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To understand why the DOD must address Postpartum Depression (PPD), one must look at these disorders and grasp their impacts on military families and military readiness. Maintaining the integrity of the family foundation is essential to ensuring the success and effectiveness of service members. Although the term "Postpartum Depression" (PPD) is often used, there is a wide spectrum of disorders which affect mothers and families both during pregnancy and postpartum, referred to as Perinatal Mood and Anxiety Disorder (PMAD). Understanding PPD and its impacts on the family environment, addressing current DOD healthcare treatment options, and overcoming different forms of stigma throughout pregnancy and the postpartum periods, will lead to providing recommendations to military leaders, ensuring not only a continued resilient force, but the well-being of our service members and their families.

**15. SUBJECT TERMS**

Postpartum Depression, PPD; Mental Health; Stigma; Perinatal Mood and Anxiety Disorder, PMAD

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MASTER OF MILITARY STUDIES

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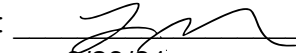
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## Executive Summary

**Title:** Postpartum Depression and the Impacts on the Joint Force

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**Thesis:** Postpartum Depression (PPD) affects up to 20% of newborn mothers and families across the Department of Defense.<sup>1</sup> The resulting stigma and education associated with mental health treatment is counterintuitive to establishing the family stability necessary to provide an effective combat force, thereby reducing readiness across the Joint Force.

**Discussion:** The DOD healthcare system is well equipped to treat service members and families coping with PPD. The significance of PPD treatment for both female and male military service members and educating leaders on PPD and its impacts on the Joint Force is relatively new and warrants further study. Current research indicates that many military members view family as the rock or foundation for a military service member, and the stability afforded in the household allows the military member to focus on his/her work life. Initial research shows the ranging severity of PPD, not only on the mother, but equally important, on the child and spouse. A growing family and newborn already induce changes and stress for a family, and a PPD diagnosis can further exacerbate stressors associated with childbirth and parenting. Further, anxiety and depression within the military often go unrecognized and are undertreated, likely because of the negative stigma associated with mental health in this population.<sup>2</sup> This study examines the impact that PPD can have on military families, therefore impacting readiness and effectiveness of the Joint Force. To ensure minimal impacts to force readiness and promote positive family and social support amongst the military community, it is necessary for leaders to be able to effectively screen, educate, and treat service members and their families who are coping with PPD.

**Conclusion:** DOD's current medical infrastructure is capable of diagnosing and treating PPD for military families. However, the most recent study on PPD cases and diagnoses within the DOD concluded in 2011. Due to the negative stigma associated with mental health disorders and treatment, especially among military service members, it is likely that PPD is under reported amongst active duty personnel and dependent spouses. Coupled with several recommendations for the medical field, the root of the solution lies with the military leadership and commanders who interact daily with the men and women who may be unknowingly managing PPD. Commanders have the ability to influence policies which may enhance screening, care, and treatment, while improving unit cohesiveness and welfare. To avoid disruption to military joint force readiness, commanders and supervisors must have a solid educational foundation on PPD, to include: screening, treatment, stigma, and the impacts on the family.

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<sup>1</sup> Do, Tai, Zheng Hu, Jean Otto, and Patricia Rohrbeck. 2013. "Depression and Suicidality During the Postpartum Period After First Time Deliveries, Active Component Service Women an Dependent Spouses, U.S. Armed Forces, 2007-2012."

<sup>2</sup> Appolino, Kathryn Kanzler, and Randy Fingerhut. 2008. "Postpartum Depression in a Military Sample." *Military Medicine*, November: 1085-1091.

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## **Preface**

I chose to write about PPD due to the preponderance of the disease across the DOD and the impacts it has had on close friends, colleagues, and subordinates throughout my career in the military. Additionally, I have seen first-hand the impacts to my family shortly following the birth of my two sons. Prior to children, I deeply felt I had mastered the work-life balance and after childbirth, the same feeling existed. With my wife's onset of PPD, the balance was thrown off and initially impacted my ability to be an effective service member. Initially, I was uncomfortable sharing my story with friends and co-workers. If my family and I were going through this problem, surely other families in the military are experiencing similar issues. This led me to opening up and discussing PPD with new mothers and families, but oftentimes, PPD was taboo and its affiliation with mental health treatment resulted in minimal discussion across leadership channels.

## **Acknowledgements**

I would also like to thank my advisor Dr. Lauren Mackenzie; my second reader, Ms. Victoria Grunberg; and the medical professionals across the DOD. Their time, support, and mentorship was invaluable to guiding me along this journey. Equally important, I would like to thank all the mothers and families who have taken the time to share their personal stories and struggles with PPD. This paper is dedicated to the families who are struggling with PPD with the hopes that they seek the help needed to overcome their internal and family battle with PPD. It is okay to reach out for help, the military and your leaders are here to help.

## Introduction

A *New York Times* article summed up the importance of the family, “The family is the nucleus of civilization and the basic social unit of society. Aristotle wrote that that family is nature’s established association for the supply of mankind’s everyday wants.”<sup>1</sup> Postpartum Depression (PPD) can disrupt these family dynamics and therefore lead to feelings of shame for women and their families as they cope with this unexpected stressor and its consequences. Within military families, this experience can be even more challenging as it can be especially stigmatizing and interfere with both family social networks and military readiness. Because of the significant impact that PPD can have on military families, it warrants further investigation. Although the term “Postpartum Depression” (PPD) is often used, there is a wide spectrum of disorders which affect mothers and families both during pregnancy and postpartum, referred to as Perinatal Mood and Anxiety Disorder (PMADs).<sup>2</sup> For the purposes of this paper, the term PPD will be used given that PPD is more prevalent in the current literature.

