential predictor variables and the mental health screening scores were calculated using Pearson correlations for continuous variables and Spearman's correlations for ordinal variables. These can be seen in Table 6, with the Pearson correlations in bold. T-test analyses were also used to assess the association between the categorical variables of past mental health diagnosis and the mental health screening scores. This can be seen in Table 7. As a result of these analyses, only the variables that showed a significant correlation or association with each mental health questionnaire were included in each regression, meaning that multiparity was not included. For the primary analysis, multiple hierarchical regression analyses for the mental health screenings were performed by entering 2 steps of variables for each analysis, as seen in Table 8. Step 1 consisted of age, highest education level, and past mental health diagnosis for all regressions apart from the adjustment score analysis, whereby highest education level was not included as a variable based on the correlation analysis. These variables were pre-identified factors known to impact on PMH. Step 2 comprised of the impact scores of military challenges that were found to be

Table 5. *The mean scores for each screened mental health difficulty with the frequency of scoring above the clinical cut-off (N = 361).*

Mental health difficulty	Mean (SD)	Clinical cut off	Above clinical cut off (N(%))
DASS-21 Depression	16.47 (12.84)	14	185 (51.25)
DASS-21 Anxiety	12.61 (10.91)	10	193 (53.46)
DASS-21 Stress	22.55 (11.51)	19	213 (59.0)
ADNM-8	19.46 (6.60)	18.5	205 (56.79)
PCL-6	14.74 (7.22)	14	185 (51.25)
PQ-16 Symptom Endorsement	3.53 (3.33)	6	84 (23.27)
Hallucinatory symptoms	1.36 (1.75)		
Delusional symptoms	1.22 (1.39)		
Negative symptoms	0.95 (0.80)		
PQ-16 Distress Rating	5.68 (6.85)	9	83 (22.99)
Frequency of reaching mental health cut off scores	N (%)		
None	70 (19.39)		
One	55 (15.24)		
More than one	236 (65.37)		

Note. N = 361; SD = Standard Deviation. DASS-21 = Depression Anxiety Stress Scale; ADNM-8 = Adjustment Disorder – New Module 8; PCL-6 = PTSD Checklist 6; PQ-16 = Prodromal Questionnaire 16-items (excluding question 16).

significantly correlated. Ratings of ‘not applicable’ were coded as user-missing data. The adjusted R^2 change was used to determine the proportion of variance explained and significance of the variables. Further exploratory analysis can be seen in the Additional Results chapter.

Table 6. *Correlation matrix for regression variables, Pearson's in bold and Spearman's Rho in regular font.*

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.
1. Depression	-	**.77****	**.81****	**.53****	**.57****	**.60****	**-.16****	**-06**	-	-	-	-	-	-
2. Anxiety	-	-	**.77****	**.57****	**.60****	**.60****	**-.27****	**-.01**	-	-	-	-	-	-
3. Stress	-	-	-	**.55****	**.57****	**.56****	**-.21****	**-.01**	-	-	-	-	-	-
4. Adjustment	-	-	-	-	**.62****	**.54****	**-.17****	**-.09**	-	-	-	-	-	-
5. Trauma	-	-	-	-	-	**.53****	**-.20****	**-.04**	-	-	-	-	-	-
6. Psychotic-like experiences	-	-	-	-	-	-	**-.26****	**.07**	-	-	-	-	-	-
7. Age	-	-	-	-	-	-	-	**.28****	-	-	-	-	-	-
8. Multiparity	-	-	-	-	-	-	-	-	-	-	-	-	-	-
9. Education	.-21**	-.17**	-.19**	-.09	-.19**	-.25**	.31**	-.12*	-	-	-	-	-	-
10. Spousal deployment	.14**	.11*	.16**	.18**	.13*	.09	.02	.04	.01	-	-	-	-	-
11. Own employment	.01	.07	.06	.15**	.14*	.08	-.04	.02	-.07	.11	-	-	-	-
12. Relocations	.06	.08	.10	.12*	.09	.00	.15**	-.03	.06	.26**	.33**	-	-	-
13. Social support	.16**	.09	.16**	.09	.12*	.07	.02	.04	-.02	.31**	.23**	.39**	-	-
14. Military accommodation	.15*	.12*	.13*	.13*	.10	.11	.30	.09	.05	.22**	.20**	.28**	.30**	-
15. Military control	.06	.09	.10	.16**	.09	.08	-.01	.10	-.01	.38**	.54**	.26**	.38**	.38**

*p<.05, **p<.001

Table 7. *Independent samples t-test between past mental health diagnoses and mental health scores.*

	***M* (SD)**		***t*(*df*)**	***p***
Mental health scores	**Past mental health diagnoses (N = 191)**	**No past mental health diagnoses (N = 170)**		
Depression	21.03 (13.38)	11.34 (9.99)	-7.84 (348.74)	<.001
Anxiety	17.19 (11.38)	7.46 (7.57)	-9.66 (333.34)	<.001
Stress	26.89 (10.74)	17.67 (10.34)	-8.28 (359)	<.001
Adjustment	21.52 (6.14)	17.15 (6.35)	-6.66 (359)	<.001
Trauma	17.08 (7.43)	12.11 (5.98)	-7.05 (355.54)	<.001
Psychotic-like experiences	4.62 (3.57)	2.32 (2.55)	-7.10 (343.18)	<.001

Table 8: *Hierarchical regression analyses for variables predicting mental health scores.*

Variable	R^2 change	*F*-change	ß	*p*
Depression				
Step 1				
Age	.17	F(3,270)=18.85**	-.09	.163
Education Level			-.14	.021*
Past MH Diagnosis			.35	<.001**
Step 2				
Impact of spousal deployment	.04	F(3,267)=5.00*	.080	.175
Impact of social support			.08	.181
Impact of military accommodation			.13	.021*
Anxiety				
Step 1				
Age	.25	F(3,270)=30.11**	-.21	<.001**
Education Level			-.05	.377

Past MH Diagnosis			.42	<.001**
Step 2				
Impact of spousal deployment	.03	F(2,268)=.5.26*	.07	.230
Impact of military accommodation			.14	.009*
Stress				
Step 1				
Age	.20	F(3,270)=22.34**	-.14	.019*
Education Level			-.11	.058
Past MH Diagnosis			.37	<.001**
Step 2				
Impact of spousal deployment	.04	F(3,267)=4.43*	.10	.071
Impact of social support			.05	.349
Impact of military accommodation			.11	.050*
Adjustment				
Step 1				
Age	.13	F(2,265)=19.56**	-.14	.018*
Past MH Diagnosis			.32	<.001**
Step 2				
Impact of spousal deployment	.06	F(5,260)=3.65*	.08	.207
Impact of own employment			.11	.069
Impact of relocations			.07	.263
Impact of military accommodation			.08	.213
Impact of military control			.04	.585
Trauma				
Step 1				
Age	.16	F(3,303)=18.71**	-.14	.012*
Education Level			-.10	.074

Past MH Diagnosis			.32	<.001**
Step 2				
Impact of spousal deployment	.03	F(3,300)=3.58*	.10	.067
Impact of own employment			.12	.020*
Impact of social support			.02	.779
Psychotic-like experiences				
Age			-.18	<.001**
Education Level	.18	F(3,357)=26.90**	-.14	.008
Past MH Diagnosis			.31	<.001**

*p<.05, **p<.001

Depression

The step one variables significantly predicted approximately 17% of the variance in depression scores. Education and past mental health diagnoses were significant predictors, with lower education level and previous mental health diagnoses associated with higher depression scores. The step two variables significantly predicted a further 4% of variance in depression scores after accounting for the step one variables. Military accommodation was a significant predictor, with higher impact ratings being associated with higher depression scores.

Anxiety

The step one variables significantly predicted 25% of variance in anxiety scores. Age and past mental health diagnoses were significant predictors, with younger age and past mental health diagnoses being associated with higher anxiety scores. The step two variables significantly predicted an additional 3% of variance after accounting for the step one variables. Similarly to depression, military accommodation was the only significant predictor, with higher impact ratings being associated higher anxiety scores.

Stress

The step one variables significantly predicted 20% of variance in stress scores, with age and past mental health diagnoses as significant predictors. Similarly to the anxiety analysis, younger age and having previous mental health diagnoses was associated with higher stress scores. The step two variables significantly accounted for an additional 4% of variance in stress scores after taking the step one variables into account. Military accommodation was the only significant predictor, with higher impact ratings being associated with higher stress scores.

Adjustment

The step one variables significantly predicted 13% of variance in adjustment scores. Age and previous mental health diagnoses were significant, with younger age and previous mental health diagnoses being associated with higher adjustment scores. The step two variables significantly predicted an additional 6% of variance. However, none of the individual variables were significant predictors of variance in adjustment scores.

Trauma

The step one variables significantly predicted approximately 16% of variance in trauma scores. Age and previous mental health diagnoses were significant predictors, with a younger age and having previous mental health diagnoses being associated higher trauma scores. The step two variables significantly predicted a further 3% of variance in trauma scores. Impact on own employment was the only significant predictor, with higher impact ratings being associated with higher trauma scores.

Psychotic-like experiences

None of the military challenges were significantly correlated with psychotic-like experiences scores and so were not entered into the regression analysis. This resulted in a simple linear regression including age, highest education level and past mental health

diagnoses as predictor variables. These variables predicted 18% of variance in psychotic-like experiences scores, with age and previous mental health diagnoses as significant individual predictors. Being younger in age and having previous mental health diagnoses was associated with higher psychotic-like experiences scores.

Discussion

Whilst PMH difficulties have been widely explored within the general population, there is limited research into these difficulties in the military spouse population, and no research specifically on this population in the UK. This study aimed to explore the challenges that military spouses face, levels of self-reported PMH difficulties, and if the identified challenges were associated with poorer PMH. Findings from the present study indicate that levels of self-reported PMH difficulties are high in the UK military spouse population. All of the military challenges assessed were reported as at least minimally impactful to spouses' wellbeing by over 95% of spouses where relevant to them. Age and past mental health diagnosis accounted for some variance in current mental health scores, however, some military challenges accounted for a small proportion of additional variance. Higher perceived negative impact of military accommodation on wellbeing was associated with a small but significant increase in depression, anxiety and stress scores. Additionally, higher perceived negative impact of being a military spouse on their own employment and its implications on wellbeing predicted a small but significant increase in trauma scores. This suggests that some military challenges are associated with worse PMH, however other, non-military variables are more strongly associated.

