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RESEARCH

A Double Bind for the Ties that Bind: A Pilot Study of Mental Health Challenges among Female US Army Officers and Impact on Family Life

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Female military personnel, rising in both number and in rank, are key to the success of the US military. Currently 16% of active-duty enlisted personnel and 18% of all officers in the US military are women (Department of Defense 2018). Unique stressors for women in the military now include combat stress, the stress of a minority status, military sexual violence, divorce and parenting. Our aim was to investigate these issues related to professionalism, personal health and support networks among female military officers while they also develop and maintain a command presence. The results of our pilot with 73 female US Army Officers support generalized research with female military personnel which illustrate high self-reporting and diagnoses of stress, anxiety and depression (Haskell et al. 2010; Bean-Mayberry et al. 2011; Shekelle et al. 2011). Importantly, 65.7% of servicewomen in our sample self-reported feelings of stress, anxiety, and depression as a direct result of their leadership role in the military. When women were asked how their psychological condition impacts their family as a wife and/or mother (caregiver), they responded with comments such as low energy, less patience and family discord because of distinct roles in and out of the military. As a result of these dichotomous roles, some reported that they hid their distress from their families. These findings offer important insight for US veteran support services and highlight an under-researched set of health challenges experienced by US female military officers facing mental fatigue who simultaneously serve as a caregiver.

Keywords: military health; mental health; military personnel; military family; women's health; veterans

Background

Question:

"If, as a female military officer, you suffer from a mental health condition (such as anxiety, depression or PTSD), how do you feel this psychological condition impacts your family unit?"

Answer: Greatly.

"Military spouse" vs. servicewoman and spouse: Unseen and unrecognized challenges

With all US military occupations and specialty assignments now open to women, experiences in the military can be different for female personnel than for their male counterparts (Davis, Myers, and Bowling 2018; Pellerin 2015; Adams et al. 2016). More than 1.7 million US veterans and nearly 1 million active military personnel received treatment in a US Veteran Affairs (VA) or Military Treatment Facility mental health program in year 2018 (US Department of Veteran Affairs 2019b; Military Health System, 2019). Spouses of military personnel encounter unique difficulties related to caring for those with physiological and psychological distress. These challenges often include the management of the military member's often complex diagnoses (such as a Traumatic Brain Injury [TBI]), the military member's skepticism of treatment options, fear of repercussions in the workplace, and fear of medication side effects (Acosta et al. 2014). Managing outbursts, managing anger, change in attitude or mood, lack of sexual drive or intimacy, and feelings of personal insecurity are just a few of the issues observed by military spouses in their returned soldiers (Baptist et al. 2011; Blow et al. 2013; Wilcox et al. 2015). In addition to relational difficulties, military couples report increased levels of physical violence, intimate partner violence, and divorce (Negrusa and Negrusa 2014; Burgh et al. 2011; Marshall, Panuzio, and Taft 2005; Newby et al. 2005).

It is important to note that in the US, 92% of military spouses are women and the majority of these spouses are civilians (Department of Labor 2019). Only 12% of female military spouses are military personnel themselves, but

nearly half of all married female military members are in dual-military marriages (Department of Labor 2019). For those spouses who are female and military personnel, the policies and procedures affecting the responsibilities of wives and mothers are particularly challenging. When the military was primarily comprised of unmarried men, the military had an ethos of the "military family" that was comprised of loyalty, comradery and brotherhood (Holm 1992).

The military now has attempted to keep in step with its changing "family" in the face of societal changes to include provisions for mothers and childbirth that promote an inclusive and more family-friendly environment. Current US Army policy allows mothers six weeks of non-chargeable maternity convalescent leave, extendable if medical complications exist. The mother is entitled to an additional six weeks of primary caregiver leave. If both parents are active duty, one parent is entitled to six weeks of primary caregiver leave and the other is entitled to 21 days of secondary caregiver leave. These policies also apply to adoptions (Department of the Army 2019).

All female US Army personnel are given 180 days, starting from their delivery date, to recover from birth. Importantly, within these 180 days, they must train to take a required physical fitness test and must meet height and weight requirements without provision for normal challenges faced within the postpartum period, notably cesarean section or breastfeeding status (Department of the Army 2009). Following the 180-day postpartum period, women strive to reach a passing score on the physical fitness test, but many often find it difficult to achieve a similar pre-pregnancy score. This score is something they have worked hard for in order to be competitive for highly skilled jobs and hard-earned promotions, but may not be attainable this soon after childbirth.

