Military Spouses' Perceptions of Suicide in the Military Spouse Community

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Newly released data from the U.S. Department of Defense shows military spouse suicide to be an imminent concern for the U.S. military. Currently, there is an absence of research in the counseling profession related to suicide prevention and intervention for this population. Therefore, this qualitative phenomenological study explored the perceptions of military spouses regarding suicide within their community. Ten military spouses were interviewed twice and were asked to provide written responses to follow-up questions. Six main themes emerged: (a) loss of control, (b) loss of identity, (c) fear of seeking mental health services, (d) difficulty accessing mental health services, (e) the military spouse community as a protective factor, and (f) desire for better communication about available mental health resources. Implications for practicing counselors and military leadership in helping to prevent military spouse suicide as well as recommendations for future research regarding ways to support military spouse mental health and prevent suicide in this community are included.

Keywords: military spouse, suicide, prevention, intervention, phenomenological

In 2018, there were 624,000 active-duty military spouses in the United States, 92% of whom were female (U.S. Department of Defense [DOD], 2018). Recent data also noted that the average age of a military spouse was 31.5 years and 88% of spouses had postsecondary education (U.S. Chamber of Commerce, 2017). Twenty-four percent of spouses were unemployed (DOD, 2018) and 35%–40% were underemployed (U.S. Chamber of Commerce, 2017). Further, 74% of military spouses had children under the age of 18 and often acted as single parents because of the responsibilities of the service member (Institute for Veterans and Military Families, 2016). And of particular note, the Substance Abuse and Mental Health Services Administration (SAMHSA; 2015) reported that 29.1% of military spouses have had a mental illness, with 11.8% having had at least one major depressive episode, and 6.5% having had a major depressive episode with severe impairment.

Military Lifestyle and Spousal Mental Health

Military spouses do not serve in combat as service members do, but they are subject to many stressors brought on by the military lifestyle that may affect their mental health (Cole, 2014). One of the primary stressors of the military lifestyle is frequent moving (Tong et al., 2018). Military families move every 2–3 years to a new location (Burke & Miller, 2016), which they may not have adequate time to prepare for, adding to the stress of the relocation process (Tong et al., 2018). Military spouses may feel isolated after moving, as 70% of military families live in civilian communities rather than in military housing (Blue Star Families, 2019). Although social support has been found to be key in ameliorating mental health issues in military spouses (Ross et al., 2020), this support is lost and must be rebuilt when the family moves to a new duty station.

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Because of these frequent moves, military spouses are often unable to build consistent careers or finish their education (Institute for Veterans and Military Families, 2016). Relocating spouses may experience difficulty finding a new job or utilizing their professional license or certification in their new home state or country (DOD, 2020b). As a result of these lifestyle challenges, 24% of military spouses are unemployed (DOD, 2018) and 77% of employed spouses have been underemployed at least once (Blue Star Families, 2019). These employment challenges often result in anxiety and depression among military spouses (Linn et al., 1985). In addition, the inability to find work may result in financial stress for the family and often affects spousal mental and behavioral health (Blue Star Families, 2019; Center for the Study of Traumatic Stress, 2020).

In addition to stressful relocations and career disruption, spouses also face frequent deployments of their partners (Allen et al., 2011). These deployments result in increased depression and anxiety in spouses (Baer, 2019; Eaton et al., 2008; O'Keefe, 2016), with 92% of spouses reporting increased stress during a deployment, and 85% reporting that they feel anxious or depressed during a deployment (Romo, 2019). This deployment stress may be amplified when the spouse lives overseas and is away from their friends and family in an unfamiliar culture (McNulty, 2003). When their service member is deployed, military spouses have to take on new roles and responsibilities in the home, which may contribute to these high stress levels (Eaton et al., 2008). In addition, they may live in constant fear for their service member's physical safety, as they are unable to contact their spouse regularly, or communication may be limited to social media with inherent limits to tone or context that prove to be anxiety-inducing (Allen et al., 2011; O'Keefe, 2016).