The rates of PMH difficulties in military spouses are largely unknown. Estimates in the US range between 4% and 50% for postnatal depression, however the prevalence of other PMH difficulties in military spouse populations is sparsely reported, with only minimal reporting of subjective stress levels (Haas et al., 2005; Haas & Pazdernik, 2007; Klaman and

Turner, 2016). The rates of PMH difficulties in UK military spouses have never been reported. This study found that approximately 50-60% of participants met the clinical cut-off on self-reported screening measures of depression, anxiety, stress, adjustment disorder and PTSD. The frequency of participants scoring above clinical cut-off for psychotic-like experiences, suggesting they may have higher psychotic vulnerability, is lower than the other mental health difficulties measured, at just over 20%. This data fits approximately with some of the previously mentioned US literature, however as it is the first of its kind, cannot be compared to any similar UK literature to assess the reliability.

A recent study reported self-reported PMH difficulties, with almost 50% of participants scoring above clinical cut off for depression, anxiety and/or stress, as measured by the DASS-21 (Foreman, 2024). This suggests that the military spouse population have slightly higher self-reported rates of these difficulties compared to the general population. This is unsurprising when considering the additional stressors that military spouses face, which may suggest that military spouses are more at risk of PMH difficulties when compared to the general population (Spencer et al., 2025). However, Foreman also reported that just over 35% of the general population sample met the cut-off for increased vulnerability to psychotic-like experiences, as measured by the PQ-16. This frequency is almost 15% higher than in the military spouse population measured in the current study. This is surprising as absence of a partner during birth has been identified as a risk factor for postpartum psychosis, which could be assumed to occur more commonly in the military spouse population compared to the general population (Upadhyaya, Sharma & Raval, 2014). A potential explanation for this unexpected comparison may be that the self-selected sample in the Foreman study was biased towards parents who had had these experiences as this was the focus of their study, therefore producing unusually high rates of psychotic-like experiences.

The present study found that the impact of the military challenges was similar across the challenges, with spousal deployment having the largest number of spouses rating it as ‘big impact’, however this was only marginally higher than some of the other challenges. There was variation in ratings, with 17.5% of participants not rating any of the challenges as having a ‘big impact’ on their wellbeing and 6% rating all the challenges as having a ‘big impact’. This suggests variation in how military spouses experience these challenges, with potential for other factors to be influencing how the challenges are perceived. Additional exploratory analysis was conducted to investigate this in the Additional Results chapter. Further research should continue exploring the mechanisms underlying how military challenges are perceived by spouses and the effect this may have on their wellbeing both in and out of the perinatal period.

The most significant predictors of variance in mental health scores came from the step one variables, which were previously identified risk factors for poorer PMH. Unsurprisingly, past mental health diagnoses were a significant predictor for all the measured mental health difficulties, along with age in all but the depression measure. These findings mostly fit with previous research on PMH in the general population, however there is no current literature to compare these findings to in relation to PMH in military spouses (Lin & Hung, 2015; Yang, Wu & Chen, 2022). However, there is some conflicting evidence regarding the impact of age on PMH, with a previous systematic review finding advanced maternal age to be associated with poorer PMH in military spouses in the US (Godier-McBard et al., 2019). The current study challenges this finding. It is unclear why this may differ between the US and UK, however one could hypothesise it may be due to the military culture of “just get on with it” in the UK, as described in the Systemic Review chapter, which may not exist to the same extent in the US. Further research is required to further understand the mechanisms behind younger age being associated with poorer PMH in the military spouse population in the UK.

Our findings indicate a significant positive association between the perceived negative impact of military accommodation on wellbeing and depression, anxiety and stress scores. This association was statistically significant but accounted for a small proportion of variance above other existing risk factors, suggesting accommodation difficulties may function as a background stressor rather than a primary driver of PMH difficulties. It is known that in the general population, housing instability is associated with increased PMH difficulties, which military spouses may be likely to experience due to relocations (Suglia, Duarte & Sandel, 2011). Furthermore, self-determination theory could be used to understand the impact of these difficulties, as autonomy may be reduced by spouses' potentially limited control over where and how they live, whilst relatedness may be affected where accommodation issues reduce opportunities to establish stable social networks. However, this study did not explore what factors surrounding military accommodation are relevant, and so further research is required to understand this finding in more depth. Whilst there is no research showing a link between accommodation and PMH in military spouses, there is anecdotal evidence suggesting this link, such as a letter written by Dandelion Military Families (2023). The recent publication of the Defence Housing Strategy also supports the notion that military accommodation requires improvement (MOD, 2025a).

Furthermore, our findings also indicate a significant positive association between perceived impact of being a military spouse on own employment and trauma scores. As with accommodation, this association accounted for only a small amount of variance, also suggesting employment difficulties may be a background stressor and not a primer driver of PMH difficulties. It is unclear how employment difficulties relate to trauma scores. It may be that spouses facing difficulties with their employment are more likely to be of lower socio-economic status based on income, which has been found to be a predictor of post-traumatic stress disorder (Kessler et al., 2021). Alternatively, this association could be understood

through self-determination theory. Spouses facing difficulties with their employment may be experiencing reduced autonomy, competence and opportunities for relatedness. The theory suggests that these psychological needs being limited can lead to reduced wellbeing and increased vulnerability to mental health difficulties. However, causal links cannot be made due to the cross-sectional nature of the study. Future research is required to understand the relationship between these two variables.

Strengths and Limitations

A strength of this study is that it is the first of its kind to investigate PMH and military challenges in military spouses in the UK, starting to fill a gap in the literature. Furthermore, whilst the ethnic demographics of military spouses in the UK are not reported by the military, white serving personnel make up 87.8% of the military (MOD, 2025b). Assuming that the spousal population is similar, the sample used in this study is close to being representative of the general population of military spouses. The required sample size was met quickly and so recruitment continued to help improve the representativeness of the sample, by attempting to Increase the diversity of the sample, which aided in improving the generalisability of findings.

However, it is also important to consider the limitations of this study. The sample is likely to be biased for various reasons. First, the sample is self-selecting and so military spouses with PMH difficulties were potentially more likely to take part. Second, the main source of recruitment was through Dandelion Military Families, an organisation set up to support military parental mental health, again increasing the chance that participants were more likely to already have some level of association with PMH difficulties. Third, the use of screening measures is known to inflate the rate of clinical difficulty found. These three factors are likely to have resulted in inflated rates of PMH difficulties being found. As a result, the findings in relation to PMH frequency should be interpreted with caution and cannot be generalised to the whole military spouse population in the UK.

The mental health screening measures used within the study, whilst validated measures, are not specific to the perinatal population. As a result of this, the instructions for the ADNM-8 were altered to make it perinatal specific, which may have impacted on the validity and reliability of the measure. Furthermore, the removal of question 16 from the PQ-16 may have also impacted on the validity and reliability of the measure. Given the limited number of psychotic-risk screening tools, and even more so limited ones validated in the perinatal population, the adapted PQ-16 likely produced the most reliable data. Future research should focus on the development of a perinatal specific psychotic-risk screening tool. Perinatal specific screening tools could have been used, such as the Edinburgh Postnatal Depression Scale (EPDS), however this would have increased the length of the survey. It was important to keep the screening measures brief to allow the inclusion of them all without making the survey too long and potentially hindering participation. Furthermore, the military challenges rating scales was not a validated measure of the impact of military challenges; however, no such measure currently exists and therefore the development of this rating scale appeared sufficient to measure the concept of interest.

Finally, the cross-sectional design of the study results has various limitations. It prohibits any causal links being made from the data, limiting the strength of conclusions made. For example, the directional relationship between the military challenges and mental health scores cannot be concluded as those with higher PMH scores may feel more impacted by the military challenges, or those who feel more impacted by the military challenges may experience more PMH difficulties. Furthermore, the cross-sectional design prohibits the identification of the impact of timing on the perceived impact of military challenges and PMH difficulties. For example, during times of war the impact of deployments may be greater. Future research of a longitudinal design is required to overcome these limitations of the cross-sectional design.

Implications

This study produces some of the first data on PMH difficulties in the military spouse population in the UK, as well as insight into the specific challenges that military spouses face. It is essential to understand the experiences of military spouses during the perinatal period to help guide support and services to appropriately meet their needs.

Our findings indicate that the perceived impact of military accommodation is the main military factor that is associated with poorer PMH. This is important to be aware of as anecdotal evidence shows that NHS services do not understand the challenges that military spouses face, and it may be assumed by services that more typical military challenges, such as deployment, would be more impactful for spouses (Dandelion Military Families, 2023). Therefore, this research is vital to improving the understanding of the challenges of military life and providing the empirical evidence to support the voices of military spouses. This understanding can then be used to guide future research and to inform practice and procedures within the NHS to be more military-informed.

Furthermore, it is also key for service to be aware that whilst some of the usual risk factors for PMH difficulties apply to military spouses, there are also differences in these risk factors. Whilst it might be expected that older maternal age would predict poorer PMH, as previous research has found, this study found the opposite in military spouses in the UK (Godier-McBard et al., 2019). It is essential that services are aware of this difference to ensure younger military spouses are highlighted as potentially at greater risk of PMH difficulties.

The use of these findings to improve services and how they care for military spouses is a key step to then improving the PMH of military spouses themselves. The potential implications of improved PMH are far reaching beyond the spouse themselves, with improvements possible in the child and in partner and family relationships (Stein et al., 2014). This should also be a key consideration for the MOD, as research has shown that a significant

factor in the decision for serving personnel to leave the military is because of increased pressure on family life and poor military family welfare support (Dandeker et al., 2009).

Conclusions

The current study is the first of its kind to begin to understand the PMH of the UK military spouse population and start to unpick the unique challenges that they face that impact on their PMH. Self-reported PMH rates appear higher in this population than in the general population and spouses rated the military challenges are mostly having at least some negative impact on their wellbeing. This study is also the first to identify an association between the impact of military accommodation and PMH in this UK population, providing empirical support for the existing anecdotal evidence.