The life of a military wife and mother can be lonely at times. Picking up and transplanting a family and one’s way of life every two to three years can cause significant challenges. New friends, schools, jobs, and towns, coupled with increased separation from the comforts of a childhood home, is a way of life for military families. Unfortunately, these normal stressors associated with a military lifestyle can be exacerbated throughout a woman’s pregnancy. Oftentimes, the stigma of “happiness” portrayed on social media regarding childbirth and the postpartum experience combined with the negative stigma of receiving mental health care for military members and their families, can lead mothers to avoid seeking help for PPD and suffering unbeknownst to their family and friends. The online blog, *Her View From Home*, illustrates this struggle, which impacted a military family, “Not every new mother’s journey is

happy and bright. Sometimes it is dark, lonely, scary, miserable, and uncertain. The guilt that we self-impose and that society imposes on us is overwhelming. If our journey as a mother isn't daisies and butterflies, we feel alienated and ashamed.”<sup>3</sup> The author portrays the tragic story of her friend's inner struggle with PPD, resulting in a military spouse taking her own life, leaving behind a daughter and husband. This event is a microcosm of a larger problem, both inside and outside the military, affecting families throughout the world. The impact this incident had not only on a military family, but also on a service member's readiness was unmeasurable, requiring closer attention from military leaders. PPD diagnoses are equally prevalent within military families, and the various stigmas with treatment, government programs, and social media are potentially precluding families from seeking the necessary treatment.

In an attempt to better understand this problem, the current study draws from scholarly research and discussions with medical experts related to PPD, both inside and outside the military, to address the following research questions: 1) How do PPD diagnoses among the DOD population compare to the civilian population? 2) Within DOD, what are the protocols in place to treat mothers and families coping with PPD? Are current protocols effective in ensuring minimal impacts to force readiness and well-being among military service members and their families? 3) What can the DOD do to improve the treatment of PPD? Would an education campaign for our military leaders across all levels of the chain of command be a useful way to inform policies?

The remainder of this paper is designed to: define key terms, outline several of the causes and effects of PPD, and highlight the impact of PPD on the military family, and ultimately on force readiness. Postpartum Depression affects up to 20% of newborn mothers and families across the Department of Defense.<sup>4</sup> The resulting stigma and education associated with mental health treatment is counterintuitive to establishing the family stability necessary to provide an

effective combat force, potentially resulting in a decrease in force readiness across the military. If leaders are committed to working towards strengthening the family unit, they must first understand the prevalence and treatment options of PPD, as well as the stigma associated with mental health treatment, specifically PPD treatment. This will ensure not only a continued resilient force, but the well-being of the nation's service members and their families.

### **Importance of Family**

The well-being of military families is vital to the DOD in ensuring military readiness and mission execution. The National Academies of Sciences, Engineering, and Medicine outline three key elements pertaining to the importance of a service member's family.<sup>5</sup> First, the military healthcare system offers service members and their families an enticing benefit oftentimes not available to them outside the service, therefore providing an essential retention tool for continued service and retaining critical military experience. Second, an independent study group concluded that the family has powerful impacts on military readiness, morale, and motivation. Lastly, family difficulties detract from the service member's ability to focus on the mission and readiness.<sup>6</sup> A healthy and stable family household ensures service members continue to seamlessly train and deploy. The National Academies further concluded that conflicts between the military and family responsibilities are among the top three stressors of military life.<sup>7</sup> Postpartum Depression can have a detrimental impact on military families and negatively affect the readiness of the Joint Force.

The importance of the family bedrock is evident throughout the military. Rarely does a Change of Command occur in the military where both the incoming and outgoing commanders don't thank their families for their unwavering support. Oftentimes, these outgoing commanders emphasize the journey is a family process and much of the success is attributed to the family

foundation and support. These acknowledgments should serve as a message to all the leaders across the DOD that leaders should encourage and foster the well-being of individuals and families they lead to promote an effective and resilient force.

### **What Is Postpartum Depression (PPD)?**

Postpartum Depression (PPD) is a major depression disorder occurring within the first four weeks post-childbirth.<sup>8</sup> However, throughout clinical practice, a major depression disorder occurring within the first year of delivery is also considered PPD.<sup>9</sup> Signs of PPD vary but may include disturbances in sleep, energy level, and appetite, but these signs may also be normal behaviors associated with parenthood, making PPD diagnosis more difficult.<sup>10</sup> PPD symptoms can include crying more than usual, feelings of anger, withdrawals from loved ones, feeling numb, anxious, or disconnected from the baby, feeling guilt or incapable of being a good mother, irritability, and hopelessness.<sup>11</sup> The importance of receiving a proper diagnosis from a clinical physician is necessary to differentiate from normal signs of parenthood and PPD.

There are several risk factors that can lead to the emergence of PPD. A history of depression or anxiety, low marital satisfaction, domestic violence, lack of a social support system, and isolationism may increase susceptibility to PPD.<sup>12</sup> Additionally, PPD is associated with increased rates of suicidal ideation.<sup>13</sup> Few studies have been conducted on preventing PPD. Lewis and colleagues' (2018) noted that psychosocial treatments comprised of telephone based interventions coupled with exercise regimes may prevent PPD among women at risk.<sup>14</sup> Postpartum women coping with PPD have reported poorer social adjustment in the first three to six weeks following childbirth and poorer marital adjustment within the first nine weeks.<sup>15</sup> There are various stigmas associated with mental health treatment, and families suffering from PPD and military leaders must be cognizant these stigmas may exist, creating roadblocks to

treatment and recovery. Therefore, a military lifestyle coupled with these risk factors can exacerbate symptoms and their consequences.<sup>16</sup>

## **Stigma**

### **DOD Policy**

There are multiple stigmas that can affect a service member or his or her family's desire to seek help and treatment for mental health disorders, such as PPD. These negative stigmas are associated with mental disorders in the military, the Exceptional Family Military Program (EFMP), and social media usage. Oftentimes, medical treatment comes with a perceived notion that seeking help will negatively impact a military career, limiting advancement and promotion.