Military Spouses and Mental Health Treatment

Although military spouses are under constant stress in their everyday lives (Cole, 2012; Eaton et al., 2008; Mailey et al., 2018), they often resist seeking mental health treatment (Lewy et al., 2014). Past studies have revealed that spouses often do not seek therapy because they cannot locate a counselor they trust or who understands their culture, they are concerned that someone will find out they are seeking counseling, or they do not know where to find counseling services (Lewy et al., 2014). The stigma that military spouses fear regarding mental health treatment affecting their service member's career progression mirrors that of the active-duty service member population (Britt et al., 2015). In addition, the pressure that spouses feel to take care of their families without their service member's support and the sense that they must prioritize their families before themselves has led them to resist receiving mental health help for themselves (Mailey et al., 2018). When they do seek mental health services, spouses are likely to visit their primary care doctor at a military care facility; however, these facilities are not equipped to meet spouses' mental health needs because of lack of personnel and resources for specialized mental health services (Eaton et al., 2008; Lewy et al., 2014).

Military Spouses and Suicide

Although many of these studies have focused on risk factors and barriers for military spouse mental health treatment, no research has focused on the consequences of these barriers, including suicide in this population. Although much focus has been placed on researching service member and veteran suicide (Blosnich et al., 2010), statistics regarding military spouse suicide were recently tracked for the first time and released to the public in September 2019 (DOD, 2019). In 2018, 128 military spouses died by suicide, with a suicide rate of 12.1 deaths per 100,000 individuals (DOD, 2020a). Of those who committed suicide, 57.8% were female and 85.1% were under the age of 40. Given the alarming numbers of spousal suicide outlined in the DOD report, it is essential that pioneering research be done to investigate suicidality in the military spouse population. This study, therefore, explored the perceptions of military spouses related to suicide in this population by interviewing military spouses

themselves, who are the experts on the military spouse lifestyle and experience (Sargeant, 2012). The purpose of this study was not to focus on the experiences of spouses who have themselves attempted suicide, but rather how members of the military spouse population made meaning of suicide within their community. Thus, a qualitative phenomenological design was appropriate for exploring this meaning making (Christensen et al., 2017; Creswell & Poth, 2017). As experts on their own community and experiences, the participants provided perceptions that proved valuable in understanding the causes and risk factors associated with suicide in this population.

Purpose Statement and Research Questions

The purpose of this qualitative phenomenological study was to explore the perceptions of military spouses related to military spouse suicide and how these spouses made meaning of suicide within the military spouse community. Based on the perceptions and recommendations of the participants, this study makes suggestions to the civilian and military communities regarding best practices for preventing suicide in and providing mental health services for this population. This study was guided by the following research questions:

1. What are the perceptions of military spouses of suicide in the military spouse community?
2. What are the perceptions of military spouses regarding resources to prevent military spouse suicide?

Method

Our research team utilized the descriptive phenomenological tradition in qualitative inquiry, in which the researcher explores the participants' meaning-making experience and how they translate this experience into their consciousness (Christensen et al., 2017; Creswell & Poth, 2017). In order to gather information and perspective regarding suicide within the military spouse community, Rebekah F. Cole, our team's principal investigator, interviewed 10 spouses of active-duty service members, using a semi-structured interview, to explore their experiences in-depth and to understand how they make meaning of suicide within the military spouse community. A qualitative researcher does not aim to generalize but to draw out depth of insight from participants; hence, a small sample size was appropriate and justified with the aim of collecting a wealth of information from each participant (Creswell & Poth, 2017). Cole interviewed each spouse two times for approximately 30 minutes over the course of 4 weeks and then sent each participant an email with follow-up reflection questions (e.g., "What was it like for you to participate in this study?") and demographic questions regarding the participants' age group, gender, race/ethnicity, military branch, years as a spouse, and spouse's rank.

Participants

We selected the participants based on their status as active-duty spouses as well as their willingness and availability to participate in two interviews and complete the follow-up questions. We identified and recruited participants via purposeful sampling following approval by the IRB at our university (Creswell & Poth, 2017). Cole made a posting on a military spouse Facebook page explaining the nature and purpose of the study and asking for volunteers who were married to an active-duty service member. We offered each participant a $250 Target gift card to participate in the study, given to them upon completion of the two interviews and return of the emailed follow-up questions. We selected the first 10 volunteers who responded to the Facebook post as the 10 participants in this study. Once they showed interest in participating in the study, Cole contacted each participant via email to explain the nature and goals of the study and provide the participants with the informed consent document to sign and return.