This study should form the basis for future research to continue understanding the experiences of military spouses in the perinatal period in the UK. More understanding is needed of the mechanisms of the perceived impact of military accommodation and own employment being associated with poorer PMH, and military spouses' voices need to be heard in a qualitative approach to continue exploring the present findings in more detail. These findings, along with future research, should be used to inform NHS practice and procedure, ensuring it is military-informed and military spouses receive the care and support they require with understanding of their individual circumstances.

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Chapter Five

Additional Results

Word count: 1032

Additional results

Research question one: What are the main challenges faced by military spouses and partners in the perinatal period in the UK?

Exploratory analysis was conducted to assess the relationship between when spouses experienced deployments and relocations, and their rated impact of these challenges on their wellbeing. There was a significant relationship between having experienced a deployment during the perinatal period and the rated negative impact of deployments on spouses' wellbeing ($\chi^2(4, N = 316) = 21.38$, $p < .001$), with those who have experienced a perinatal deployment reporting higher impact ratings. However, there was not a significant relationship between having experienced a relocation during the perinatal period and the rated negative impact of relocations on spouses' wellbeing ($\chi^2(4, N = 265) = 3.33$, $p = .919$).

Further exploratory analysis was also conducted to investigate any relationship between the military challenges impact ratings and other military factors. Chi-square analyses compared the rated military challenges across partners rank, the associated branch of the military and if participants were living in service family accommodation with the military challenge ratings. Bonferroni adjustment was utilised to reduce the family-wise error rate, resulting in an adjusted alpha level of .003. This analysis showed that those living in service family accommodation rated difficulties with own employment as significantly more impactful than those not living in service family accommodation ($\chi^2(4, N = 332) = 24.34$, $p <.001$). Furthermore, participants whose partner was an "officer" rank rated relocations as significantly more impactful than those with a partner in an "other" rank ($\chi^2(4, N = 307) = 10.42$, $p = .002$). None of the other comparisons were significant.

Additionally, exploratory analyses were conducted to investigate the relationship between where participants lived, either in service family accommodation or not, and their mental health scores. Independent samples t-test analyses indicated that those living in service

family accommodation had significantly higher depression ($t(213) = 2.01$, $p = .046$, $d = .22$), anxiety ($t(218) = 2.60$, $p = .010$, $d = .29$), stress ($t(359) = 2.18$, $p = .030$, $d = .25$), and trauma symptom ($t(359) = 2.04$, $p = .042$, $d = .24$) scores compared to those not living in service family accommodation. There was no significant difference in adjustment and psychotic-like experience scores between those living in service family accommodation and those not.

Finally, exploratory analysis was conducted to assess the cumulative effects of the military challenges ratings by conducting correlational analyses between participants' total military challenge impact score and the individual mental health screening scores. A Spearman's Rho correlation showed significant relationships between total military challenges impact scores and depression ($p < .05$), anxiety ($p < .001$), stress ($p < .001$), adjustment ($p < .001$) and trauma ($p < .001$) scores. There was not a significant relationship found between total military challenge impact scores and psychotic-like experience scores.

Research question three: Are military challenges associated with poorer perinatal mental health in military spouses and partners in the UK?

Given the conceptual overlap among the mental health screening measures and the strong correlations observed between them, additional exploratory analyses were conducted. A third step was added to each hierarchical regression model, in which scores from the other mental health screening measures were entered. This step was included to explore whether associations between military challenges and mental health outcomes were attenuated after accounting for concurrent mental health symptomatology (see Table 1).

Following the inclusion of other mental health screening scores at step three, very few of the individual variables entered at steps one or two accounted for a significant proportion of variance in the dependent variable across the regression models. Past mental health diagnoses accounted for a significant proportion of variance in anxiety scores, with having previous diagnoses being associated with higher scores, and age accounted for a significant

Table 1. *Three step hierarchical regression analyses.*

Variable	R^2 change	*F*-change	ß	*p*
Depression				
Step 1				
Age	.20	F(3,266)=22.52**	.04	.288
Education Level			-.04	.221
Past MH Diagnosis			.00	.907
Step 2				
Impact of spousal deployment	.05	F(3,263)=14.95**	.01	.792
Impact of social support			.04	.315
Impact of military accommodation			.03	.415
Step 3				
Anxiety	.49	F(11,258)=68.41**	.33	<.001**
Stress			.48	<.001**
Adjustment			.01	.899
Trauma			.05	.294
Psychotic-like experiences			.08	.061
Anxiety				
Step 1				
Age	.27	F(3,270)=32.82**	-.06	.089
Education Level			.05	.132
Past MH Diagnosis			.12	<.001**
Step 2				
Impact of spousal deployment	.03	F(5,268)=.22.55**	-.05	.163
Impact of military accommodation			.04	.294
Step 3				
Depression	.45	F(10,263)=75.15**	.35	<.001**

Stress			.30	<.001**
Adjustment			.00	.951
Trauma			.13	.005*
Psychotic-like experiences			.13	.002*
Stress				
Step 1				
Age	.21	F(3,266)=23.84**	-.04	.319
Education Level			-.03	.478
Past MH Diagnosis			.01	.734
Step 2				
Impact of spousal deployment	.05	F(6,263)=15.15**	.02	.519
Impact of social support			.05	.197
Impact of military accommodation			-.02	.519
Step 3				
Depression	.48	F(11,258)=63.96**	.50	<.001**
Anxiety			.30	<.001**
Adjustment			.09	.042*
Trauma			.03	.523
Psychotic-like experiences			-.02	.707
Adjustment				
Step 1				
Age	.12	F(2,238)=16.13**	-.00	.937
Past MH Diagnosis			.08	.137
Step 2				
Impact of spousal deployment	.10	F(7,233)=9.09**	.02	.745
Impact of own employment			.11	.044
Impact of relocations			.02	.725

Impact of military accommodation			.06	.250
Impact of military control			.03	.630
Step 3				
Depression			-.01	.837
Anxiety			.04	.709
Stress	.24	F(12,228)=16.08**	.11	.214
Trauma			.37	<.001**
Psychotic-like experiences			.17	.009
Trauma				
Step 1				
Age			-.02	.703
Education Level	.16	F(3,285)=17.27**	-.01	.815
Past MH Diagnosis			.01	.899
Step 2				
Impact of spousal deployment			-.01	.864
Impact of own employment	.03	F(6,282)=10.57**	.03	.533
Impact of social support			.02	.735
Step 3				
Depression			.08	.336
Anxiety			.26	<.001**
Stress	.37	F(11,277)=31.20**	.12	.119
Adjustment			.32	<.001**
Psychotic-like experiences			.11	.050
Psychotic-like experiences				
Step 1				
Age	.18	F(3,357)=26.90**	-.09	.043*
Education Level			-.08	.064

Past MH Diagnosis			.05	.231
Step 3				
Depression			.26	<.001**
Anxiety			.18	.012*
Stress	.29	F(8,352)=40.31**	-.02	.840
Adjustment			.21	<.001**
Trauma			.10	.063

p<.05*, p<.001**

proportion of variance in psychotic-like experience scores, with younger age begin associated with higher scores. This overall attenuation likely reflects substantial shared variance and conceptual overlap among mental health constructs, rather than the absence of an association between military challenges and mental health outcomes. Overall, concurrent mental health symptom measures accounted for the largest proportion of variance in the assessed outcomes.

Chapter Six

Discussion and Critical Evaluation

Word count (excluding references): 4243

Discussion & Critical Evaluation Chapter

Summary of Results

The systematic review in this portfolio identified the impact of military challenges on military spouses' wellbeing, with spouses reporting the felt expectation to suppress or hide their emotions, a lack of recognition of their difficulties from the military, and a range of impacts on their sense of self. Spouses described their experiences changing depending on whether they lived on base or off base, with positives and negatives of both locations. Finally, spouses spoke of the many expectations placed upon them as part of the military culture to be a "military wife" as influencing their wellbeing.

The empirical study in this portfolio followed on from the systematic review by focusing specifically on the impact of military challenges on spouses' mental health during the perinatal period. A large majority of spouses rated all the assessed military challenges as having at least some negative impact on their current wellbeing, with minimal differences between the rated impact of the different challenges. The self-reported PMH difficulties were high in frequency, with over 50% of participants scoring above the clinical cut off in most of the screening questionnaires used. Non-military factors of age and previous mental health diagnosis were significantly associated with changes in all mental health scores. After accounting for these factors, challenges associated with military accommodation were identified as significantly associated with increases in depression, anxiety and stress scores, although this additional variance was small. Additionally, challenges associated with spouses own employment was significantly associated with a small increase in trauma scores.

The additional analysis identified a significant relationship between when spouses experienced deployments and the rated impact of deployments on their current wellbeing, with spouses who had experienced a deployment during the perinatal period rating deployments as more impactful on their current wellbeing. However, the same was not found

for relocations, with no significant relationship between when a spouse experienced a relocation and the rated impact of relocations on their current wellbeing. Additionally, living in service family accommodation was found to be significantly associated with higher impact ratings on difficulties with spouses own employment, and spouses whose partner was an "officer" rank rated relocations to be significantly more impactful, suggesting that other military factors may be mediating how impactful spouses find the military challenges assessed. Further exploratory analysis also revealed significant positive relationships between total military challenge rating scores and all of the mental health screening scores, apart from the psychotic-like experiences scores, suggesting there is likely a cumulative effect of the military challenges. Finally, when the other mental health scores were included in the regression analyses, the associations between the control variables and military variables with the mental health score was attenuated.

Challenges Faced by Military Spouses

This thesis portfolio identified various challenges faced by military spouses as a result of military life and were mostly consistent over the systematic review and empirical paper. The challenges identified are documented in the current literature, however, much of this literature is based on US studies. Our findings indicate that rating military accommodation as having more of a negative impact on wellbeing was predictive of increased depression, anxiety and stress scores. Furthermore, findings from the additional results chapter indicated that those living in service family accommodation had significantly higher depression, anxiety, stress and trauma scores. Findings from the systematic review showed factors such as the lack of control and agency spouses have in Service Family Accommodation are key to spouse wellbeing, which could be a potential explanation for the findings of the empirical study. However, the empirical study did not explicitly explore what factors surrounding the military accommodation are relevant, and so further research is required to understand this

finding in more depth. Whilst there is no current literature showing a link between accommodation and PMH in military spouses, there is anecdotal evidence suggesting this link, such as a letter written by Dandelion Military Families (2023). The recent publication of the new Defence Housing Strategy (2025) also supports the notion that military accommodation requires improvement. However, the strategy focuses on improving housing for "morale and retention of service personnel", with limited mention of families and partners.