In order to combat the negative stigma associated with mental health disorders, DOD has released an instruction (DoDI 6490.08) to address command notification requirements to dispel the stigma often associated with providing mental health care to service members.<sup>17</sup> It is DOD policy to foster a culture of support for service members seeking voluntary treatment.

Additionally, healthcare providers shall not notify a service member's chain of command when the service member obtains mental health care or educational services. Healthcare workers are not required to notify a service member's commander unless they intend to harm themselves, harm others, harm the mission, part of a Personnel Reliability Program (PRP), enrolled in a substance abuse treatment program, or admitted into inpatient care. Furthermore, healthcare workers will only provide the minimum amount of information to the service member's commander. The information provided will be a diagnosis, impact on duty, duty limitations, and treatment. Most importantly, the healthcare official will provide a commander with "ways the command can support or assist the Service member's treatment."<sup>18</sup> DOD policy is for

commanders to reduce stigma “through positive regard for those who seek mental health assistance to restore and maintain their mission readiness, just as they would view someone seeking treatment for any other medical issue”.<sup>19</sup> The DOD Instruction provides direction to mental health professionals and military leaders ensuring there are no setbacks to service member’s careers, while also eliminating the negative perception and stigmas associated with treatment.

Half of women with perinatal mental illness, including PPD, fail to get the necessary professional treatment despite regular contact with healthcare professionals.<sup>20</sup> This is partially attributed to the stigma associated with mental illness, which can be a barrier to treatment and seeking necessary support. According to Moore and colleagues’ (2017) on online forum use, stigma is further divided into external and internal stigma. The external stigma is a negative attitude held by the general public, or the military in this case, towards the individual seeking treatment. The internal stigma results from the stigmatized individual succumbing to the external stigma; therefore, impacting their ability to seek out treatment for PPD and other mental disorders.<sup>21</sup> The negative outcomes of internal stigma can result in lowered self-esteem, lowered life satisfaction, and an avoidance of disclosure and help-seeking behavior.<sup>22</sup> Military leaders should encourage service members to seek treatment for their families who are suffering from the effects of PPD without the need for concern over the impacts treatment might have on one’s career. The DOD is making significant efforts to dispel the stigma for mental health treatment, but the fear of career setback can also exist due to the Exceptional Family Military Program (EFMP).

## **Exceptional Family Military Program (EFMP)**

The Exceptional Family Military Program is a mandatory enrollment program created by the DOD for family members with special medical or educational requirements. These special requirements imposed by the EFMP can limit service members and their families Permanent Change of Station (PCS) assignments. In 2008, the program discovered approximately 70% of Marines believed a negative stigma was associated with EFMP designation.<sup>23</sup> The negative stigma propagated due to idea that limited assignment opportunities could result in reduced potential for promotion and advancement.<sup>24</sup> There is a possibility for families, diagnosed and treated with the effects of PPD, to be enrolled in the EFMP, limiting future assignments. The DOD Instruction and EFMP exist to help families struggling with PPD, but the use of social media, both inside and outside of the military, may present significant roadblocks for treatment.

### **Social Media**

Social media presents a “Catch-22” when addressing the impacts it has on coping and seeking treatment for PPD. Undoubtedly, social media and the countless blogs available to expecting and new mothers provide ample resources and avenues to seek anonymous help for PPD. However, social media can also distort the reality of pregnancy, childbirth, and motherhood, which many families experience. The result of this false reality, often projected as a “highlight reel” focusing on and skewing positive aspects of motherhood, and stigma may preclude a mother and family in seeking the necessary treatment when combatting PPD.

Romper.com, a leading blog site for millennial moms, provides a voice for many mothers affected by the realities of social media stigma and a mother’s struggle for perfection. As one mother describes her experience with social media following childbirth, “as amazing as that is, there is a darker side to having the ability to ‘see inside’ other people’s lives in this way.”<sup>25</sup> She

further explains most images portrayed on social media “just aren’t real.” Many use social media to fuel their respective careers; therefore, they tend to potentially portray a false reality of motherhood. There is no allure to posting unfiltered photos of crying, colicky babies and sleep-deprived parents on social media. These photos surely exist on social media, but oftentimes, they are buried beneath the scenes of an unrealistic image of motherhood and perfection.<sup>26</sup> The author summarizes the negative stigma between postpartum and social media, “Next time you are scrolling through your feed and you stumble across a photo that makes you feel like the people in it have perfect lives or it makes you feel like you somehow aren’t good enough, remember: people only show you what they want you to see.”<sup>27</sup> The impacts social media can have on mothers and families can propagate the effects of PPD and hinder the ability for one to seek the necessary treatment. Social media coupled with the stigma of mental health disorders in the military can further exacerbate the isolation and lack of willingness to reach out for help.