Mothers in the military, however, can elect not to take these leave options, and some do. Concerns of being passed over for job promotion or fear that staying at home with children may negatively impact their careers is cited by many for early return (Russell-Kraft 2016). The status of officer is something female military personnel are proud of, and many mothers also seek to maintain a balance between work and family responsibilities. Although they miss their children if deployed, female military personnel are proud of their skill set and want to continue to use it (Gewirtz et al. 2014). These reasons were also clearly noted in our recent study. Indeed, many respondents discussed a need to "fight for" officer status in the military or a pressure to maintain their command presence within their units while acting as spouse and mother.

Focus on readjustment distress among female military personnel

Some studies have focused on female military personnel who have been deployed and aspects of readjustment and psychological distress. Such research is beginning to explore how women feel upon return and their behavioral coping (Hoge, Auchterlonie, and Milliken 2006; Mattocks et al. 2012). Noted in this research were marital problems, loss of friendships, and difficulty returning to daily routines (Mattocks et al. 2012, p. 543). Further work by Gerwirtz et al. (2014) and Haskell et al. (2010) examined the adjustment of both deployed and non-deployed mothers and female VA patients. Lara-Cinisomo et al. (2012) was one of the first to note the direct relationship between increased deployment months with poorer emotional well-being and relationship difficulty in female military caregivers. This new work importantly highlights a lack of attention in previous research on the link between caregiving tasks and well-being amongst female military personnel.

Female soldiers returning from deployment must undergo the same mental health screening as their male peers. At that time of the above studies, it was noted that no female-specific screening tools or services were mandated by the Department of Defense (Mattocks et al. 2012). Upon discharge from the military, soldiers transition to care under the Veterans Administration (VA). Only recently has the VA begun to recognize female military caregivers' return to home as an issue of medical importance (Department of Veteran Affairs 2019a). In addition to individual and family counseling, bereavement counseling, and health reassessment for mental distress (such as TBI), the VA provides its own series of specially designed mobile apps. These apps help female military personnel employ self-help and educational techniques for support following trauma (Department of Veteran Affairs 2019a). However, these services and innovations are only available to veterans discharged from the military, effectively excluding women who remain on active duty from these modes of support.

Wife and mother, shame and sacrifice

Academic discourses surrounding the role of wives and motherhood have moved away from traditional gender stereotypes to include feminist research that challenges functionalist ideas of gender roles as a core analytic concept. These new approaches reframe the focus on gender relationships as powerful components in the structure of changing families (for examples, Ferree 2010; Coltrane and Adams 2008; Bittman et al. 2003). In the context of a military family, however, with over 90% of military spouses being in traditional roles of civilian female military wives, the structure of the majority of military families in the US has remained largely unchanged and continues to be traditionally modeled. The emergence of the idea of a "warrior caste" in America, where families often have multiple generations of active duty and veteran members, has added to the entrenchment of traditional gender roles (Schafer 2017). These positions have historically been male dominated and put unusual pressure on female military personnel. While the words "wife" and "mother" continue to be paired culturally, the words of "active-duty military," "officer," and "combat" are still felt as unsettling concepts and are the focus of much debate in the US connected to female military personnel. As Thomas et al. (2017) discuss, women in the military

are more likely to face issues of discrimination and lack the social support within their units and feel a sense of isolation (Thomas et al. 2016; Kline et al. 2013).

Although "military moms" have caught the attention of the press and the American public (Mann 2008; Tamm 2019; Slater Tate 2018; Freeman 2019), our research wanted to reach beyond the more popularized news stories and blogs. We sought to explore issues related to the well-being of female soldiers in leadership roles with regard to psychological distress and peer support. Below we outline our methodology, then follow with a focused discussion of the quantitative and qualitative results regarding stress, anxiety and depression with respect to caring for oneself and caring for one's family simultaneously.

Methods

Study design

In response to the increasing awareness of the challenges faced by female military servicewomen and veterans, this research team sought to focus on mental, behavioral, and social health of female military officers in the United States Army. While previous attempts to survey female servicewomen have largely provided data on veteran populations, active duty personnel, particularly those in leadership positions, have not been adequately represented in many research reports. As the role of women in the military has shifted to include more senior leadership roles and opportunities for direct combat, the stressors and needs of the youngest generation of military servicewomen would understandably differ from previous cohorts.