Furthermore, employment difficulties were described across the systematic review and the empirical study. The systematic review identified difficulties in maintaining or finding employment, often as a result of relocations, impacting on spouses' identity, financial independence and sense of agency. The empirical paper provided quantitative support for these findings, with higher ratings of difficulties with employment impacting on wellbeing being associated with higher trauma scores. Whilst it is well documented that military life can have a negative impact on employment, the association between employment difficulties and trauma scores has not been reported (Castaneda & Harrell, 2008; Runge et al., 2014). Therefore, the mechanisms behind this association are unknown. It may be that the impact of employment difficulties described in the systematic review leave spouses more vulnerable to experiencing post-traumatic symptoms following traumatic events. Furthermore, the systematic review highlighted the importance of support systems and that many spouses felt they fell between the military and civilian communities. Those not in employment may have less opportunity to develop support systems elsewhere and therefore may lack the support required to buffer the impact of traumatic events (Ozer et al., 2003). This is further supported by the finding that those in service family accommodation rated difficulties with employment as significantly more impactful on their wellbeing, as the systematic review identified that living on base can negatively impact how supported spouses feel. Future research may want

to focus on the potential protective impact of social support on mental health difficulties and the felt impact of military challenges.

A common theme across this portfolio is that the challenges spouses face do not occur in isolation. Much of the current literature on military spouse wellbeing documents various challenges that spouses face concurrently (de Burgh et al., 2011; Blakely et al., 2012; Runge et al., 2014; Gribble et al., 2018). The additional exploratory analysis supports this as it identified a likely cumulative effect of the impact of military challenges on spouses' PMH scores. This portfolio supports the idea that spouses face a complex interplay of various challenges and future research is required to fully understand the mechanisms behind these challenges impacting wellbeing generally and during the perinatal period.

The empirical study showed strong intercorrelations between the mental health screening questionnaires, and so further exploratory analysis was completed which showed that shared variance across mental health difficulties explained more variance in individual mental health scores than the perinatal risk factors or the military challenges. This suggests that the mental health difficulties operate as more of a cluster of difficulties than as discrete outcomes to be measured individually. This does not mean that the military challenges are not important, but that they may act more as stress amplifiers rather than disorder specific predictors. This highlights the need for further investigation into the PMH of military spouses as a more latent variable rather than symptom by symptom analyses, using theory-driven models.

Impact on Wellbeing

Participants in the empirical study reported lower levels of previous PMH difficulties and general mental health diagnoses than was found in the mental health screening scores. This suggests that spouses may be, either consciously or subconsciously, downplaying their difficulties by not considering their experiences to be classified as mental health difficulties.

This would fit with the findings from the systematic review, whereby many spouses reported feeling the expectation to downplay or hide their emotional responses to stressors. This may also be an explanation for the finding that being younger in age is significantly associated with poorer PMH scores, as younger spouses may have had less time to internalise this unhelpful coping norm. This coping expectation may also begin to explain the systematic review finding that spouses feel a lack of recognition by the military. If the expectation is to suppress emotional responses, this is likely to normalise the distress they feel and result in their distress not being recognised by the institution. These expectations reflect socially constructed expectations norms within military culture, potentially producing barriers to help-seeking through both internalised beliefs and perceived organisational consequences. The findings extend Segal's (1986) theory by demonstrating how the "greediness" of the military institution is internalised by spouses, resulting not only in structural sacrifice but in emotional regulation aligned with institutional priorities. This expectation to suppress emotions has not been specifically researched in the UK literature, only appearing within a study investigating other aspects of military life, and requires further investigation to understand other expectations that may come with military life and how this may impact on spouses' wellbeing and help-seeking, particularly at times of additional stress such as the perinatal period (Hassett, 2020).

Although validated measures of wellbeing such as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) would have enabled direct comparison with UK population norms and closer links to the systematic review, the empirical project aimed to investigate specific perinatal mental health difficulties rather than overall wellbeing. Measures of depression, anxiety, stress, trauma and psychosis risk were therefore selected because they better addressed the research questions and identified clinically relevant symptoms requiring support. Consequently, the empirical paper should not be interpreted as measuring wellbeing

directly, but rather one aspect of psychological functioning that contributes to wellbeing. Future research would benefit from including both validated wellbeing measures and symptom-specific measures to understand how military challenges influence overall wellbeing alongside clinical mental health outcomes.

Understanding Military Spouse Wellbeing Through Self-Determination Theory (SDT)

Although neither paper directly measured the constructs highlighted in SDT, the findings consistently suggest that many of the challenges associated with military life may influence wellbeing through the frustration of these psychological needs.

Across both studies, autonomy appeared to be repeatedly challenged by aspects of military life that limited spouses' control over important life decisions. Participants described having little influence over relocations, service accommodation and employment opportunities, while the systematic review also identified expectations associated with the military spouse role that constrained opportunities for independent decision-making and individual identity. The empirical findings similarly demonstrated that accommodation difficulties were associated with poorer mental health outcomes, suggesting that situations characterised by reduced personal control may be particularly detrimental to psychological wellbeing. These findings align with SDT, which proposes that environments restricting personal choice and self-direction are associated with reduced wellbeing.

Competence also emerged as an important mechanism linking military life with wellbeing. The systematic review highlighted repeated disruption to employment, increased caregiving responsibilities during deployments and separations, and difficulties maintaining valued identities outside of military life. Whilst some spouses described developing resilience and confidence through adapting to military demands, many more reported feeling that their abilities and aspirations were constrained by the practical realities of military life. During the perinatal period, these challenges may be further compounded by the transition to parenthood,

where there is already increased demand on changing roles. The cumulative effect of military demands and perinatal adjustment may therefore contribute to increased psychological vulnerability.

Relatedness was the most consistently represented psychological need across both studies. The systematic review demonstrated that prolonged separations, frequent relocations and feeling misunderstood by both military and civilian communities often disrupted opportunities to develop and maintain meaningful relationships. Although some spouses described strong connections within military communities, these experiences were not universal and frequently depended upon geographical location. The importance of social support during the perinatal period is well established, and the high prevalence of self-reported mental health difficulties observed within the empirical study may partly reflect the additional burden of navigating the perinatal period alongside reduced opportunities for consistent social connection.

Although the present research did not directly assess psychological need satisfaction, the consistency with which the findings align with SDT suggests that it may provide a valuable theoretical framework for future research. Measuring autonomy, competence and relatedness alongside military-specific stressors may help identify the mechanisms through which military life influences wellbeing and, in turn, inform the development of interventions designed to promote psychological resilience in military spouses. Such an approach moves beyond identifying individual risk factors towards understanding the psychological processes that underpin wellbeing, providing a more integrated framework for supporting military spouses throughout both military life and the perinatal period.

However, SDT does not fully account for the complex nature of many military stressors, such as housing allocation or deployment policies, which are influenced by wider

institutional factors beyond individual psychological need fulfilment. Consequently, SDT should be viewed as one explanatory framework alongside broader systemic perspectives.

Appraisal of Challenges

Whilst the systematic review and empirical paper suggest a range of military challenges that can impact on military spouses' wellbeing both generally and in the perinatal period, there is variety in how these challenges are appraised. For example, some spouses saw increased independence as an opportunity for growth, and some saw it as detrimental to their individuality. Furthermore, in the empirical paper, 17.5% of participants rated none of the military challenges as having a 'big impact' on their wellbeing in the perinatal period. These ranges in how the challenges are experienced suggests that it is likely not exclusively the challenges that are impacting on wellbeing, but how they are appraised. The empirical study in this portfolio did not explore what is influencing the appraisal of these challenges. There could be many factors influencing this appraisal, such as the level of choice that spouses feel they have, or maybe the level of pressure spouses feel to suppress their true emotional responses. Future research should include investigating the appraisal of these challenges to help understand these differences in responses from military spouses. The challenges themselves are unlikely to be changed significantly, for example experiencing deployments and relocations as military families is often unavoidable. However, further understanding of the appraisal of these challenges will aid in being able to consider how spouses are supported when experiencing these challenges.

Strengths and Weaknesses

The systematic review within this portfolio is the first, known to the author at the time of writing, focusing on the wellbeing of military spouses in the UK. Previous systematic reviews on this area completed by UK researchers have focused on studies from the US, where the majority of the current literature is based (de Burgh et al., 2011; Blakely et al.,

2012; Gribble et al., 2018). By beginning to synthesise the evidence base from the UK, the impact of being a military spouse on wellbeing can be understood further to allow for policy and practice improvement. Furthermore, the empirical paper within this portfolio is also the first, known to the author at the time of writing, investigating the PMH of military spouses in the UK. Similarly to the systematic review, by beginning to understand the PMH of military spouses in the UK, recommendations can be made to develop policy and practice to more effectively support this population.

However, there are also weaknesses to consider for this portfolio. The diversity of the samples across the systematic review and the empirical study are limited. Almost all participants were female and white. Whilst every effort was made to increase the ethnic diversity in the empirical study by continuing recruitment beyond the required sample size and searching for specific social media groups relating to minoritised groups, the sample remained limited in diversity. Furthermore, the sexual orientation of participants was not collected in the empirical paper or reported in any of the studies included in the systematic review. It may be that the experiences of those in the perinatal period who are in same sex relationships is different to those in heterosexual relationships. Additionally, women make up 11.9% of the UK Armed Forces, and the MOD aims for this to increase to 30% by 2030, indicating a need to also understand the wellbeing of male spouses as a growing population (MOD, 2025b). Increasing the diversity of samples being studied is key to understanding the experiences and wellbeing of this population as a whole and avoids perpetuating the stereotypical “military wife” narrative. Future research may want to focus on understanding the experiences of minoritised groups to enable a more holistic picture of this population to be formed.