### **PPD Screening**

Signs of symptoms that are reported or observed by close family members can be difficult to distinguish between normal behaviors associated with taking care of a newborn child (e.g., changes in sleep, appetite, fatigue). This can result in difficulty or delaying diagnosis of PPD.<sup>28</sup> The Edinburgh Postnatal Depression Scale (EPDS) is often used in primary care providers in screening and detecting PPD.<sup>29</sup> The questionnaire consists of ten items related to common PPD symptoms and requires patients to respond based on their past week’s experiences.<sup>30</sup> The answers are scored based on the emotional and cognitive symptoms of PPD and generate a score from 0 to 30, with a score of 13 or more indicating clinically significant depression.<sup>31</sup> Overall, the EPDS is accepted across the clinical community and has a solid reliability. Long and colleagues’ (2015) reported that screening rates are inconsistent and low

among healthcare professionals in the United States, with only 55% of healthcare professionals assessing for PPD.<sup>32</sup> In 2016, the US Preventive Service Task Force recommended that pediatricians screen mothers for PPD at the one, two, and four month visits. Additionally, all adults should be screened for depression and systems should be in place to ensure accurate diagnosis and treatment for depression.<sup>33</sup>

Within the DOD, medical records are maintained within the Defense Medical Surveillance System (DMSS). This system not only tracks various diagnoses of active component service women across all the military services but also their dependents, if enrolled in a Tricare health plan. Within DMSS, certain codes are associated with respective diagnoses. In the study of active component service women and dependent spouses, four codes were associated with a case of PPD: major depressive order, recurring major depressive order, depressive order not elsewhere classified, and mental disease postpartum complication.<sup>34</sup> Do and colleagues' (2012) study of mothers who gave birth for the first time yielded 5,267 (9.9%) active component service women and 10,301 (8.2%) dependent spouses were diagnosed with PPD. Overall, the percentages of PPD diagnoses were within the Center of Disease Control's (CDC) range for the general civilian population.<sup>35</sup>

Do and colleagues' (2012) further revealed additional risk factors among both the active component mothers and dependent spouses diagnosed with PPD. Both groups were at higher odds for suicidality compared to their counterparts not suffering from PPD. When compared to dependent spouses, service women were diagnosed with PPD at later stages in their postpartum period.<sup>36</sup> The study highlighted that this discrepancy can be attributed to some service women delaying care or treatment due to lack of knowledge about treatment or fear of reprisal, damage, or adverse impacts to their military careers.<sup>37</sup>

Active Duty members may be further hesitant to reveal emotional concerns or struggles with PPD due to occupational repercussions associated with negative mental health stigma. The unwillingness to disclose these disorders can be considered a risk factor in the military demographic and result in undiagnosed and untreated PPD disorders within the military work environment. Additionally, findings from Appolino and colleagues' (2008) revealed that parental stress associated with PPD may increase family-work conflict, further decreasing functioning and increasing depression.<sup>38</sup>

### **PPD Prevention & Treatment**

Understanding the underlying factors and symptoms contributing to PPD amongst Active Duty mothers can lead to effective prevention, treatment, and intervention. Coupled with the stigma of mental illness across the DOD, understanding risk factors can enhance awareness and in turn, improve screening of PPD. Early identification and treatment of PPD could improve quality of life and the quality of health care for military service members, while also improving work quality for the member diagnosed with PPD.<sup>39</sup>

There are several interventions and preventative treatment studied for women who show risk factors for PPD or have been diagnosed with PPD: psychotherapy through cognitive-behavioral therapy (CBT) or interpersonal therapy (IPT), other supportive interventions such as peer monitoring, prophylactic use of antidepressants, physical activity or alternative therapies, and a health system-level intervention.<sup>40</sup>

Cognitive-behavioral therapy (CBT) is a common type of psychotherapy, where one works with a mental health counselor or therapist in a structured environment. CBT helps patients become aware of negative thinking, to view difficult situations clearer, resulting in the ability to respond effectively.<sup>41</sup> Specific programs have been developed for perinatal women and

their children during the postpartum period. One such program is the *Mothers and Babies Program*, which consists of 8 to 17 group sessions during pregnancy and postpartum periods.<sup>42</sup> The program's goal is to help participants in creating a foundation of a healthy physical, social, and psychological environment for the patients and their infants.

Interpersonal Psychotherapy (IPT) is an evidence-based approach to treat mood disorders and used to improve upon interpersonal relationships and social functioning to assist in reducing stress.<sup>43</sup> There are many IPT programs, such as the *Reach Out, Stand Strong, Essentials* (ROSE) program, which uses interpersonal therapy techniques to treat disorders such as PPD. This program consisted of 4 to 6 sessions with a focus on developing a social support system, changes associated with role transitions, and interpersonal conflicts surrounding childbirth. O'Connor and colleagues' (2019 ) concluded these interventions may be effective in preventing PPD, but the study was limited to mothers with increased risk factors, such as a history of depression.<sup>44</sup> A 2013 review of these types of interventions to prevent PPD found women who received these types of treatments were 22% less likely to develop PPD when compared to those who received routine care.<sup>45</sup>

The use of antidepressants during pregnancy revealed mixed results due to the potential in developing adverse events. The use of these medications in pregnant people is complex, and very little evidence is available to determine its effect in preventing PPD.<sup>46</sup> However, antidepressant medication is the most common treatment method for PPD even though women say they prefer other treatment methods. Trials of antidepressants have shown the improvement of symptoms over an eight-to-twelve week period of treatment.<sup>47</sup>

Health system-level interventions, involving home-visiting services, were shown to be an effective tool in preventing PPD in settings outside the United States. These services are not

widely or routinely available in the US, but they show the potential to be effective if utilized in the US.<sup>48</sup> Additionally, there are several other health system-level intervention types in screening for PPD: education, electronic medical records (EMR) screening, and standardized patient exercises. Education screening incorporated material on PPD symptoms, detection tools, treatment options, and impacts on the family. Changes in screening electronic medical records (EMR) and the implementation of patient exercises showed positive receptivity among patients and providers. All three of the intervention methods yielded positive screening results and diagnosis of PPD.<sup>49</sup>