The participants in this study were all spouses of active-duty service members (see Appendix A for a demographic chart). Three of the participants were Army spouses, three were Air Force spouses, three were Navy spouses, and one was a Coast Guard spouse. Two of the spouses were in the 18–29 age range, five were in the 30–39 age range, and three were in the 40–49 age range. The time spent as a spouse ranged from 1–20 years with a mean of 9.5 years. Eight of the spouses identified as White or having a European heritage and two of the spouses identified as having Asian or Pacific Islander heritage. All of the spouses identified as female. The participants were assigned numbers (Participant 1, Participant 2, etc.) to protect their confidentiality throughout the study.

Research Team

The research team in this study consisted of Cole and two school counseling graduate students, Hayley Dunn and Taryn Lincoln. These students had been trained in research methodology and were familiar with the qualitative data analysis process. Lincoln is a 35-year-old White female whose husband is a retired service member. Dunn is a 33-year-old White female with no military connections. Cole worked closely with Dunn and Lincoln to review the transcriptions of the interviews, develop a comprehensive codebook, and discuss the themes and patterns that emerged from the data.

Data Collection

Cole conducted and recorded the interviews via phone. She transcribed the interviews using an automated transcription service and reviewed each transcription word-by-word to verify the accuracy and reliability of the transcription (Creswell & Creswell, 2018; Creswell & Poth, 2017). In each interview, Cole asked questions related to suicide in the spouse population (see Appendix B). She also utilized probing follow-up questions (e.g., "Can you tell me more about that?" or "Why do you think that is?") to gather additional information throughout the interviews (Creswell & Creswell, 2018). Finally, Cole sent a follow-up email consisting of process questions related to the interview experience (see Appendix B) as well as demographic questions.

Data Analysis

We analyzed the data in a step-by-step process: 1) organizing the data, 2) looking over all of the data, 3) coding the data, 4) generating a description of themes, and 5) presenting the description of themes (Creswell & Creswell, 2018). Cole first organized the data, sorting each participant's file and memoing ideas that began to emerge from the data (Creswell & Creswell, 2018; Creswell & Poth, 2017). We then each reviewed the transcripts and email responses in detail. After reviewing the data, we coded the interviews and follow-up questions. Cole compiled the codes that we generated into a codebook. We then identified and defined themes and patterns that emerged from the study. This collaboration continued until we decided that no additional themes and patterns were emerging from the data. Cole then sent the codebook, as well as the themes and patterns, to the external auditor of the study, Rebecca G. Cowan, who confirmed the findings of the research team. Cole then wrote a detailed narrative of the themes, which are presented in the Findings section of this article.

Strategies to Increase Trustworthiness

In order to increase trustworthiness of the study, Cole, the key data collector in this study, engaged in reflexivity and self-analysis throughout the study (Creswell & Creswell, 2018; Darawsheh, 2014; Meyer & Willis, 2019). As a military spouse and professional counselor, Cole inherently has her own thoughts and feelings related to spousal mental health. Thus, it was important to bracket these thoughts and feelings to prevent them from interfering with the data collection and analysis process. Cole used reflective journaling throughout the study to engage in self-reflection and to increase her self-awareness of her reactions to the participants' perspectives (Malacrida, 2007; Meyer & Willis, 2019). She also

discussed these thoughts and feelings with the research team to explore her position as the researcher in the context of this study (Barrett et al., 2020).

In addition to this reflexivity, Cole kept an audit trail throughout the study, which included the transcriptions of the interviews, the participants' emailed responses, the codebook, reflexive journal entries, and the notes from the research team (Creswell & Creswell, 2018; Creswell & Poth, 2017). Cowan, an auditor with a PhD in counselor education who has been a counselor and counselor educator for the past 10 years, reviewed the study in full to verify the data collection and analysis process (Creswell & Creswell, 2018) as well as the rigor of the study (Patton, 2002).