To best understand the concerns and issues important to these women, we worked with two organically created, private support networks for female officers in the US Army on *Facebook*. Historically, many formal, military-supported networks and veteran support organizations, have low female membership and participation levels (Thomas et al. 2017). In the younger generation of servicewomen, informal, non-military social media has become an increasingly popular and powerful method of social networking, peer growth and female support. These online social support platforms connect an otherwise isolated minority population with each other to form a virtual community of supportive female servicewomen.

In August 2019, the research team assembled to develop a survey instrument that would accurately characterize the concerns and issues important to this population relating to their mental, behavioral, and social health. Of particular interest were the topics of peer support and behavioral health issues on the family unit given the added responsibilities *female* military members face as a spouse and/or mother while serving in the military. The finalized survey instrument and procedures for this study were submitted to the Ohio University Institutional Review Board for review. Full approval was granted for this inquiry (approval number 19-E-275) and formal research proceedings began in October 2019.

Measures

The pilot survey instrument created by the research team covered several broad topics including demographic/familial status, support networking/social media usage, military status, professionalism, command presence, and mental health. This survey instrument consisted of a maximum total of 75 questions that operated in a dichotomous fashion. Depending on the participant's response, additional follow-up questions would then be queried. A variety of multiple choice questions and free response text boxes were utilized to capture both quantitative and qualitative data points.

Dichotomous questions were employed to determine eligibility for question blocks. Once determined as applicable to the respondent, multiple choice questions were asked on a Likert scale, requiring the respondent to identify the degree to which she agreed or disagreed with the posed statement. Responses at either extreme of the scale were asked to further elaborate on the answer selected in a free response text box.

All respondents were asked a series of open-ended questions and provided the opportunity to respond with the amount of detail she felt most comfortable. These questions focused on support networking, service utilization, professional conduct, and the impact of career and mental health issues on their family unit.

Due to the nature of an anonymous survey, all questions regarding mental health were dependent on self-reporting by the respondent. Questions were specifically worded to indicate if the respondent had received a formal mental health diagnosis from a qualified healthcare provider. Other questions were formulated to gauge feelings of stress, anxiety, and depression experienced by the respondents *regardless* of formal diagnosis. As mental health conditions frequently go undiagnosed in the military population and particularly among female military personnel (Brunner et al. 2019; Wilson et al. 2019), it was important to the research team that these self-reported symptoms be captured by the survey instrument.

Procedures

Once the survey instrument was written, it was programmed on the Qualtrics (Provo, Utah, USA) survey management platform. The survey was distributed via secured online links and was optimized for mobile phone administration as well.

This survey was deployed over the course of three weeks (October 2nd through October 22nd, 2019). Links were distributed via a posting on two private *Facebook* groups exclusively for female US Army officers. These two groups were chosen due to their rigorous vetting process of applicants who request to join the group. Once an officer is added to one of the groups by a current member, administrators crosscheck their credentials against the current Army Global Human Resource Network, an official military database, to verify rank and status. Members are then asked to agree to the terms of the group and maintain the privacy agreement. In this way, the group preserves the integrity of its purpose,

along with the security required to ensure only the intended individuals are members. One of the research team members is a verified member of these two groups and distributed the survey link in these groups. In order to increase response rates, a second posting of the research announcement and survey link was issued ten days after the initial post.

Analysis

All survey data was collected in an anonymous manner to protect the identity of the participants and promote security in disclosing personal issues. The responses were collected and reviewed in aggregate via the QuatricsXM software platform. Any identifying information provided in the free-response questions was removed prior to data analysis. In addition to the security vetting provided by the group administrators, the survey instrument itself also contained internal validity measures. Any respondent who did not indicate female gender (inclusive of transgender individuals) or rank of officer was redirected to the end of the survey instrument and prohibited from attempting to complete or retake the survey.

To best understand trends and frequencies in the quantitative survey responses, a series of cross-tabulations was conducted. One-way frequencies were calculated automatically for each question in the survey as an exportable data report in Qualtrics. This data report was reviewed by the research team independently and then it was determined which factors would be included for contingency (two-way frequency) tables. The cross-tabulations are described below and include variations by relationship status, whether they had children of any kind (including adoption and step-children), military rank, and concerns on their mental health.