O'Hara and colleagues' (2013) suggested the use of social support as a treatment option for women with PPD, highlighting that these support persons do not have to be mental health professionals. Trials have used visiting health nurses, child health nurses, or case managers with bachelor's degree training. As discussed earlier, these treatment methods would be conducted in the comfort of the mother's home or choice of location.<sup>50</sup>

Unfortunately, there are roadblocks to treatment due to some mothers' hesitation and reluctance to attend medical appointments for fear of transmission of antidepressant medication to a breastfeeding infant. Over a 12-year period, O'Hara and colleagues' (2013) noted that incidences of depression or antidepressant prescription in the first year postpartum were nearly 14%, with slow declines to 6% and remained constant until the participants' children reached twelve years of age.<sup>51</sup> Additionally, women who developed signs of depression in the postpartum period were at increased susceptibility for developing future PPD, but they were not vulnerable to developing signs of depression outside the postpartum period.<sup>52</sup> These findings should be taken into consideration by the DOD as it considers their messaging and education campaigns to prevent, diagnose, and treat military families suffering from PPD.

### PPD in the DOD

In a 4-year study conducted among active component service women and dependent spouses, it was revealed 9.9% of active component service women and 8.2% dependent spouses received PPD diagnoses during the one-year period following childbirth. Of the cases of PPD, 0.4% service women and 0.2% dependent spouses were diagnosed with incident suicidality.<sup>53</sup> Service women diagnosed with PPD had 44.2 times the odds of receiving a diagnosis of suicidality compared to their peers without PPD, while dependent spouses with PPD had 14.5 times the odds of a suicidality diagnosis compared to those without PPD.<sup>54</sup>

When compared to the civilian population, active component service women and dependent spouses of active duty members may experience unique stressors associated with the military lifestyle and environment. Active component women may experience stressors, such as working longer hours during pregnancy, while also working longer into their pregnancy as compared to their civilian counterparts.<sup>55</sup> Additionally, active component women are susceptible to being selected for a deployment as early as six months post-childbirth. First-time mothers who deployed in the first six months after childbirth had a 37% higher incidence rate of mental health disorders than mothers whose deployment was much later post-childbirth.<sup>56</sup>

Deployments adversely impact dependent spouses of active duty service members as well. Spouses scored significantly higher on the EPDS scale when compared to spouses not coping with upcoming or current deployments. Additionally, in early pregnancy when the spouse was deployed, the proportion of women with high-risk depression was nearly double that of those with a spouse in garrison.<sup>57</sup> Dependent spouses face different challenges including an absent spouse due to deployments during pregnancy, childbirth, and/or postpartum. Deployments disrupt customary marital support systems resulting in higher vulnerability to

PPD.<sup>58</sup> Research has reported rates of PPD symptoms among active service women range from 11-20%, while the civilian population range is from 8-15%. Suicidal ideations, resulting from PPD, were found to be significantly higher in active component women (15.4%) compared to the civilian population (5.3%).<sup>59</sup>

### **Child Impact**

If only the male spouse suffers from PPD, studies show the mother reacts to her partner's depression with a compensatory attitude.<sup>60</sup> Additionally, studies show the negative impacts of paternal PPD can have on the child. Child behavioral difficulties can be associated with paternal depression and negative parenting. PPD coupled with the associated symptoms can negatively impact one's ability to parent.<sup>61</sup>

On the other hand, maternal PPD can impact parenting style.<sup>62</sup> Similar to the effects of major depression that occur at other times in a woman's life, PPD is challenging to cope with and can diminish a mother's ability to function effectively in many aspects of daily life. The significant difference in postpartum women is the increased responsibility for infant care, while coping with the effects of depression, which can interfere with parenting and thereby negatively impact the child, both near and long term. Studies have revealed that depressive symptoms have been associated with more difficulties in detecting affective cues, including infant cues.<sup>63</sup> The result can have a varying degree of consequences on the child's development resulting in increased stress on the family's stability.

The severity of depression experienced by mothers during the postpartum period has been associated with child behavioral problems. These behavioral problems have been shown to exist from early childhood through adolescence. Aside from child behavioral problems, PPD has shown to affect language and IQ development across childhood and adolescence.<sup>64</sup> Lastly, there

is evidence linking PPD to a decline in the child's physical health. If a mother were to disregard her caretaking behaviors, to include consistent breastfeeding and attending child well-visits, her infant's health may suffer as a result.<sup>65</sup>

Additionally, studies and literature indicate that women who suffer from depression and anxiety may display more difficulties in recognizing facial emotional expressions.<sup>66</sup> Mothers with PPD are less accurate in identifying happy infant faces and respond differently to sad faces, when compared to mothers not suffering from PPD.<sup>67</sup> In essence, mothers diagnosed with PPD may have difficulty interpreting the emotions from their child. PPD can result in increased negative bonding between a mother and child. Friedman and colleagues' (2016) indicated impaired bonding during the postpartum period is a significant factor in the relationship between symptoms of depression and the mother's more negative perception of her child's mood and temperament. Additionally, the severed bonding reduces the mother's ability to interpret her child's needs and emotions.<sup>68</sup> The impacts of PPD on the entire family taken together highlight the importance and necessity of identifying signs of PPD early in pregnancy.