A further limitation relates to the potential pathologisation of adaptive distress within this population. Many of the emotional responses reported by military spouses, particularly

during the perinatal period, may represent understandable and proportionate reactions to cumulative stressors such as relocations, deployments, and limited social support, rather than indicators of discrete mental health disorders. The use of self-report screening measures, whilst valuable for identifying individuals who may benefit from support, risks framing these normative responses within a diagnostic paradigm that emphasises individual psychopathology over contextual adversity. The use of screening measures has also likely resulted in inflated rates of clinical difficulties, adding to the potential risk of pathologising this population. Whilst qualitative findings suggested emotional suppression, the quantitative data revealed high levels of symptom endorsement. This may indicate that suppression does not eliminate distress but alters its expression. Alternatively, anonymous survey methodology may have reduced social desirability effects compared to interviews. However, the described need to suppress or hide emotions may have impacted on which spouses chose to take part in the study or how they responded to questions, which may have countered the increased clinical rate from using screening measures. This highlights the importance of conceptualising PMH difficulties among military spouses through a biopsychosocial and systemic lens.

Both the systematic review and the empirical study had interpretive limitations, as described in their individual discussions. Whilst these limitations were mitigated as much as possible during the conducting of the research, their implications are still important to consider. The limitations greatly reduce the confidence in the findings, meaning any conclusions made are tentative. Future research is required to overcome these limitations to enable more generalisable outcomes to be developed, which act as stronger evidence when used to bring about change in the policy and practice in the UK.

Finally, this thesis portfolio only focuses on specific types of military challenges. As described in the systematic review discussion, the studies included mostly focused on specific aspects of military life, and therefore these are the challenges that were identified in the

synthesis as influencing their wellbeing. Furthermore, the empirical study also asked about specific military challenges that spouses face. Whilst these challenges were identified through the current literature, the quantitative nature of the study did not allow for spouses to report on any other military challenges they may have faced. Future research is required to understand the experiences of military spouses and the impact on their wellbeing both generally and during the perinatal period in broader context. A qualitative, inductive approach would allow their voices to be heard and to gain a more in-depth understanding of the challenges that spouses themselves feel they face which may not have been captured using the design of this empirical study. Furthermore, the measure used in the empirical paper to understand the challenges that spouses face was not a validated measure. A measure of this kind does not exist currently, so future research is required to validate the measure that was used. This could include cognitive interviewing with military spouses to establish face and content validity, followed by psychometric testing of reliability, construct validity and responsiveness within larger samples.

Theoretical Implications

Whilst there are interpretive limitations to this thesis portfolio, there is still potential implications that are important to consider. This portfolio has highlighted the need to further understand the mechanisms behind associations found, such as between accommodation and PMH difficulties. Many of the challenges that spouses face are unlikely to be changed, for example deployments will always be necessary within the military. Therefore, the mechanisms underlying these associations must be understood before any meaningful change can be brought about to better support military spouses. This portfolio also provides some of the empirical evidence needed to support the anecdotal evidence that exists, strengthening its legitimacy and validating military spouses themselves.

Clinical Implications

Whilst further research is needed to strengthen any call for change in UK policy and practice, some alterations can be made. This portfolio indicates the need for military-informed care in services, particularly during times of high stress, such as during the perinatal period. This could include routine enquiries about housing, relocations and partner absence. This may also include proactive screening or outreach to younger spouses who may be at increased risk of difficulties, particularly during the perinatal period, as well as those with previous mental health difficulties. Clinical Psychologists (CPs) can play a key role in improving the military-informed nature of services. The additional challenges that military spouses face should be taken into consideration when their difficulties are being formulated and the potential impact of these challenges in being able to access care. There should be consideration of how these challenges may impact on spouses' ability to engage in treatment offers, such as thinking about how services respond to spouses' moving out of area during treatment. It may be that online approaches are more suitable for some spouses who are likely to relocate during treatment. From an SDT perspective, interventions should seek to increase opportunities for autonomy, for example through greater involvement in housing and relocation decisions, competence, through employment and practical support, and relatedness, through accessible peer support and community integration. Future research may want to investigate the effectiveness of any military-specific interventions. Furthermore, this research has highlighted the importance of spouses being recognised as independent people and not as secondary dependents to their serving spouse. This is key to empowering military spouses, which may have positive influences on their wellbeing, and is particularly pertinent for the military institution to embrace. The interplay between mental health symptomology and multiple military challenges found in this portfolio highlights the complexity of military life for spouses. This indicates the importance of co-production being utilised when considering how to appropriately adapt services within the NHS and military that support military spouses.

Most importantly, both the systematic review and the empirical study provide the basis for future reviews and research on these topics in the UK military spouse population. The correct support cannot be provided if we do not understand the experiences and needs of this population.

Future Research

As discussed, the methodological limitations of the empirical study can be overcome through conducting longitudinal research to investigate PMH over time. This will allow for causal pathways to be explored and will also give insight into changes across the perinatal period. Furthermore, this will help to identify cumulative or time-limited effects of military life, such as changes to wellbeing before, during and after a deployment or relocation. This will allow services to understand when military spouses may be most vulnerable to experiencing difficulties and to implement preventative or early intervention support.

Furthermore, future research should investigate the mechanisms and mediators of wellbeing in military spouses. For example, understanding the influence of autonomy and control, and how emotional suppression may impact on help-seeking. This will help to understand the appraisals of the challenges that spouses face to help guide adaptations to policy and practice.

Future research is also required to develop and evaluate military spouse specific interventions, such as military-informed perinatal interventions or housing and employment initiatives. Positively, some initiatives have existed, such as the MOD Spouse Employment Support (SES) Trial in 2015, and have shown positive outcomes, such as spouses feeling better supported by the military and valued as independent constituents (Godier-McBard, Caddick & Fossey, 2020). The recent publication of the new Defence Housing Strategy (2025) is also positive in showing that the MOD is aware of difficulties with housing and is working to improve this for military families. Future research may investigate any changes in

the reported impact of military accommodation on wellbeing following the improvements outlined in the Housing Strategy.

Finally, the general understanding of PMH difficulties in military spouses in the UK needs to be continued to be researched. This portfolio has only begun to the unpick this in the military spouse population in the UK and this must be continued and extended in future research.

Conclusions

The systematic review in this portfolio highlights the impacts of military life on military spouses' wellbeing, with reports of mental health difficulties, felt expectations to hide or suppress their emotions and a lack of recognition of the emotional impact by the military. Factors such as whether spouses live on or off base, and the expectations placed upon them as part of the "military wife" identity were identified as factors influencing the wellbeing of military spouses. In the perinatal period, spouses identified a complex inter-play of various military challenges as impacting on their wellbeing. Rates of self-reported PMH difficulties were high, with military accommodation as the main military factor being associated with small amounts of variance in depression, anxiety and stress scores. However, the mental health difficulty scores were highly correlated, and their shared variance explained more variance in individual mental health scores than the perinatal risk factors or military variables. The mechanisms behind the appraisals of the military challenges needs further investigation to understand the variation in responses to challenges from spouses, which would allow for more targeted support for those most at risk. Future research is needed to overcome the limitations of this portfolio and to continue building the literature around the general wellbeing and PMH of military spouses in the UK. This will help to guide adaptations to the policy and practice in both the NHS and the military to provide more effective and appropriate support to military spouses, which should be done in a co-produced way.

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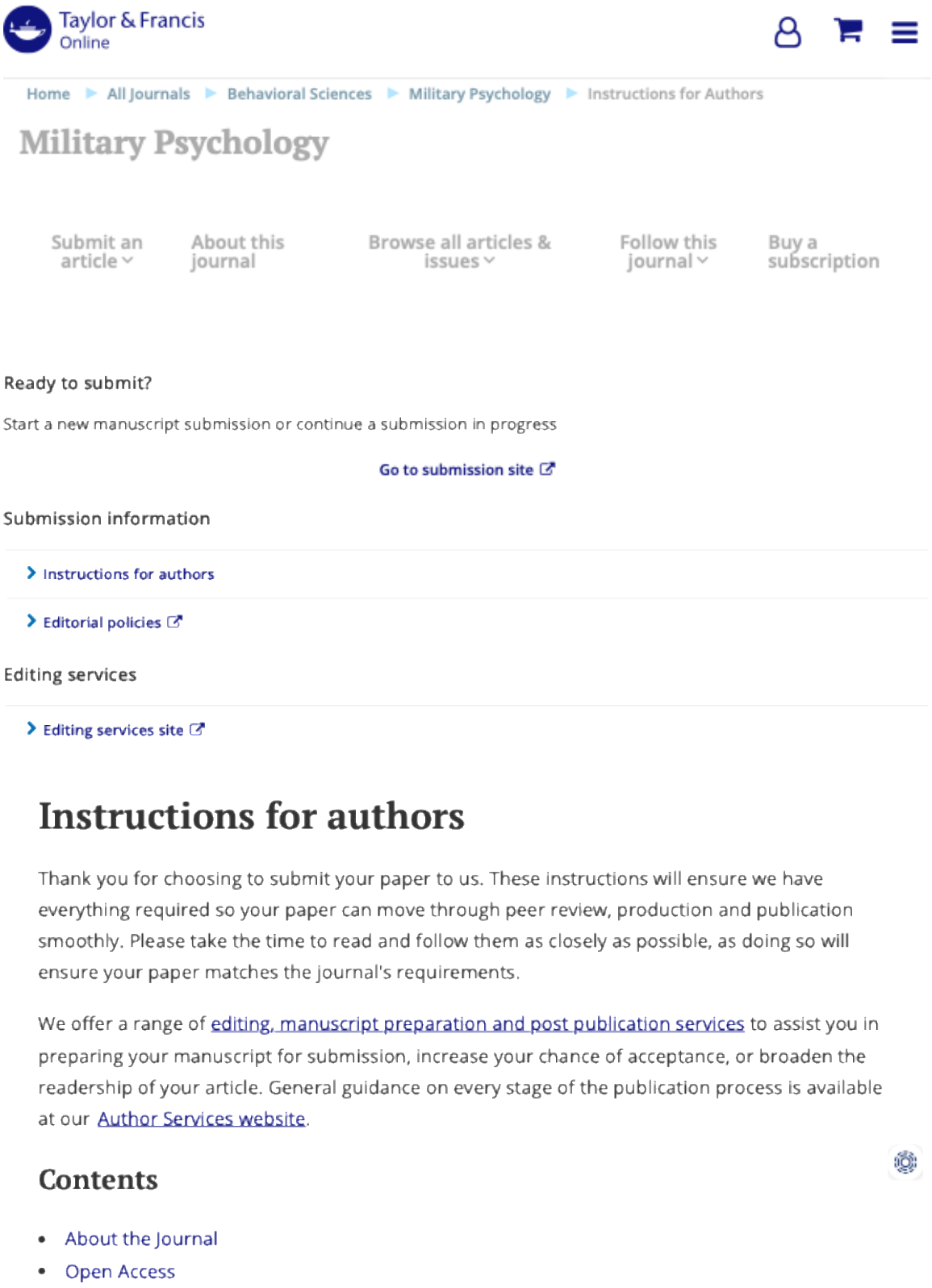
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Appendices