Qualitative responses also were included in this survey to provide clarity to responses on the extreme ends of quantitative scales and to garnish new information on topics not readily expressed in a multiple choice fashion. These responses proved invaluable to us and to the servicewomen, because they can express their concerns in a completely anonymous fashion. Qualitative survey responses were compiled by the Qualtrics software into a data report. Researchers reviewed this data and independently coded the responses using an inductive content analysis method to provide a systematic classification of current themes and patterns in the texts (Hsieh and Shannon 2005). The researchers compared their independent coding to determine a consensus regarding emergent themes. Codes that were repeated with greater frequency in the responses were given more weight in this analysis. Depending on the frequency and quantity of content provided, the researchers distilled each question to the two highest order themes reflective of the responses. The use of three independent coders was used to validate the quantification and characterization of the qualitative data.

Limitations discussion

It is worth noting the use of social media platforms for research is becoming more common for research sampling, particularly in healthcare (McKee 2013). Both patients and researchers are using platforms to discuss information shared within the groups. Such dialogue is also sparking the growth of "infodemiology" in public health to track the response of public concerns (Chew and Eysenbach 2010) and to possibly capture information on emerging disease trends before data becomes available (Chunara, Andrews, and Brownstein 2012; Greaves et al. 2013). However, this kind of monitoring can be silent, and possible use of data without informed consent rightly has come under scrutiny (McKee 2013; Martin 2012).

Important to note is that in our pilot, we distributed an approved, anonymized survey within two private groups for female officers. We considered these groups as they were described – private – and no data from private conversation between the female officers was used even though it may have fit our topic areas. In this way, our sample utilized convenience sampling protocols (Coleman 1958; Naderifar, Goli, and Ghaljaei 2017).

Other drawbacks include that as a pilot, this study surveyed a small portion of the population of US Army servicewomen. With that said, however, our small sampling was reflective of the make-up of rank representation of female officers in the US Army overall (see "Results" section). Also, this study only surveyed female officers in the US Army. The experiences of officers may differ from enlisted soldiers, and the experiences could vary by branch of the military. Although these characteristics add to the limitations of the study, we feel our cohort fits a category a rare and limited group cohort at this time. Our hope is that this pilot has yielded both informative and intimate responses that we may not have known unless we utilized such a platform.

Results

Quantitative data on mental and behavioral health

In total, 73 female US Army officers from across the United States completed our pilot survey. For purposes of this study, respondents were grouped and compared by familial status. Within the survey, respondents could identify their relationship status as: single, married, in a domestic partnership, divorced, or widowed. In this cohort, no respondents indicated that they were in a domestic partnership or widowed. Respondents could also indicate if they had any children or stepchildren that they provided care to; a group which represented 25 (34.2%) of respondents. Collectively, a separate group was created for the sake of analysis called "caregivers," which indicated a respondent as a mother and/or wife – essentially, responsible for providing some form of care to at least one other family member. Of completed responses, 48 (65.8%) met the caregiver criteria. Of note, there was one divorcee with children/stepchildren, and no women identified themselves as single mothers.

A summary table of demographic information for this cohort can be seen in **Table 1**. The average age of all respondents was 33.1 years old, with a significant difference between the mean ages of single and married respondents (27.3 vs 35.4, $p = <0.01$), single and mother/stepmothers

Table 1: Demographics of Survey Respondents by Familial Status.

Familial Status*	Single *n* (%)	Married *n* (%)	Divorced *n* (%)	Child/Stepchild (any marital status) *n* (%)	Caregiver *n* (%)	Total *n* (%)
Female	22(30.1)	47 (64.4)	4 (5.5)	25 (34.2)	48 (65.8)	73 (100)
Mean Age (Years)	27.3	35.4	38.0	40.7	35.7	33.1
Children/Stepchildren	–	47 (100)	1 (25.0)	48 (100)	25 (52.1)	48 (65.8)
Race/Ethnicity						
White	19 (86.4)	40 (85.1)	4 (100)	22 (88.0)	41 (85.4)	63 (86.3)
Black	–	2 (4.3)	1 (25.0)	2 (8.0)	3 (6.3)	3 (4.1)
Hispanic/Latina	2 (9.1)	1 (2.1)	–		1 (2.1)	3 (4.1)
Asian	1 (4.5)	3 (6.4)	–	1 (4.0)	3 (7.1)	4 (5.5)
NA/HI/PI	1 (4.5)	1 (2.1)	–	1 (4.0)	1 (2.1)	2 (2.7)
Other	–	1 (2.1)	–	1 (4.0)	1 (2.1)	1 (1.4)
Sexual Orientation						
Heterosexual	19 (86.4)	41 (87.2)	4 (100)	24 (96.0)	42 (87.5)	64 (87.7)
Homosexual	1 (4.5)	3 (6.4)	–	1 (4.0)	3 (7.1)	4 (5.5)
Bisexual	2 (9.1)	3 (6.4)	–	–	3 (7.1)	5 (6.8)