To triangulate the study's data and increase the validity of the study's results, data were collected through two individual interviews as well as through an email questionnaire, both open-ended forms of data collection (Creswell & Creswell, 2018). Prolonged engagement assisted with the development of trust and rapport (Korstjens & Moser, 2018). Additionally, through the collection of both verbal and written data, the study's themes gained more credibility, as they emerged from both data sources (Creswell & Creswell, 2018).

Finally, we used member checking (Creswell & Creswell, 2018) to request the participants' feedback on the credibility of the data (Creswell & Poth, 2017). Member checking allows the study's participants to become actively involved in and make additions to the data review process (Birt et al., 2016). Cole emailed the participants transcriptions of their interviews and asked them to review and make any additions or changes they would like to the transcriptions, allowing them ownership of their thoughts and words and increasing the trustworthiness of the data (Birt et al., 2016). In addition, Cole discussed the findings of the study with the participants as the themes and patterns emerged (Shenton, 2004).

Results

The study's data yielded six main themes: (a) loss of control, (b) loss of identity, (c) fear of seeking mental health services, (d) difficulty accessing mental health services, (e) the military spouse community as a protective factor, and (f) desire for better communication about available mental health resources.

Theme 1: Loss of Control
Each of the 10 participants perceived their circumstances as a military spouse to be out of their control. For example, all of the participants mentioned deployments, especially those on short notice, to be a risk factor for suicide. One spouse described how her active-duty husband "might be home on Thursday and then he's gone the next day. He finds out on such short notice, that's really tricky, and a lot of my friends are constantly, you're just so constantly anxious all the time."

Four of the participants described how they fear for their spouse's safety during these deployments, which impacts their mental health. One spouse, for example, described how she lives "just constantly not knowing what's happening, but then being fearful for the significant other as well." Another spouse explained how spouses live with a "constant fear of whether or not your spouse will return." One participant discussed how military spouses are thus more prone to mental health issues:

> [T]he stress of your life and the stress you have over your spouse's military career, whether they're in danger or not, worrying about their mental health . . . probably aggravates all of the mental disorders that anyone could experience, but just magnifies them if you're a military spouse.

Participants also felt like they lacked control because of frequently relocating. All 10 participants described the stress involved with moving unpredictably. One spouse described how "you're always worried about what's coming next and what you can plan for and what you can't plan for." Another participant mirrored this same sentiment: "It's that 'Where are we going to be next? We just moved here, but I know in two years we're going to move again' type deal . . . always just kind of being on your toes and not knowing what to expect." Another spouse expressed similar thoughts: "I hope for the best but expect the worst, which is kind of sad, but that is the kind of mentality I've had to live by because of how unpredictable this lifestyle is."

As a result of these constant relocations, spouses are separated and isolated from family and friends, or their "network of support" in the words of one participant. All of the participants recognized the risk of losing this support with regard to their mental health. One spouse, for example, explained the danger of not having "long-standing relationships where you could say like, 'Wow that person really seems like they're going through something.'"

Theme 2: Loss of Identity

All 10 participants struggled with a loss of their identity, especially regarding their careers. Many participants described how career struggles and finding purpose are related to spousal mental health. One spouse explained how "not having that career is part of the anxiety and depression. And not having a purpose in life." Another spouse described the struggle to maintain a career: "Eventually, it kind of weighs on you and eventually your mind can play tricks on you and you feel like you're not worthy." One participant summed up these career struggles in these words: "Part of being a military spouse is sacrificing your own life . . . there's a lot of hurt and loneliness and sacrifice."

In addition to this struggle for career identity and purpose, five of the participants described how the military fails to recognize their value. One spouse described how spousal suicide "is definitely brushed under the rug because people are kind of like, 'You're not going to war, you're not doing any of these things.'" Another participant described her own experiences: "We've had situations where wives were struggling, but . . . he couldn't get off that day, he had to report in because she's not at the hospital . . . it's not serious." Another explained how "the military in general, they're so focused on their job that they kind of forget that we're all humans and that we are people." One participant said that "spouses get beat down and they just kind of feel like there's the whole 'If the military wanted you to have a family, they would have issued you one.'"