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  - References
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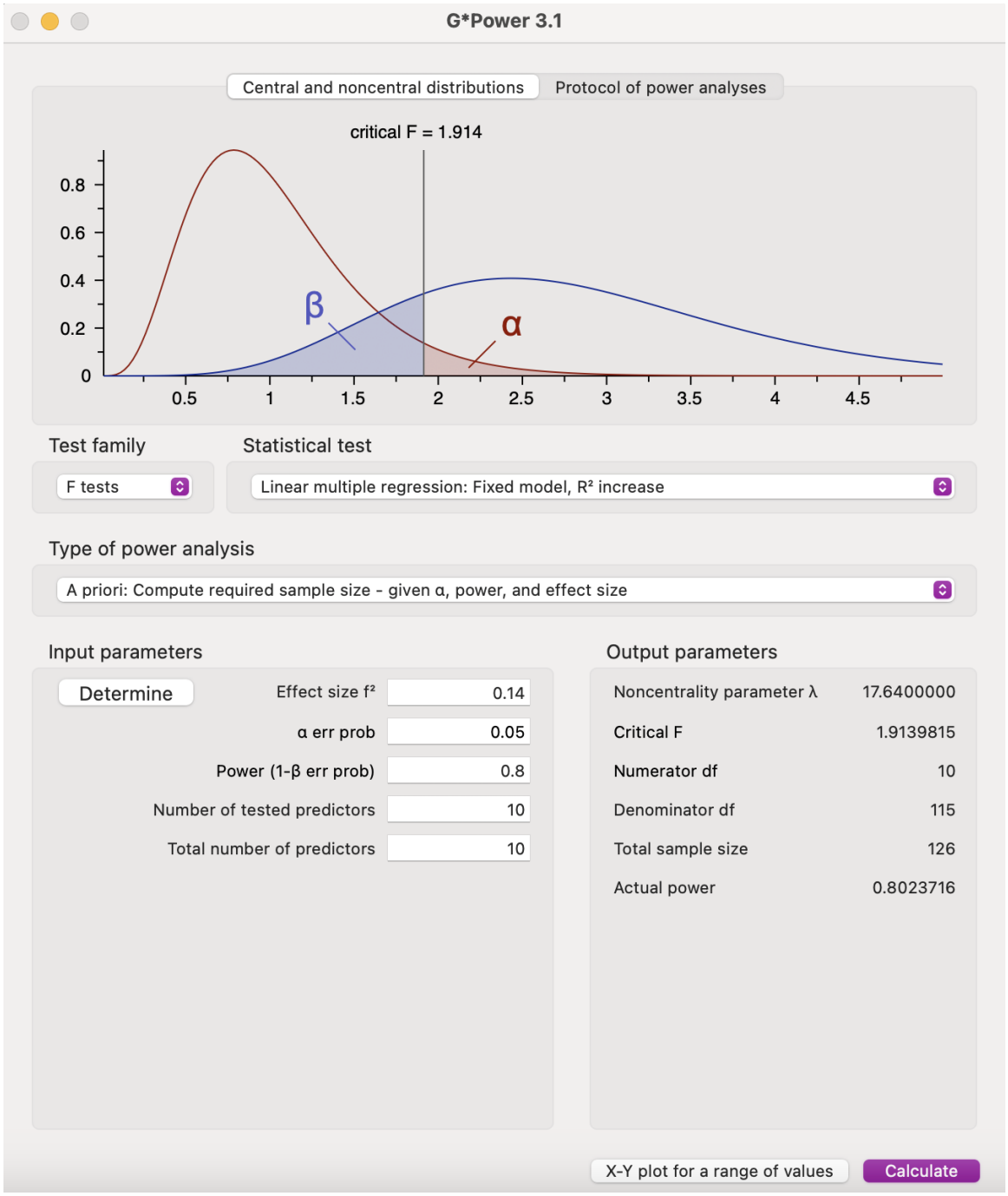
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Appendix B. G*Power Analysis



Appendix C. Survey (relevant questions are highlighted in yellow)

Screening questions

1. I am aged 18 or over
    a. Yes/No
2. My spouse is an active service member in the British Armed Forces
    a. Yes/No
3. I am a military spouse or partner, and have never been an armed forces serving personnel
    a. Yes/No
4. I am currently pregnant and/or have had a live birth in the past 24 months
    a. Yes/No
5. I am based in the United Kingdom
    a. Yes/No

If NO to any, survey end.

Demographics

6. Age
    [numerical entry]

7. Ethnicity
0. Asian or Asian British
0. Black, Black British, Caribbean or African
0. Mixed or multiple ethnic groups
0. White
0. Other ethnic group

8. Highest education level
0. GCSE/BTEC Levels 1-2/NVQ Level 1-2 or equivalent
0. A Levels/BTEC Level 3/NVQ Level 3 or equivalent
0. Certificate of Higher Education/BTEC Professional Diplomas/NVQ Level 4
0. Foundation Degree/Diploma of Higher Education/HND
0. Bachelors Degree/PGCE
0. Master's Degree/Postgraduate certificate or diploma
0. Doctoral Degree

9. Current employment status
0. Full-time employed
0. Part-time employed
0. Self-employed
0. Student
0. Stay at home parent
0. Retired
0. Unemployed
0. Other [enter]

10. Are you currently on maternity leave?
    a. Yes
    b. No

10. Which country do you currently live in?
0. England
0. Scotland

0. Wales
0. Northern Ireland

11. Which county do you currently live in?
[Drop-down of postal counties for UK]

12. Are you currently pregnant?
0. Yes
0. No

IF YES

13. How many weeks pregnant are you currently?
[numerical entry]

14. Have you had a live birth within the last 24 months?
0. Yes
0. No

15. How many children did you have prior to the current perinatal period?
[enter figure]

16. Have you ever experienced any perinatal mental health difficulties (excluding the current perinatal period)?
0. Yes
0. No
0. I'm not sure
17. Have you previously been diagnosed with any of the following mental health difficulties since becoming a military spouse/partner (outside of the current perinatal period)?
0. Depression
0. Anxiety
0. Stress
0. Psychosis (inc. schizophrenia)
0. Post-traumatic stress disorder
0. Adjustment disorder

Military characteristics and challenges

18. In which Armed Forces service does your partner currently serve?
0. Royal Navy (including the Royal Marines)
0. British Army
0. Royal Air Force
18. What ranking is your partner?
0. Soldier (inc. private, lance corporal, corporal, sergeant, staff sergeant, warrant officer class 2, warrant officer class 1)
0. Officer (officer cadet, second lieutenant, lieutenant, captain, major, lieutenant colonel, colonel, brigadier (aka 1 star), major general (aka 2 star), lieutenant general (aka 3 star), general (aka 4 star), field marshal)

18. Do you currently live in Service Family Accommodation?
0. Yes
0. No

21. How many times have you and/or your partner been relocated due to your partner's military service?
[numerical entry]

IF 1+

22. When were you and/or your partner relocated? (Please check all that apply).
0. During a pregnancy
0. Within 24 months after a pregnancy
1. Not during a perinatal period
0. Other (please specify)

IF 1+

24. How many times has your partner been deployed during your relationship?
[numerical entry]

IF 1+

25. When was your partner deployed? (Please check all that apply)
0. During a pregnancy
0. Within 24 months after a pregnancy
1. Not during a perinatal period
0. Other (please specify)

25. Please tick the relevant box to rate how much each of these military challenges impacts negatively on your mental health and wellbeing during the current perinatal period (pregnancy to 24 months postnatal). If it is not relevant to you (e.g. your spouse has never been deployed, you don't live in military accommodation), please tick the 'Not applicable' box.

	Not applicable	0 = No impact	1 = Minimal impact	2 = Some impact	3 = Quite a lot of impact	4 = Big impact
Spousal deployment (e.g. actual deployment, the potential for it)						
Own employment (e.g. difficulty progressing career due to relocations, limited childcare)						
Relocations due to military service						
Lack of social support (e.g. due to moving away from family for military)						
Military accommodation (e.g. quality, location)						
Military control (e.g. military taking priority, last minute work, work-life balance, etc.)						

Access history

1. Have you ever wanted to seek help for perinatal mental health problems? (i.e., mental health problems arising during pregnancy or within 24 months after giving birth)
   0. Yes
   0. No

2. Have you ever sought support for perinatal mental health problems? (i.e., mental health problems arising during pregnancy or within 24 months after giving birth)
   0. Yes
   0. No

IF YES

3. Where have you sought support for your perinatal mental health problems? (Please check all that apply).
   0. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de facto)
   1. Friend (not related to you)
   2. Parent
   3. Other relative/family member
   4. NHS mental health professional (e.g. psychologist, counsellor)
   5. NHS midwifery professional
   6. Private mental health professional (e.g. psychologist, counsellor)
   7. Private midwifery professional
   8. Phone helpline (e.g. Samaritans)
   9. NHS doctor/GP
   10. Private doctor/GP
   11. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)
   12. Other (please specify)

IF YES

4. Have you received professional psychological treatment for your perinatal mental health difficulties?
   0. Yes
   0. No

IF YES

5. In your opinion, how adequate is/was the professional psychological treatment?
   0. Very adequate
   0. Adequate
   0. Undecided
   0. Inadequate
   0. Very inadequate

Mental Help Seeking Attitudes Scale (MHSAS)

0. INSTRUCTIONS: For the purposes of this survey, "mental health professionals" include psychologists, psychiatrists, clinical social workers, and counselors. Likewise, "mental health concerns" include issues ranging from personal difficulties (e.g., loss of a loved one) to mental illness (e.g., anxiety, depression).

Please mark the circle that best represents your opinion. For example, if you feel that your seeking help would be extremely useless, you would mark the circle closest to "useless." If you are undecided, you would mark the "0" circle. If you feel that your seeking help would be slightly useful, you would mark the "1" circle that is closer to "useful."

If I had a mental health concern, seeking help from a mental health professional would be...