* Other selections for familial status included "in a domestic partnership" and "widowed", but were not selected by any respondents.

(27.3 vs 40.7, p = <0.01), and single and caregivers (27.3 vs 35.7, p = <0.01). The majority of respondents identified as White/Caucasian (63, 86.3%), followed by Asian (5.5%), Black/African American (4.1%), and Hispanic/Latina (4.1%). Similarly, a majority of respondents identified as heterosexual (87.7%), with a small minority identifying as homosexual (5.5%) or bisexual (6.8%).

This study included women from the US Army, US Army Reserves, and US Army National Guard. Of note, this survey was only circulated to military officers within the Commissioned Officer and Warrant Officer ranks. Significantly, our response rate is reflective of the overall distribution of female military officers across the ranks of the US Army (Defense Manpower Data Center 2019). The military history and statuses of respondents has been summarized in **Table 2**.

Of the survey respondents, 35 (47.9%) identified their military status as active duty Army, 17 (24.6%) as Army Reserves, and 11 (15.9%) as National Guard. Three respondents (4.3%) identified themselves as retired from the military. The Nursing Corps and Medical Corps represented the two largest military branches (23.2% and 21.7% respectively) in this study, with Military Intelligence and Adjutant General tied for the third most common branch (8.7% each). In this cohort, 60.9% have been deployed at least once on behalf of the US military, with 49.3% reporting one or more deployments to active conflict zones.

All participants were asked two distinct series of questions regarding their mental and behavioral health. Participants were asked to self-report feelings of undue stress, anxiety, or depression as a result of their military roles. The participants

Table 2: Military History of Respondents.

	N (%)
Current Military Status	
Active Duty Army	35 (47.9)
Army Reserves	17 (24.6)
National Guard	11 (15.9)
Active Status – Army Reserves/NG	2 (2.9)
Active Guard Reserve	1 (1.4)
Retired	3 (4.3)
Military Branch	
Nurse Corps	16 (23.2)
Medical Corps	15 (21.7)
Military Intelligence	6 (8.7)
Adjutant General	6 (8.7)
Logistics	5 (7.2)
Military Police	3 (4.3)
Other	18 (26.1)
Rank	
O1–O3	47 (68.1)
O4–O6	22 (31.9)
Ever deployed on behalf of US Military	42 (60.9)
Deployed to an active conflict zone	34 (49.3)

were then asked to indicate if they had received a formal mental health diagnosis from a licensed healthcare provider, and if so which diagnoses. As stated in the Methods section of this report, self-reporting data became a primary focus of this investigation due to the established research indicating mental health conditions frequently go undiagnosed and/or untreated among female military personnel. **Table 3** demonstrates the outcomes of these questions in all respondents.

Three questions were specifically designed to reflect self-reported feelings of stress, anxiety, and depression among these female officers. Designed on a 7-point Likert Scale, the respondents were asked to identify the degree to which they agreed with the following statements:

1) "I believe being a female Military Officer has contributed to feelings of undue stress";
2) "I believe being a female Military Officer has contributed to feelings of anxiety";
3) "I believe being a female Military Officer has contributed to feelings of depression."

Over four out of five respondents agreed that being a female officer contributed to feelings of stress and anxiety (86.6% and 83.6%), and 65.7% agreed that being a female military officer caused feelings of depression. Both **Table 4** and the **Figure 1** illustrate how the respondents answered the above three questions by caregiver status. As compared to their non-caregiving peers, caregivers were found to be more likely to strongly agree that being a female military Officer has contributed to self-reported feelings of stress, anxiety, and depression.