The participants also described the military spouse's tendency to prioritize family and the military over oneself and the impact of this inclination on spouses' mental health. "So much of the burden of the family falls onto the military spouse, I think it's easy for the spouse to not consider their own mental health a priority, and therefore the risk factors may go undetected or untreated." Another described how spouses "go through this constant cycle that's always churning. You move to a new place, you try to get settled . . . then we hit the point of going, 'Ok, now what about me?' If we ever get to that point." One spouse described that after each of the moves and deployments, "I feel like we lose a sense of ourselves too . . . it's like having a new baby all of the time. . . . You kind of reach a point where you're like, 'Where am I? What the heck am I doing?'"

As a result of prioritizing family and the military over themselves, spouses feel unworthy of receiving mental health services and feel guilty for suffering, as described by eight of the participants. One spouse explained that "spouses can feel weak or feel like they're not holding up their end of the bargain if they get help." Another participant noted that spouses "consider themselves less worthy of

getting treatment or that their problems [are] not as important." Finally, a spouse explained that there is a "weird mentality, I think, in the military spouse community, where you don't complain because someone else has it worse. . . . If you're an Air Force spouse, maybe the Army deployments are longer, so you just don't want to complain."

Theme 3: Fear of Seeking Mental Health Services

Despite these challenges that military spouses face, eight of the participants described a fear of seeking out mental health services. Five of the participants, for example, said that spouses fear appearing to be unstable or, as one spouse described, a "fear of being ostracized, or the fear of having people talk behind your back, or embarrassment." One spouse explained how mental health issues are viewed as, "Oh, she was a crazy spouse. Oh, she got everything that she needed . . . so she was just kind of crazy." Another participant described how a spouse was viewed after verbalizing her mental health struggles: "I've been told by other spouses not to go hang out with her in group settings because she's batshit crazy." One spouse noted that "there's still that stigma of reaching out and being known to have the mental health issue." Finally, spouses may fear being honest with their medical providers for this same reason. One participant described her own perception of this fear of being transparent with the doctor regarding a suicidal assessment: "If you answer it honestly, sometimes you're like 'They're going to put me in a padded room if I really tell you what my last 2 weeks has been like.'"

In addition to appearing unstable, seven of the participants described how military spouses fear that seeking mental health services would negatively impact or bring "backlash" on their service member's career. One participant noted: "People keep it quiet because they don't want their spouse, their military member, to not get promoted or not get more responsibility and stuff like that because they're not keeping it together." Another participant stated that often "you run into people who are kind of skittish about going just because of the stigma." She further explained that "you don't want to hurt your husband's career, and that's what you've heard for a long time. He looks like he can't handle the situations at home.'"

Theme 4: Difficulty Accessing Mental Health Services

Spouses who do decide to seek help for their mental health may experience difficulties in securing an appointment, as described by six of the participants in this study. Each of these spouses expressed difficulties with finding a mental health provider in the community or accessing mental health treatment at a military facility. One participant explained that "the reality is they can't guarantee that the local community and local providers will be able to provide everything we need when we need it." Another spouse expressed frustration that "TRICARE can sometimes be a pain when you're trying to schedule something, and it will make you schedule at 6 weeks out because that's the first available." One participant described her experience with trying to find a counselor covered by TRICARE. She stated, "You hope that you get an appointment and hope you can jive with whoever you called because you may have to wait another month or two to try to find someone else." Three spouses in the study also expressed concern about the consistency of care due to frequent relocations. One participant explained the need to streamline mental health services at each duty station "so that if [spouses] are seeing a psychiatrist in one place and they go to the next place, they're not waiting for 2 or 3 months before they can get in to see a new psychiatrist."

Five of the study's participants also expressed concern over not having access to a mental health specialist. For example, one spouse shared that "the person I did see, who was a social worker, I just don't feel was very equipped to talk to me about the things I wanted to talk about." Another spouse described her perception of military family life consultants' work with spouses on military bases:

They just kind of give them the same spiel, like you should exercise, make sure you're eating well, getting enough sleep, instead of saying, "You know what? This is outside of the realm of what I can handle, let's get you in to the type of professional that you need."