### **PPD and the Male Partner and Impacts to the Joint Force Environment**

Maternal Depression has an influence on the behavior of the male partner which may impact the family dynamic and foundation. The resulting marital relationship coupled with the mother's PPD can have a negative impact on the child development and interactions with the outside world. Mothers who had stronger social support from their partners throughout pregnancy were shown to have lower distress postpartum, and as a result, their children were reported to be less distressed.<sup>69</sup> De Magistris and colleagues' (2013) further conclude that a relationship that is not "firm" (i.e., strong) before pregnancy, then it is very difficult to be strengthened postpartum.<sup>70</sup> For example, the physical appearance of the woman undergoes

significant changes during pregnancy, and these changes, oftentimes, need the support and reassurance of the partner. If the partner is unable to provide the support, the woman may struggle in accepting the changes in her shape and size, feeling embarrassed of her appearance. These changes potentially contribute to the onset of male PPD and shake the marital foundation.<sup>71</sup>

The news of pregnancy comes with a wave of emotions, from excitement to happiness to anxiety. Furthermore, De Magistris and colleagues' (2013) ascertain these emotions occurring in the early stages of pregnancy are more stressful for the male partner than the period following birth, and for male partners with a weak psychic equilibrium can be a factor for exposing underlying vulnerabilities.<sup>72</sup> The effects of pregnancy on the male partner can be further exacerbated by a military lifestyle and contribute to PPD and distress during pregnancy. Some gender-specific risk factors include: a weaker support network around the child's father as compared to the mother and a greater increase in responsibility in the workplace concerning the financial aspects resulting from a growing household.<sup>73</sup>

Studies conducted on expecting fathers during and post-pregnancy reveal results that can impact the military force and readiness. The results show during pregnancy, the male partners were more depressed and irritable, drank more alcohol, and had more negative sentiments.<sup>74</sup> Twenty percent of new fathers do not develop an immediate attachment to their newborn child, and the resulting anxiety of being unable to love their child can cause the fathers to undergo a crisis.<sup>75</sup> In the postpartum period, some fathers develop increased levels of nervousness, lack of concentration, fatigue, insomnia, and irritability.<sup>76</sup> If coupled with maternal PPD, the impacts and pressures on the male spouse are significantly greater when compared to a mother not suffering from PPD.

A depressed mother can result in the development of a father's protective behavior.<sup>77</sup> As time progresses, the father may be unable to sustain this behavior and may fear that the care for the child will be solely his responsibility due to the mother's struggle with PPD. If the father is able to cope with this additional responsibility of assuming a greater role of childcare successfully, the result may lead the mother to believe she is incapable of raising her child. Furthermore, the outcome could lead the father to blame the mother and thereby, creating a ferocious cycle of ineptitude and magnifying the depression for both parties.<sup>78</sup> Those impacted by this cycle may suffer from increased cases of addiction to drugs and alcohol, coupled with hypercriticism and violence. Furthermore, mothers afflicted with PPD tend to experience poorer dyadic adjustment resulting in less spousal satisfaction, approval, and support. The combination of these effects do not necessarily lead to separation amongst couples, but instead, these problems can aggravate the issues that existed between the couple prior to pregnancy. Very few studies have been conducted on PPD in men, but most agree "that partners of depressed mothers run a risk 2.5 times higher than controls of developing postpartum depression."<sup>79</sup> Living with a depressed mother can be difficult, and partners may feel less supported in their daily lives; oftentimes, the spouses experience fear, confusion, frustration, helplessness, anger, poor family stability, and the uncertainty in the future.<sup>80</sup>

PPD not only is a problem concerning the mother but also impacts the partner and child, which can negatively impact the family unity, and in turn, military readiness. The importance of providing a support network for our military mothers and spouses is imperative. The ability to take paternity leave strengthens the relationship between father and child, while providing support to the mother.

## **Summary**

DOD's current medical infrastructure is capable of diagnosing and treating PPD for military families. However, the most recent study on PPD cases and diagnoses within the DOD concluded in 2011. Due to the negative stigma associated with mental health disorders and treatment, a potential exists for an increased likelihood that PPD amongst active duty personnel and dependent spouses may be under reported. In order to overcome the negative stigmas and provide the necessary treatment to military families, it is essential that military leaders are equipped with PPD education and treatment options provided by the DOD healthcare system. The root of the solution lies with the military commanders who interact daily with the men and women who may be unknowingly suffering (or living with someone unknowingly suffering) from PPD. Education for military leaders may result and provide the enhanced awareness, resources, support, and treatment for those military members and families struggling with PPD. In order to sustain and not disrupt military joint force readiness, commanders and supervisors must have a solid foundational knowledge of PPD, screening, treatment, stigma, and the impacts on the family. Both clinical and leadership recommendations for the content of this educational intervention are outlined in the pages to follow.

## **Recommendations**

### **Screening, Education, and Treatment**

Across the DOD healthcare system, mothers typically only have one postpartum visit, around six weeks post-delivery and may not be seen by a provider again until their annual wellness check-up.<sup>81</sup> Long and colleagues' (2018) illustrated that screening rates for PPD across the United States are inconsistent and low, with only 55% of healthcare professionals assessing

for signs of PPD.<sup>82</sup> These numbers may not necessarily correspond to DOD practices, but they emphasize the limitations with regard to PPD assessment and referral to treatments.

The last DOD-wide study regarding PPD prevalence among active duty personnel and dependent spouses was completed in 2011. Do and colleagues' (2013) described how PPD is tracked throughout the DOD healthcare system.<sup>83</sup> The Defense Medical Surveillance System (DMSS) is a DOD system which stores both ambulatory and hospitalizations of active component members of the Armed Forces and their dependents, if enrolled in DOD Tricare health plans.<sup>84</sup> Researchers utilized the DMSS to gather the data and identify personnel diagnosed with PPD. Furthermore, they identified cases of PPD based on the following codes occurring within one year of childbirth: mental disorder-specific diagnoses indicative of single major depressive disorder, recurring major depressive disorder, unspecified episodic mood disorder, depressive disorder not elsewhere classified, and mental disease postpartum complication.<sup>85</sup> To effectively track and monitor the prevalence of PPD and the effectiveness of PPD treatment throughout the Joint Force, it is necessary to conduct routine analyses of cases throughout the DOD utilizing the inputs into DMSS across the DOD healthcare system. The DOD study highlighted the five disorders equating to a PPD case. It is recommended to standardize the DMSS inputs to a single code equating to PPD resulting in ease of tracking and monitoring across the DOD. Additionally, Appolonio and colleagues' (2008) generated information that may help identify families suffering from PPD, and it alludes to a potential disparity in treatment across DOD healthcare facilities. This disparity may lead to particularly high rates of undiagnosed and untreated cases of PPD throughout the DOD, resulting in the unnecessary suffering to mothers, families, and service members.<sup>86</sup> To accurately diagnose,

treat, and monitor PPD across the Joint Force, it is imperative the DOD standardize how diagnoses are inputted within the DMSS.