Amongst respondents, 41.8% reported being formally diagnosed with a mental health problem; most commonly anxiety (25.4%), depression (23.9%), post-traumatic stress disorder (PTSD – 16.4%), and traumatic brain injury (TBI – 7.4%). A total of 65.7% of all respondents agreed with the statement: "I have avoided seeking mental/behavioral health services due to my position in the military." Importantly, caregivers were more likely to report avoiding mental health services than their non-caregiving counterparts (68.9% vs 59.1%). As illustrated in **Figure 1**, the shades of blue coincide with percentages of respondents in agreement

Table 3: Mental Health Challenges Identified by All Respondents.

	Agree*	Neutral	Disagree*	Total
Self-Reported Feelings				
Stress	58 (86.6)	1 (1.5)	8 (11.9)	67 (100)
Anxiety	56 (83.6)	1 (1.5)	10 (14.9)	67 (100)
Depression	44 (65.7)	5 (7.5)	18 (26.9)	67 (100)
Formal Mental Health Diagnosis				28 (41.8)
Anxiety				17 (25.4)
Depression				16 (23.9)
PTSD				11 (16.4)
TBI				5 (7.4)
Other				4 (6.0)
Avoid Treatment	44 (65.7)	7 (10.4)	16 (23.9)	67 (100)

* Inclusive of Somewhat Disagree/Agree, Disagree/Agree, and Strongly Disagree/Agree.

Table 4: Self-Reported Feelings of Stress, Anxiety, and Depression, *n* (%).

	Stress		Anxiety		Depression	
	Caregiver	Non-CG	Caregiver	Non-CG	Caregiver	Non-CG
Strongly Disagree	1 (2.3)	–	1 (2.3)	–	2 (4.5)	2 (8.0)
Disagree	3 (6.8)	3 (12.0)	4 (9.1)	2 (8.0)	7 (15.9)	3 (12.0)
Somewhat Disagree	1 (2.3)	–	2 (4.5)	1 (4.0)	3 (6.8)	1 (4.0)
Neutral	1 (2.3)	–	1 (2.3)	–	3 (6.8)	2 (8.0)
Somewhat Agree	9 (20.5)	8 (32.0)	6 (13.6)	8 (32.0)	10 (22.7)	8 (32.0)
Agree	11 (25.0)	5 (20.0)	12 (27.3)	5 (20.0)	9 (20.5)	3 (12.0)
Strongly Agree	19 (43.2)	6 (24.0)	19 (42.3)	6 (24.0)	11 (25.0)	3 (12.0)

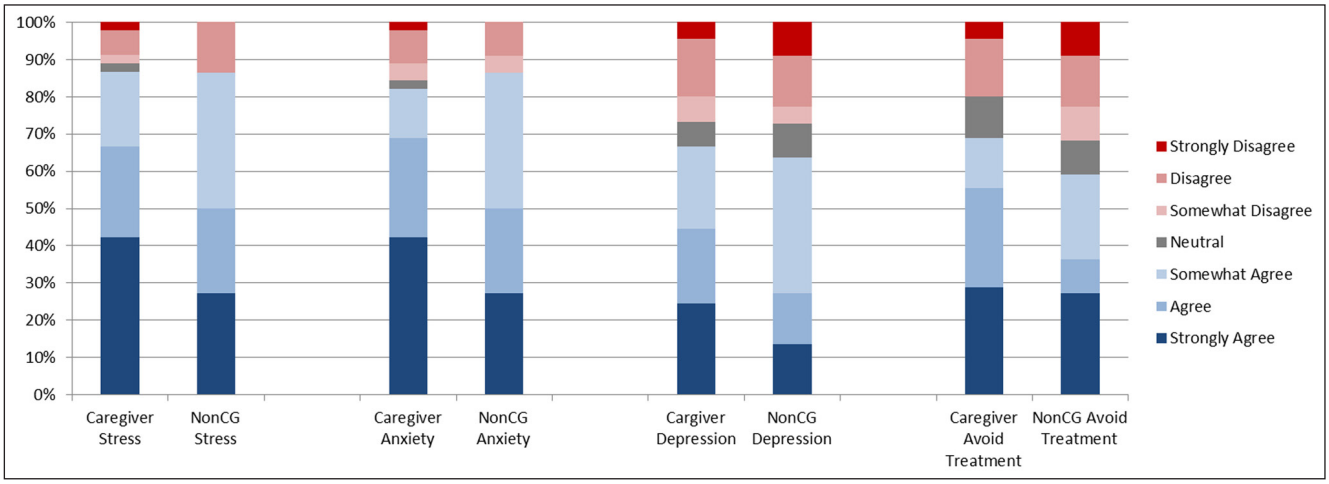

Figure 1: Self Reported Stress, Anxiety, Depression, and Treatment Avoidance – Caregiver vs Non-Cargiver (NonNC).