Theme 5: The Military Spouse Community as a Protective Factor

In the midst of these mental health challenges and difficulty seeking and accessing mental health services, seven of the participants described the military spouse community as a protective factor against suicidal ideation. As one participant explained, "Anyone can try to take their own life, but if they have people around them who are looking out for them, who are with them physically and emotionally, it's harder to do." In addition, one participant pointed out that the spouse community can offer a sense of shared understanding: "Someone else probably very close by has gone through the same thing that you have . . . and you're not the first person to go through this and someone might be able to help lighten your load." The participants emphasized the need to create "a friendly, inclusive environment where spouses can network and establish relationships" as well as establish a "connection and feeling of belonging." One participant noted that within this environment and community, it is important to normalize conversations about mental health in order to decrease the stigma attached to it. "Letting people see that while we might post pretty pictures on Facebook and someone looks all together when they're at that unit function, we've all had to reach out for help, and looking at that as being strong."

To increase this protective factor as a community, six spouses described the importance of training for spouses geared toward suicide prevention so they could recognize the signs of suicide in others. One spouse said that training in "prevention measures of how to spot suicide, signs of suicide, or who to talk to, where to go, what to say" would be helpful "because spouses are probably already witnessing all of these signs in their homes or in their neighbors or in their friend groups of depression and suicidality." Another participant described how "spouses could be looking out for friends, if they know some warning signs or give friends resources to go to so their friend could find it if they need help."

Theme 6: Desire for Better Communication About Available Mental Health Resources

Each of the 10 participants expressed the need for the military to communicate more with them about mental health resources. One spouse, for example, pointed out that such "information needs to be put out there clearly at military hospitals, on military bases. . . . So I think the military could make it more clear, destigmatize it, and just make the programs more widely available and advertised." In this proposed advertisement, the spouses would want to know "what kind of help we can get, what it costs, where we can get help, and will it matter to our spouse's career?"

In addition to this suggested advertising, six of the participants said they would like the military leadership to communicate with them directly regarding available mental health resources specifically designed for spouses. One participant described how "it's harder for the spouse to get that information . . . if they had information sent directly to them, I think they would be more willing to seek it out and use those resources." Another spouse noted that "military spouses need to be presented with the resources available for their mental health directly instead of solely relying on the service member to relay the information." As a result of receiving this information on resources available specifically for them, one participant explained that "the military spouse wouldn't have to consider themselves less worthy of getting treatment or that their problems [were] not as important."

Finally, six of the spouses suggested that the check-in process for each duty station could be a key opportunity to provide spouses with resources and preventative services. One spouse noted: "I think

that when you move somewhere new there should be someone checking to make sure you're okay and you're not alone all the time. I think it's the military's responsibility to make sure there's a process in place." Another spouse proposed this check-in process as being "part of the standard procedure to make sure the spouse maybe is brought in and made aware of all of the programs that are available to them."

Discussion

In this study, all of the military spouse participants described how spouses' loss of control and loss of identity may contribute to their increased risk for suicide. These feelings resulted from continually moving to new duty stations (often unexpectedly), being isolated and separated from their support systems, fearing for their spouse's safety during deployments, and struggling to maintain a sense of self and a career while making their families and the military their priority. Although they were committed to prioritizing the military lifestyle and their spouses' career, these spouses did not feel that their needs were prioritized by the military in turn.

Each of these challenges for military spouses has been previously addressed in the professional literature (Eaton et al., 2008; Lewy et al., 2014; Mailey et al., 2018), although their direct correlation to suicidality has not yet been explored. Because increased levels of suicidality have been found in other populations when social isolation increases (Calati et al., 2019; Heuser & Howe, 2019; Pompili et al., 2007) or stressful life transitions or events occur (Oquendo et al., 2014; Paul, 2018), it is important to continue to consider how these risk factors impact military spouses' suicidality.