	3	2	1	0	1	2	3	
Useless								Useful
Important								Unimportant
Unhealthy								Healthy
Ineffective								Effective
Good								Bad
Healing								Hurting
Disempowering								Empowering
Satisfying								Unsatisfying
Desirable								Undesirable

Perinatal Mental Health Stigma (Subjective Norms)

7. We use the term 'psychological problems' in this questionnaire to refer to all sorts of distress mothers might experience when having a baby, for example, mood problems, depression, anxiety, trauma and obsessive-compulsive disorder. Please think of psychological problems to mean whatever you feel comfortable with. We appreciate that some questions may be of a sensitive nature, and we thank you for your honesty in helping us better understand how you are feeling.

   Please select the amount you agree or disagree with each of the following statements

	1 = Strongly disagree	2 = Disagree	3 = Agree	4 = Strongly agree
People think mothers with psychological problems will harm their babies				
People think mothers with psychological problems will harm themselves				

People think mothers with psychological problems will kill themselves				
People think mothers with psychological problems don't love their babies				
People think mothers with psychological problems can't cope with their babies				
People think mothers with psychological problems are abnormal				
I worry that if I told a healthcare provider about my psychological problems, my baby would be taken away				
I worry that if I told a healthcare provider about my psychological problems, social services would get involved				
I worry that if I told a healthcare provider about my thoughts, they would think I am an abusive mother				
I do not want people to know I have psychological problems, as they may think I'm a bad mother				

RAND Barriers and Facilitators (Perceived Behaviour Control)

8. Please indicate the degree to which you agree with each statement.

	1 = not at all	*2 = a little bit*	*3 = somewhat*	*4 = quite a bit*	*5 = very much*
I would be taken less seriously if I had mental health problems.					
If I had mental health problems, I would not seek professional help because treatment does not work.					
If I had mental health problems, I would not seek treatment because it would take time away from my children.					
If had mental health problems, I would be uncomfortable seeking professional help because people might find out about it.					
If I had mental health problems, I would be judged by others within the military community					

If I had mental health problems, it would be viewed as a sign of personal failure.					
If I were suffering from mental health problems, I would feel responsible for my problems.					
I would not be respected if I talked about my worries, fears, and problems.					
If I sought mental health treatment, members of the military community would think I am not a resilient military spouse.					
If I were having mental health problems, I would feel that I was a burden on my family or friends.					
My partner's career would be negatively impacted if I sought mental health support.					
If I were having mental health problems, I would worry about my personal problems being part of my partner's military records.					
If I were getting help from a mental health provider, my peers would think less of me.					
If I were diagnosed with a mental health problem, I would feel stigmatised.					
If I had mental health problems, people would feel awkward and tense when around me.					
If I sought mental health support, I would be concerned that the support would be stopped or interrupted mid-treatment.					

9. Please indicate the degree to which you agree with each statement.

	1 = not at all	*2 = a little bit*	*3 = somewhat*	*4 = quite a bit*	*5 = very much*
It is possible for people with mental health problems to recover.					
If I had mental health problems, it would be easy for me to find the time to see a professional for those problems.					
People that I am close to would support me in seeking mental health treatment.					

If I had mental health problems, I would be comfortable talking about them with a counsellor or professional.					
If friends learned that I received treatment for mental health problems, they would be supportive and understanding.					
If I had mental health problems, my family would receive good support from the military.					

Help-seeking Intention

In the future, if you were having a personal or emotional problem during the perinatal period (i.e., during your pregnancy and within 24 months after giving birth), how likely is it that you would seek help from the following people? Please select the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

	1	*2*	*3*	*4*	*5*	*6*	*7*
Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de facto)							
Friend (not related to you)							
Parent							
Other relative/family member							
Mental health professional (e.g. psychologist, counsellor)							
Phone helpline (e.g. Samaritans)							
Doctor/GP							
Minister or religious leader (e.g. Priest, Rabbi, Chaplain)							
I would not seek help from anyone							
I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave blank) _____							

In the future, if you were experiencing suicidal thoughts during the perinatal period (i.e., during your pregnancy and within 24 months after giving birth), how likely is it that you would seek help from the following people? Please select the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

	1	2	3	4	5	6	7
Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de facto)							
Friend (not related to you)							
Parent							
Other relative/family member							
Mental health professional (e.g. psychologist, counsellor)							
Phone helpline (e.g. Samaritans)							
Doctor/GP							
Minister or religious leader (e.g. Priest, Rabbi, Chaplain)							
I would not seek help from anyone							
I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave blank) _____							

Social Support

Read each statement carefully. Indicate how you feel about each statement.

1 = Very Strongly Disagree **2** = Strongly Disagree **3** = Mildly Disagree **4** = Neutral **5** = Mildly Agree **6** = Strongly Agree **7** = Very Strongly Agree

	1	2	3	4	5	6	7
There is a special person who is around when I am in need.							
There is a special person with whom I can share my joys and sorrows.							
My family really tries to help me.							
I get the emotional help and support I need from my family.							
I have a special person who is a real source of comfort to me.							
My friends really try to help me.							
I can count on my friends when things go wrong.							
I can talk about my problems with my family.							

I have friends with whom I can share my joys and sorrows.							
There is a special person in my life who cares about my feelings.							
My family is willing to help me make decisions.							
I can talk about my problems with my friends.							

Clinical Measures

27. Depression, Anxiety and Stress

Please read each statement and tick the box which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

	0 = Did not apply to me at all	1 = Applied to me to some degree, or some of the time	2 = Applied to me to a considerable degree or a good part of time	3 = Applied to me very much or most of the time
I found it hard to wind down				
I was aware of dryness of my mouth				
I couldn't seem to experience any positive feeling at all				
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)				
I found it difficult to work up the initiative to do things				
I tended to over-react to situations				
I experienced trembling (e.g. in the hands)				
I felt that I was using a lot of nervous energy				
I was worried about situations in which I might panic and make a fool				

of myself				
I felt that I had nothing to look forward to				
I found myself getting agitated				
I found it difficult to relax				
I felt down-hearted and blue				
I was intolerant of anything that kept me from getting on with what I was doing				
I felt I was close to panic				
I was unable to become enthusiastic about anything				
I felt I wasn't worth much as a person				
I felt that I was rather touchy				
I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)				
I felt scared without any good reason				
I felt that life was meaningless				

28. Adjustment

Finding out you are pregnant and/or giving birth can be stressful. This can have numerous consequences for our wellbeing and behaviour. Below you will find various statements about reactions these events can trigger. The 'stressful situation' referred to is finding out you are pregnant and/or giving birth in the current perinatal period. Please tick the box to indicate how often the respective statement applies to you ("never" to "often").

	Never (1)	**Rarely (2)**	**Sometimes (3)**	**Often (4)**
I have to think about the stressful situation repeatedly.	☐	☐	☐	☐
I have to think about the stressful situation a lot and this is a great burden to me.	☐	☐	☐	☐

Since the stressful situation, I find it difficult to concentrate on certain things.	☐	☐	☐	☐
I constantly get memories of the stressful situation and can't do anything to stop them.	☐	☐	☐	☐
My thoughts often revolve around anything related to the stressful situation.	☐	☐	☐	☐
Since the stressful situation, I do not like going to work or carrying out the necessary tasks in everyday life.	☐	☐	☐	☐
Since the stressful situation, I can no longer sleep properly.	☐	☐	☐	☐
Overall, the stressful situation affected me strongly in my personal relationships, my leisure activities, or other important areas of life.	☐	☐	☐	☐

29. Psychotic-like experiences

Please indicate if you have had the following thoughts, feelings and experiences in the last month, by ticking true or false. If true, please rate the level of distress this caused you. **Do not include experiences while using alcohol, drugs or medications that were not prescribed to you.**

		If TRUE: how much distress did you experience?			
		0 - None	1 - Mild	2 - Moderate	3 - Severe
I feel uninterested in the things I used to enjoy.	☐True ☐False				
I often seem to live through events exactly as they happened before (déjà vu).	☐True ☐False				
I sometimes smell or taste things that other people can't smell or taste.	☐True ☐False				
I often hear unusual sounds like banging, clicking, hissing, clapping or ringing in my ears.	☐True ☐False				
I have been confused at times whether something I experienced was real or imaginary.	☐True ☐False				

When I look at a person, or look at myself in a mirror, I have seen the face change right before my eyes.	☐True ☐False				
I get extremely anxious when meeting people for the first time.	☐True ☐False				
I have seen things that other people apparently can't see.	☐True ☐False				
My thoughts are sometimes so strong that I can almost hear them.	☐True ☐False				
I sometimes see special meanings in advertisements, shop windows, or in the way things are arranged around me.	☐True ☐False				
Sometimes I have felt that I'm not in control of my own ideas or thoughts.	☐True ☐False				
Sometimes I feel suddenly distracted by distant sounds that I am not normally aware of.	☐True ☐False				
I have heard things other people can't hear like voices of people whispering or talking.	☐True ☐False				
I often feel that others have it in for me.	☐True ☐False				
I have had the sense that some person or force is around me, even though I could not see anyone.	☐True ☐False				
I feel that parts of my body have changed in some way, or that parts of my body are working differently than before.	☐True ☐False				

30. Post-traumatic stress disorder

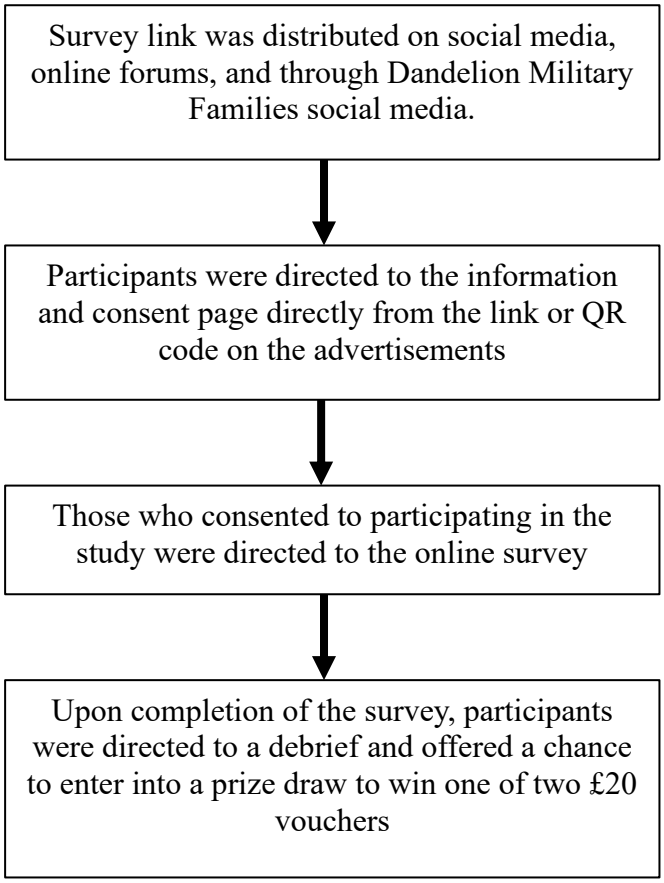
These questions are about problems and complaints that people sometimes have in response to stressful life experiences. Please indicate (by ticking the box) how much you have been bothered by each problem in the past month.