("somewhat agree", "agree," or "strongly agree") to the posed question. Many of the respondents highly identified with statements concerning self-reported stress, anxiety, depression, and treatment avoidance.

Qualitative data: Challenges as caregiver & efforts to hide that struggle

Out of 75 questions, 65 were exclusively quantitative and 10 had a qualitative component. The qualitative responses took free-text form for extrapolation on feelings about certain topics including mental health, family life and career challenges. The responses were instrumental and revealing, providing a closer look at the impact mental health and stress can have on the lives these female military officers. In total, 226 qualitative responses were analyzed. With 65.7% of our respondents self-reporting undue stress, anxiety or depression exacerbated by the role of military officer, and 31.1% of these respondents serving as wife and/or mother, specifics regarding the impacts on the family units was important to the research team. After an analysis of responses, two broad themes emerged; increased complexities of discord within the family unit, and an effort to hide that struggle.

Officers who were caregivers reported feelings of low energy, less patience, and increased family discord because of their dichotomous roles in command in the military and caregiving in the home. As a result of their roles, several respondents reported that they hid their personal distress from their family members.

Importantly, reports of negative interactions in the home environment were shared after asking the open ended question: "If, as a female military officer, you suffer from a mental health condition (such as, anxiety, depression, or PTSD) how do you feel this psychological condition impacts your family unit?" While studies can reflect prevalence of generalized anxiety, stress, and depression (Meadows et al. 2015), this type of reporting does little to get at how respondents *feel* when they are at home.

Overall, respondents noted feeing exhausted, frustrated, and having a "short fuse." Further illustrative responses regarding the effect of poor mental health on family life included:

> "It puts stress on us and my husband doesn't understand or know how to deal with it."

> "It does affect my family, and I cannot function when I get home due to headache and exhaustion."

> "Makes me irrationally angry with a relatively short fuse."

> "It negatively affects my children …most of the childcare still falls on me. Anxiety and depression impact my ability to care for my children because I have a shorter temper and less energy."

> "I have no energy at home…. all my energy is sucked up at work."

Hinting at continued isolation despite being with family, respondents also indicated that their struggles created a sense of isolation from their family members, even when not physically separated. For example, one respondent poignantly stated:

> "The condition takes you away from [my spouse and children]…"

One respondent noted that she feels her current familial situation is a direct result of traditional gender dynamics in the home that came from her officer training:

> "I lost my daughter. She went to live with her father. We divorced shortly after I finished Officer Candidate School. I believe that my identity as a wife and mother no longer fit with the officer I became and some members of my family couldn't accept that."

As mentioned above, caregivers were more likely to avoid mental health services than their non-caregiving counterparts (68.9% vs 59.1%). In the qualitative survey responses, a key source of concern became elucidated:

> "If I actually went to Army mental health providers I'd probably be diagnosed with anxiety/depression. I go off post to a therapist that I pay out of pocket for because the army keeps saying it won't affect your clearance. It will."

It is known that US military service members can mask or subdue reporting feelings of mental and behavioral insecurity (For example, Hoge et al. 2004; Holyfield 2015; Murray 2011) and that fear that stigma surrounding mental health can actively affect a serviceperson's career (Porter and Johnson 1994; Acosta et al. 2014). What does it mean if these additional pressures come into the realm of traditional spousal roles and motherhood? The most common solution reported was to hide symptoms from family members:

> "I keep it to myself as much as possible."

> "I know I suffer from anxiety and mild depression. My family has no idea. They believe I am the most cheerful enthusiastic one of us all."

Some respondents discuss briefly a conditioning in the process of subduing her feelings at home:

> "Over time, we are desensitized as we are expected to interact with peers as 'tough' and without [sic] emotion…."