Most of the participants likewise described the tendency of spouses to feel guilty for suffering, as they are not the ones on the battlefield, a new phenomenon not yet explored in the professional literature. One participant concluded that these feelings of guilt may lead to spouses feeling they are unworthy of using mental health resources intended for active-duty service members. To address these feelings of guilt, one spouse described the need to normalize the conversation about mental health among spouses, which would ameliorate these feelings of unworthiness and increase spouses' use of resources. Finally, all of the participants felt that provision and advertisement of mental health and suicide prevention programs and services specifically for spouses would help them feel more confident in utilizing these services.

When speaking about risk factors associated with suicide, most spouses described their fears of the stigma associated with accessing mental health services and the struggles associated with finding mental health providers qualified to help them when they did decide to seek help. These fears and struggles directly correspond to results in past quantitative and mixed-methods research regarding barriers to treating military spouse mental health (Eaton et al., 2008; Lewy et al., 2014). The participants in this study likewise described their frustration with not being able to get an appointment with military or community providers. These struggles echo the results of previous research describing the challenges of spouses to access mental health services (Lewy et al., 2014), highlighting the consistency of this issue.

Although the participants' struggles with mental health and mental health providers confirm the findings of existing studies, their suggestions for preventing suicide within the military spouse community are new ideas generated from this study. Primarily, the participants focused on the community itself as a protective factor against suicide. They described how building a strong spousal community prevents feelings of isolation, as spouses can care for each other because they share common experiences of the military lifestyle. This sense of connection is especially important, as spouses are separated from their support systems when relocating from one duty station to the

next (Ross et al., 2020). In order to strengthen the protective factor of their community, the spouses discussed how they wanted more training from military leadership in the areas of suicide prevention and intervention so that they can help others around them. Interestingly, contradictory themes arose in this study's findings regarding the spouse community shunning those who were struggling with mental health issues and the spouse community serving as a much-needed protective factor. Perhaps the participants' suggestions of focusing on normalizing mental health support within their community would help to reduce the current tendency to shun and would increase the tendency to support.

In addition to focusing on increasing the protective factor of the spouse community itself, all of the participants stated that they desired increased communication from the military regarding mental health services and programs available specifically to them. Some of the spouses suggested that a direct line of communication from military leadership to spouses would be helpful for finding out about mental health resources available to them, as well as to their spouses. This communication would involve more strategic and widely spread advertising about suicide prevention resources and mental health services in places that spouses often frequent, such as military hospitals or on-base/on-post facilities.

Finally, several spouses suggested an innovative, structured check-in process at each duty station that would promote spousal awareness and understanding of the resources available to them. They explained that this check-in would provide an immediate sense of connection and community for the spouse and a way to formally network with other spouses in the area. This formalized check-in process carried out by the administration at the new duty station may be especially helpful for newer spouses who may not be familiar with the military's mental health resources or health care system or who may be hesitant to reach out on their own to make connections with others, a pattern noticed by three of the most senior spouses in this study.

Implications for Future Training and Practice

Both the military community and the mental health counseling profession are called to recognize the mental health struggles that military spouses face in order to help prevent suicide in this population. Military leadership should strategize ways to provide easier access to mental health services for spouses, including suicide prevention programs designed specifically for this population. In addition, suicide education programs for spouses may help them identify warning signs in others, ultimately strengthening the protective factor of the military spouse community. Military leadership should also work to reduce the stigma of receiving mental health services, not only for active-duty service members, but for their family members as well. Military leaders may likewise consider the participants' suggestions regarding direct communication between military leadership and spouses, including a formalized check-in process for each duty station. Each of these suggestions offers a solution to the challenges outlined by both the professional literature and the spouse participants in this study regarding the mental health challenges faced by spouses and the risk factors of military spouse suicide.

Next, mental health counselors are called to be aware of and screen for the risk factors for suicide in the military spouse population that may be correlated to the inherent challenges that the military lifestyle brings. As prevention is a primary focus within the counseling profession (Sale et al., 2018), counselors might create preventative, psychoeducational groups for spouses to enhance their sense of connectedness and wellness. These groups would serve to identify spouses who may need additional supportive services to mitigate risk of depression and anxiety as well as other mental health issues. Additionally, when relocations occur, counselors should consider connecting their military spouse clients with mental health services in their new location and, with the permission of the client, reach out to those providers to ensure continuity of care. Finally, mental health counselors should actively

seek out and build partnerships with military leadership in order to develop evidence-based resources specific to preventing suicide in the spouse population and to reduce the mental health stigma present in both active-duty service members and spouse communities.