	1 - Not at all	2 - A little bit	3 - Moderately	4 - Quite a bit	5 - Extremely

Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
Feeling very upset when something reminded you of a stressful experience from the past?					
Avoided activities or situations because they reminded you of a stressful experience from the past?					
Feeling irritable or having angry outbursts?					
Difficulty concentrating?					
Feeling jumpy or easily startled?					

Thank you for completing the survey.

Appendix D. Procedure flowchart



Appendix E. Advertisement poster



Appendix F. Participant information sheet and consent form

PARTICIPANT INFORMATION STATEMENT

Titles: *Perinatal Mental Health in Military Spouses and Partners in the UK*

Main Researchers: Ashley Roberts and Emily Logan
Primary Supervisor: Dr. Joanne Hodgekins
Secondary Supervisors: Kiki Mastroyannopoulou and Dr. Jodie Finch

We are researchers at the University of East Anglia and would like to invite you to take part in this study investigating perinatal mental health in military spouses and partners. This study defines the perinatal period as the time from conception to 24 months postnatal.

The survey will take about 30 minutes to complete. You will be able to save your answers and return to the survey later if needed.

This study focuses on the challenges associated with being a military spouse or partner and how this influences perinatal mental health difficulties, and help-seeking for perinatal mental health in military spouses and partners. This study is being conducted as part of a Doctorate in Clinical Psychology qualification at the University of East Anglia and is funded by the NHS.

This information page is to help you decide if you would like to take part. Please read this page carefully. If there is anything that is not clear, or you would like to know more, please contact Ashley Roberts and Emily Logan via email at ashley.roberts@uea.ac.uk and e.logan@uea.ac.uk.

What is the study about?
The perinatal period can be a difficult time for mothers and can lead to mental health difficulties. Military spouses and partners experience unique circumstances and additional challenges that may impact on their mental health during the perinatal period. However, this is currently no research into the experiences of military spouses and partners in the perinatal period in the United Kingdom. To provide the most appropriate and person-centred care for military spouses and partners, we must first understand their experiences and what might help or hinder help-seeking.

Why am I being asked to take part?
You have been asked to take part in this study because you are a military spouse/partner associated with the British Armed Forces, aged over 18 years, and are currently in the perinatal period (pregnancy and up to 24 months postnatal).

Do I have to take part?
No, you do not have to take part in this study. If you decide that you do not wish to take part this will not affect your employment or legal rights in any way. Please close your browser.

What will the study involve?
If you decide to take part in the research, you will be taken directly to the survey at the end of this page. This will explore what military challenges you feel impact on your mental health, help-seeking behaviours, barriers and facilitators to accessing care, and your experience of mental health difficulties during the current perinatal period. Your answers will

help us to understand the experience of perinatal mental health difficulties in military spouses and partners, and the barriers and facilitators to accessing care for this.

What will happen if I decide not to continue with the study?
That is fine and it will not affect you in any way. If you wish to leave the study, please close the browser at any time and any incomplete responses to the survey will be destroyed. As the survey is anonymous, you will be unable to request withdrawal of your data after completion of the study.

What are the potential disadvantages of taking part?
Due to the nature of the research, some of the questions in this study may be distressing. The survey will ask about your experience of various mental health difficulties, which may involve asking you to think about difficult experiences or feelings. If you feel that this may cause you distress and do not wish to take part, please exit the browser.

What are the potential benefits of taking part?
There is no guaranteed benefit to participating in this study. By taking part in the study you will be helping us to understand the experiences of military spouses and partners in the perinatal period in the United Kingdom. This will help to inform care and support for this military families.

Will my data be kept confidentially?
All privacy laws and procedures will be followed during the study. Information collected from you during the study will be kept confidential and safe. Only members from the research team will have access to your data.

Electronic data will be stored on a secure Microsoft OneDrive shared between the lead researchers and supervisors. None of the information that you provide us will be attached to your name, and the results from the study will not be linked to any identifiable information. When the study has finished, your data will be stored anonymously within the University for at least 10 years for the purposes of future research.

If you decide to be entered into the prize draw at the end of the survey, you will be required to enter your email address. This will be stored separately from your survey responses, maintaining anonymity for your survey response. On completion of the prize draw, email addresses will be deleted.

Who has approved this study?
The project has been reviewed and approved through the [**]

What will happen to the results of the study?
The results from the study are likely to be published into an academic journal. Nobody who takes part in the study will be identifiable.

What if there is a problem?
If you have any concerns about any aspects of the research, you can contact any of the research supervisors Dr. Jodie Finch (jodie.finch@nsft.nhs.uk), Dr. Joanne Hodgekins (j.hodgekins@uea.ac.uk) or Kiki Mastroyannopoulou (K.Mastroyannopoulou@uea.ac.uk).

How do I find out more?

If you would like further information, please contact Trainee Clinical Psychologists Ashley Roberts and Emily Logan via email at ashley.roberts@uea.ac.uk and e.logan@uea.ac.uk.

What happens next?
If you decide to take part in the study, please read the consent statements below and tick the boxes to provide your consent to participate. On completion of these, you will be automatically taken to the study. If you do not wish to participate in the study, please close the browser.

Thank you for reading this information.

Please tick the boxes to confirm:

I have read and understood the information provided and have had the opportunity to ask questions.	☐
I understand that my taking part in this study is voluntary and that I can withdraw at any point during the survey, and it will not affect me. I understand that I will be unable to withdraw my data once I have completed the survey.	☐
I consent to the storage and processing of my personal information for the purposes of this and future research studies. I understand that such information will be treated as strictly confidential and handled in accordance with the Data Protection Act 1998.	☐
I give my consent to take part in the above study.	☐

Appendix G. Participant debrief sheet

DEBRIEF SHEET

Titles: *Perinatal Mental Health in Military Spouses and Partners in the UK*

Thank you for taking part in this study, we appreciate the time you have spent answering these questions. Your information will help us to understand the challenges associated with being a military spouse or partner and how this influences perinatal mental health difficulties, and the barriers and facilitators of help-seeking for perinatal mental health in military spouses and partners.

If you have any questions or concerns about the study, or you would like to receive a summary of the findings, please contact Ashley Roberts and Emily Logan via email at ashley.roberts@uea.ac.uk and e.logan@uea.ac.uk.

The results of the study may be shared as publications in academic journals, presentations at research conferences, and project reports for associated services and funders.

Some of the questions in this survey may have been difficult to think about or caused you distress. If this is the case, or you are struggling with your mental health, please see the below resources:

- Your GP
- Hub of Hope - https://hubofhope.co.uk/
- Samaritans - 116 123 https://www.samaritans.org/
- SHOUT - 85258
- Mind - https://www.mind.org.uk/information-support/
- The following link will take you to the NHS website and provides an extensive list of available support resources: https://www.nhs.uk/conditions/stress-anxiety-depression/mental-health-helplines/
- If you feel you need urgent mental health support or are in crisis you can call NHS 111 or follow the link below: https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/where-to-get-urgent-help-for-mental-health/

If you have any problems or complaints about the study, please contact any of the research supervisors, Dr. Jodie Finch (jodie.finch@nsft.nhs.uk), Dr. Joanne Hodgekins (j.hodgekins@uea.ac.uk) or Kiki Mastroyannopoulou (K.Mastroyannopoulou@uea.ac.uk).

Thank you again for taking the time to complete this research.

If you would like to be entered into the prize draw for one of the two £20 Amazon Vouchers, please follow the link below and enter your email address.
Email addresses will be stored securely in line with privacy laws and will not be linked to your survey response. Email addresses will be deleted after the prize draw is completed.
[Link]

Appendix H. UEA ethical approval

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

Study title: Perinatal Mental Health in Military Spouses and Partners in the UK

Application ID: ETH2425-0008

Dear Emily,

Your application was considered on 28th November 2024 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **30th December 2026**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Katie Chambers

Appendix I. MODREC written opinion

From: Pieter.Brown310@mod.gov.uk
Date: October 9, 2024 at 3:27:23 PM BST
To: "Ashley Roberts (MED - Postgraduate Researcher)" <Ashley.Roberts@uea.ac.uk>
Subject: 20241009-MODREC Query Q24-028

Dear Ashley,

A MODREC Sub-Committee has considered your query (numbered Q24-028) and because you state that serving military personnel will not be involved in the study, are content for this to be reviewed by the University ethics committee.

Please note, this advice is not binding and the responsibility for interpreting JSP536 and making the final decision as to whether a MODREC ethics review is required lies with the research Sponsor (i.e. whoever has final legal responsibility for the research, see JSP 536 Part 1 https://www.gov.uk/guidance/apply-for-ethical-approval-for-mod-research-involving-humans). What the Sponsor gains from a MODREC review is an independent ethics review, which can reassure the Sponsor (and anyone else who might enquire) that the research proposal is ethical. Critically, the MOD's No Fault Compensation Scheme will not apply if a MODREC review has not been undertaken. Therefore, the research Sponsor should take this into account when making the decision to undertake a MODREC review (or not).

Kind regards,

Piete

Ministry of Defence **Dr Piete Brown.** PhD. MSc. PGCE. BSc. **DST-MODREC Chief Secretary** | Defence Science and Technology | Dstl

Portsdown West | Fareham | PO17 6AD | Phone: 0300 153 5372 | Email: Pieter.Brown310@mod.gov.uk

Please send MODREC business to the Mulituser email account, DST-MODRECTeam@mod.gov.uk

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