The importance of preventative treatment, including screening early and often is paramount, and the military healthcare system provides these opportunities for expectant mothers. Appolonio and colleagues' (2008) suggest screening all pregnant women before delivery and six weeks post-delivery, while allowing doctors and nurses to begin making the necessary referrals to behavioral health specialists.<sup>87</sup> Additionally, the importance of educating expectant mothers and families on the risk factors associated with PPD throughout a pregnancy may help healthcare providers effectively identify women at increased risk for PPD.

The period immediately following childbirth and prior to discharge from the hospital, presents an opportune time to provide psycho-education regarding PPD. Prior to discharge, some hospitals require the mother and spouse to watch educational videos on newborn behaviors. Hospitals across the DOD have an opportunity to show families an educational video detailing the information about the signs, symptoms, and effects of PPD. This video can also outline resources and treatment options available to families who may begin to show signs of PPD. Oftentimes, a spouse may not have had the opportunity to attend pregnancy appointments and screenings with their pregnant spouses. These videos may be the first time a spouse is exposed to PPD education. It is equally important for a spouse to be aware of and knowledgeable about the signs and symptoms of PPD. These videos should include information on the prevalence of PPD, signs and symptoms of PPD, impacts to the family, dispelling stigma with mental health treatment, and avenues for help. *Pacific Post Partum Support Society* and *KidCareCanada* have released a six-part informational video addressing the various aspects of PPD, to include stories of spouses also impacted from PPD ([Appendix A](#)).<sup>88</sup> Whether DOD produces their own

informational video or utilizes the media published by these organizations, the time spent in the hospital prior to discharge provides an exceptional opportunity to provide families this beneficial information on PPD.

Preventative treatment begins with military members knowing the risk factors and notifying healthcare professionals. Service members must set aside perceived stigmas associated with mental health treatment in the military and fear of work-related repercussions in order to receive the help necessary to treat this disorder. Prevention methods and early treatment not only reduces government costs resulting from lost work, but more importantly, prevents disruption to the family foundation required for service members to remain an effective and resilient component of the Joint Force. Individual knowledge of risk factors and healthcare professionals are part of the solution, and equally important, is the role military commanders and leaders have in ensuring suffering families receive the help that is needed to combat PPD.

### **Military Leaders**

In his book on leadership, John MacArthur illustrates the role of a leader which many commanders and leaders throughout the military should and do aspire to.

*A leader is not someone who is consumed with his/her own success and his/her own best interests. A true leader is someone who demonstrates to everyone around him/her that their interests are what most occupy his/her heart. A real leader will work hard to make everyone around him/her successful. His/her passion is to help make the people under his/her leadership flourish. That is why a true leader must have the heart of a servant.<sup>89</sup>*

This quotation illustrates the importance of leadership and providing for the men and women one leads. Not only should leaders develop their subordinates but also care for them. This includes the well-being of the individuals and by extension, their families. One way to do so, would be to ensure service members have time for their personal lives and provide them with the time needed

to strengthen their family foundation.<sup>90</sup> As mentioned earlier, a solid foundation and family stability affords service members the work-home balance necessary to be an effective warfighter. PPD has the potential to disrupt the work-home balance and impact unit cohesion and readiness on the Joint Force.

Military leaders and commanders possess the ability to create and foster an environment within their organizations to educate service members on PPD. All the service branches have their respective “preparation for command” courses to prepare commanders for potential leadership challenges. Similar courses and opportunities exist for senior enlisted leaders as well. Additionally and equally beneficial in combatting PPD, the services have established courses for “key spouses” of future commanders and senior enlisted leaders. Service commands can schedule a behavioral health professional to conduct presentations on mental health issues, including PPD, and the associated stigma. These platforms provide an exceptional opportunity to provide our leaders with a PPD educational foundation. With the knowledge gained at these courses, leaders will be able to return to their units aware of how to identify and address signs of PPD within their organizations. To create this environment, commanders must adhere to DoDI 6490.08, which addresses mental health treatment and stigma in the DOD, while fostering an environment of open dialogue on mental health treatment and awareness.

To increase awareness amongst the greater population of the Armed Services, DOD should publish a form of Computer-Based Training (CBT) available and easily accessible to service members. This CBT should not have a mandatory requirement for service members, but instead, the CBT can be utilized as an informational tool for military leaders and commanders to establish open communication with the men and women they lead regarding mental health disorders, including those during pregnancy and postpartum periods. Not only will this

demonstrate a military leader's understanding of the potential problems impacting families and the force but will also allow leaders an opportunity to dispel stigmas associated with mental health treatment in the DOD. A one page summary for PPD 101 is available in [Appendix B](#).