Limitations

Several limitations to this study exist related to the nature of qualitative methodology. First, in qualitative research, the researcher is the primary source of data collection and analysis. Thus, inherent biases exist throughout this data collection and analysis process (Anderson, 2010). However, bracketing and reflexivity reduced the potential impact of this limitation. Additionally, because mental health stigma exists within the military community, it is possible that participants were guarded during their interviews. Prolonged engagement assisted with mitigating this limitation. Finally, because of the nature of qualitative research, the sample size of the study is small (Atieno, 2009). For instance, the sample in this study did not include the perspectives of any male spouses or spouses who are African American or Hispanic. Additionally, although the sample includes Army, Navy, Air Force, and Coast Guard spouses, no Space Force or Marine Corps spouses are represented. Because of these limitations in gender, ethnicity, and branches, the sample is not representative of the military spouse community as a whole.

Implications for Future Research

Given these limitations of qualitative research, future quantitative research might focus on specific causes of suicide among military spouses. For example, studies might look at the characteristics of spouses who have committed suicide to detect any patterns or correlations that may exist. There should be particular focus on exploring any ethnic, racial, sexual minority, or gender identity disparities. Future researchers could pilot training programs in the military aimed at preventing military spouse suicide to develop best practices in this area. Finally, future qualitative studies should focus on the experiences of male military spouses. This is critical as the male military spouse suicide rate was recently found to be statistically higher than the overall male suicide rate in the U.S. population (40.9 per 100,000 and 28.4 per 100,000, respectively; DOD, 2020a).

Conclusion

Overall, the military spouses' perceptions of risk factors for suicide in this study align with previous studies regarding military spouse mental health that have been conducted throughout the past 12 years. With a new knowledge of the number of spouses that are committing suicide, it is imperative that both the counseling profession and military leadership continue to work toward solutions for spousal mental health. These stakeholders are called to recognize the inherent risk factors of the military lifestyle and provide military spouses with the resources, training, and services that they need (and want) to address and prevent suicide within their community.

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Appendix A
Demographics

Participant	Age Group	Gender	Race	Military Branch	Spouse's Rank	Years as Spouse
Participant 1	30–39	Female	White	Army	Officer	10
Participant 2	18–29	Female	White	Army	Officer	1
Participant 3	30–39	Female	White	Coast Guard	Enlisted	11
Participant 4	18–29	Female	White	Navy	Officer	3
Participant 5	30–39	Female	Asian	Air Force	Officer	2
Participant 6	40–49	Female	White	Army	Officer	20
Participant 7	40–49	Female	Asian	Air Force	Officer	20
Participant 8	40–49	Female	White	Air Force	Officer	18
Participant 9	30–39	Female	White	Navy	Enlisted	8
Participant 10	30–39	Female	White	Navy	Officer	2

Appendix B
Interview Protocol

First Interview

1. What are your perceptions of suicide in the military spouse community?
2. What are the risk factors for suicide in the military spouse population?
3. What mental health challenges do military spouses face?
4. What resources currently exist to help prevent military spouse suicide?
5. What would you like to let the civilian world know about your life as a military spouse that they might not be aware of?
6. Is there anything else you would like to add?

Second Interview

1. Do you have anything else to add from our first interview?
2. What do you think causes military spouses to commit suicide?
3. What needs to be done to prevent suicide in the military spouse community?
4. What might be the consequences of not addressing suicide in the military spouse community?
5. What type of mental health support is most needed for the military spouse community?
6. How would your mental health differ, if at all, if you weren't a military spouse?
7. Is there anything else you would like to add?

Follow-Up Email Questions

1. Is there anything else you would like to add to your interview responses?
2. What was it like for you to participate in this study?
3. What is the most important resource that military spouses need to prevent future suicides?

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