Additional respondents also tapped into the juxtaposition of their professional and personal lives. These respondents discussed the need to hide one, many, or all aspects of their lives. Beyond hiding their mental health from their families, some officers hid their identity as a mother, wife, or caregiver from their professional colleagues. In fact, 67.2% of respondents agreed with the statement: "I have felt the need to hide an aspect of my personal or family life (in person or online) in order to maintain my image of command presence." Here, one respondent stated: "I've withheld that I had a young child in order to not be perceived as 'soft or 'motherlike' by my Soldiers." Such statements shared with us about the dichotomy of serving in a leadership role as well as a caregiving role are revealing. Below we discuss the need for further qualitative work in this area.

Discussion and Future Directions

Qualitative surveying of mental health stressors

It is becoming commonly known that military families face problems associated with extended time away from family members, and research suggests that military culture and its emphasis on emotional and mental toughness hinders US troops from getting the help they need to return to civilian life. Coupled with continued traditional roles in the military family and definitions of "military wife" being in majority associated with civilian females, female military personnel who are caregivers can become almost invisible. Add to this a necessity for a command presence in a highly and historically masculinized environment, these wives and mothers find themselves in a double bind where they must manage their homes and their families, as well as their soldiers.

The Health Related Behaviors Survey (HRBS), first distributed in 1980, assesses military health and readiness. This periodic survey has identified US Army personnel as having the highest perceived need for mental health services and highest use of these services compared to other branches (Meadows et al. 2015). In our pilot, however, only 26.2% of our Army respondents reported using mental health services (including psychologists, chaplain, self-help etc.). Despite need and perceived use of these services, mental health services among these Army servicewomen remain largely underutilized.

This pilot research has found that those who feel they suffer stress, anxiety and depression are less likely to seek help and more likely to hide their need. The implications of such discoveries are important. First, while important access to services for female service personnel and veterans has been gaining attention and important ground (Department of Veteran Affairs 2019a), responses in our pilot may show these measures are not enough. We believe that this survey has empowered us to try to obtain further qualitative interviews with women who are both military leaders and caregivers. The nuanced responses of everyday life can often be missed in larger, military/government-led quantitative surveys and our efforts have revealed that more personalized and qualitative work would be of immense value.

The growing role of female leadership in the military

Women in the military, mothers in the military, female military officers, all remain rare categories. However, albeit rare, these categories are growing. As noted above, our pilot reflected the makeup of the female population across officer ranks of the US Army. To be an officer in the US Army is challenging. Captain (O3) duty positions can vary widely but often serve at the level of Company Commander, in charge of 80–150 soldiers as well as all budget and equipment. Field Grade Officers (O4–O6) are unique not only for their rank, but for their experience and ability to perform in the competitive promotion structure. They are expected to have completed key leadership positions as junior officers, completed their civilian education to the level of a Master's degree, attend advanced training in their branch specialties while having completed the Command and General Staff College or an equivalent level course. Only then does she become a Field Grade Officer (Department of the Army 2014). These advanced officers are reflective of the modern experience of women in the military and are the forefront of leadership that today's junior enlisted soldiers see on a day to day basis.

As the face of military leadership begins to change, so do the challenges experienced by female officers. These challenges on the battlefront and the home front are a unique reflection of the dual burden society places on women in leadership positions, particularly within the military. While their male counterparts are praised for exhibiting strong leadership characteristics, women can be chastised for exhibiting the same characteristics in the field and at home. The repercussions of the moral injury sustained from this experience have lasting effects on the mental wellbeing and family lives of these female officers. In order to honor the great strides these women have made towards equality in the armed forces, military leadership must first recognize the struggles experienced by these women and their families. In much the same way the struggles of caregivers/spouses of military members are addressed by the military, official support networks, the VA, and veteran organizations, these organizations must put forth an equal emphasis on serving those individuals who are both services members and caregivers.

Conclusion

To our knowledge this was one of the very first studies to explore cultural, behavioral and mental health challenges among female military officers in the US Army. This investigation found that the dual burden of providing leadership on the battlefield and at home creates a distinctive experience for caregiving military servicewomen that has not be previously explored. The mental health challenges faced by female military officers often go under-reported and untreated. In addition to the exhaustion expressed as a result of stresses and demands at work, these women feel that they cannot share their experiences with their family members and must maintain a façade often at odds with their professional persona. This internal conflict has profound impact on mental health and their functioning as a part of a family unit. In this pilot we sought to describe and characterize these women's experiences, however, further research is needed to address and prevent these issues in the future generations of female US Army officers.

Competing Interests

The authors have no competing interests to declare.

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