### **Policy**

In the last several years the DOD has adjusted the Parental Leave Program and each service has incorporated various changes to their respective policies. The Military Parental Leave Program includes non-chargeable leave following a qualifying birth event (QFE) or adoption (QFA) and includes: Maternity Convalescent Leave, Primary Caregiver Leave, and Secondary Caregiver Leave.<sup>91</sup> Maternity Convalescent Leave is authorized following a QFE, a birthparent suffering a miscarriage, or a baby is given up for adoption. The Primary Caregiver is designated as the parent with primary responsibility and is usually the parent who physically gives birth. The Secondary Caregiver is the parent not designated as primary and may be approved for an unmarried parent.<sup>92</sup>

The Departments of the Navy, Army, and Air Force have approved 42 days of non-chargeable leave under Maternity Convalescent Leave immediately following the birth event and discharge from the medical facility. Additionally, Primary Caregiver Leave of 42 days is authorized, can be used within one year of the birth event or adoption, and may be taken immediately following Maternity Convalescent Leave. Secondary Caregiver Leave differs amongst the services. The Army and Air Force have authorized 21 days of Secondary Caregiver Leave which may be used up to one year following a birth event or adoption.<sup>93</sup> On the other hand, the Department of the Navy has authorized 14 days of Secondary Caregiver Leave for members of the Navy and Marine Corps.<sup>94</sup> Current parental leave policies across all service

branches must be taken in a single increment and may not be broken up. Additionally, if the leaves are not used within the first year, all leave will be forfeited by the member.

Research has indicated that PPD may not occur immediately following childbirth and can develop up to a year following childbirth.<sup>95</sup> The inability to break apart both Primary and Secondary Caregiver Leaves is currently prohibited throughout each of the service branches. There is currently no data to support the rationale behind the current policy. Instead, the services should adjust the policy, allowing service members to use the leaves in incremental periods as necessary, ensuring families are able to receive the necessary support if parents were to be diagnosed with PPD later in the postpartum period. Additionally, the support provided to both the mother and child by the Secondary Caregiver is equally important for family stability. The Department of the Navy should extend the Secondary Caregiver Leave to 21 days.

### **Conclusion**

Postpartum Depression affects up to 20% of families across the DOD, potentially resulting in detrimental impacts to families, unit cohesion, and readiness.<sup>96</sup> Cases of PPD within the DOD closely resemble the prevalence of cases outside the military, but the potential of a higher prevalence exists due to undiagnosed cases throughout the DOD. To accurately assess the impact PPD has on the DOD, military leaders must ensure the stigmas associated with mental health treatment are discussed, addressed, and dispelled. To address these various stigmas, the DOD must employ an informational campaign across all ranks and services to educate leaders across all ranks. To provide the support and treatment to families suffering from PPD, it is imperative that DOD standardize their assessment methods to accurately identify PPD across the Joint Force. The DOD is well-suited and equipped to provide healthcare treatment for mothers and families suffering from PPD, and the solution lies with a service-wide informational

campaign and dispelling stigmas relating to mental health treatment in the Joint Force. The family foundation, support structure, and work-personal life balance must be maintained to preserve the integrity and readiness of the Joint Force; therefore, leaders should continue to prioritize the well-being of the men, women, and families, to include those suffering unknowingly from PPD.

## APPENDIX A

### **Postpartum Depression Educational Videos (KidCareCanada PPD Series)**<sup>97</sup>

1. Postpartum Depression: Not the Baby Blues
  - a. <http://postpartum.org/videos/video/postpartum-depression-baby-blues/>
2. New Mothers Need Support
  - a. <http://postpartum.org/videos/video/new-mothers-need-support/>
3. The Myth of Motherhood
  - a. <http://postpartum.org/videos/video/myth-motherhood-kidscarecanada-ppd-series/>
4. Treatments: An Introduction
  - a. <http://postpartum.org/videos/video/treatments-introduction-kidscarecanada-ppd-series/>
5. Group & Phone Support
  - a. <http://postpartum.org/videos/video/group-phone-support-kidscarecanada-ppd-series/>
6. Treatments: Self-care
  - a. <http://postpartum.org/videos/video/treatments-self-care-kidscarecanada-ppd-series/>
7. Allen's Journey (Male Spouse's Struggle with PPD)
  - a. <http://postpartum.org/videos/video/allens-journey/>

## APPENDIX B

### Leadership Guide to PPD 101

Postpartum Depression (PPD) is a major depression disorder occurring within the first four weeks post-childbirth. However, throughout clinical practice, a major depression disorder occurring within the first year of delivery is also considered PPD. Signs of PPD vary but may include disturbances in sleep, energy level, appetite, and libido. Studies have shown that nearly 20% of newborn mothers suffer from PPD.<sup>1</sup> Positive screens of PPD have associated with increased rates of suicidal ideations.<sup>2</sup>

1. Service members' families and home life provide the foundation and stability which the military and joint force rely upon. PPD not only affects mothers, but PPD can also impact the spouse and development of the child. To ensure the readiness of the force, it is essential maintain the integrity of the family's foundation.
2. Many stigmas in today's society and military complex which may preclude mothers from seeking the necessary treatment for PPD, including: social media, EFMP, and mental health disorder stigmas within the military. Leaders should be familiar with DoDI 6490.08 which addresses command notification requirements to dispel stigma in providing mental health treatment to service members.
3. The DOD healthcare system is well-equipped and staffed to provide the necessary treatment and support to families suffering from PPD. Leaders, including commanders, senior enlisted leaders, and key spouses should be familiar with treatment options in order to educate service members and their families on the avenues of PPD support.
4. PPD can be exacerbated by military service due to the negative stigmas associated with mental health treatment in the military. Leaders throughout all ranks should establish open communication channels with new mothers and families and discuss the available treatment options. The path to preserving the family foundation lies in an education campaign and the ability to detect the signs and symptoms of this disorder as early as possible. To remain an effective and cohesive unit free from disruptions in force readiness, DOD should be informed on PPD, dispelling stigmas, and effective assessments and treatment options for service members.

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