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Women Veterans' Perceptions of Mental Health Outpatient Services

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Women Veterans’ Perceptions of Mental Health Outpatient Services

A dissertation submitted and presented in partial satisfaction of the requirements for the degree of Doctor of Philosophy in Nursing

by

Lindsay Williams

2015
ABSTRACT OF THE DISSERTATION

Women Veterans’ Perceptions of Mental Health Outpatient Services

by

Lindsay Williams

Doctor of Philosophy in Nursing
University of California, Los Angeles

Professor Sally Louise Maliski, Chair

Women Veterans are the largest growing population Veterans, yet have a significant mental health disparity, greater than both civilian women and Veteran men. This disparity continues in the mental health outpatient treatment options for women Veterans. Veteran Administration (VA) healthcare services may not be suited to their needs as women, and civilian services are not well suited to manage their needs as Veterans. Therefore, this dissertation study used constructivist Grounded Theory methods to explore the experiences of women Veterans when accessing mental health outpatient services, their decision-making process when make the choice to enter mental health service, and aspects of the experience that are important or meaningful to them.

Twelve women Veterans revealed meaningful, personal stories on their experiences of trauma and their use of mental health outpatient services. While addressing each of these factors, what emerged from the data was a broader Grounded Theory Process model of how women Veterans process trauma, and the categories of Trauma, Transitions, Identity and Structure. Women Veterans who
participated in the study used mental health outpatient services to assist in reestablishing identity after trauma and to propel forward in their lives.

This research provides key insight into how women Veterans make healthcare related choices and process traumatic events, like military sexual trauma (MST). This has implications for research, practice, and policy to improve the provision of care for women Veterans.
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2015
Dedications

To each of the twelve women who shared their stories, thank you for your courage and your sacrifice.

To my family, the Williams and the Kimbles, for setting the example and being my backbone.

To my fellow students who shared this journey, thank you for your support.
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CHAPTER 1- Introduction, Specific Aims, and Significance

Introduction

In 2011 women comprised 10% of the Veteran population, with that number expected to grow to 15% by 2035 (National Center for Veterans Analysis and Statistics, 2013). Women Veterans tend to have a higher mental health morbidity than both civilian women and Veteran men, with a lifetime depression rate of 29.3% for Veteran women, compared to 15.9% of Veteran men, and a post-traumatic stress disorder (PTSD) rate of 21%, compared to 5% of civilian women (Freedy et al., 2010; Zinzow, Grubaugh, Monnier, Suffoletta-Maierle & Frueh, 2007). Overall the mental health status of women over the lifespan is that of a higher mental health burden related to depression and anxiety disorders, including panic disorder, generalized anxiety disorder, PTSD, phobias, and separation anxiety disorder (B. Bean-Mayberry et al., 2011; California Research Bureau, 2012b; Carlson & Gabriel, 2001; Washington, Davis, Der-Martirosian, & Yano, 2013; Yano et al., 2011). This suggests that mental health care for women Veterans is an unmet healthcare need, with post-traumatic stress disorder (PTSD) and depression identified as the most prevalent service related injury for women Veterans (Freedy et al., 2010; Kimerling et al., 2010).

As treatment for depression and anxiety disorders begin in the primary care setting, it has been found that women Veterans face obstacles in utilizing care through the Veterans Health Administration (VA) and non-VA facilities (Freedy et al., 2010; Haskell et al., 2011). Women Veterans’ perceptions of their needs can influence seeking and receiving primary care services (Street et al., 2009). However, women Veterans are more likely to seek their care in non-Veteran community based settings.
(Washington, Davis, et al., 2013; Washington, Yano, Simon, & Sun, 2006). The literature ranges in its estimates of women Veterans’ use of outpatient services, from one in 66 women Veterans, to 40% to 87% of women Veterans (Buttice, 2014; Swords to Plowshares Institute for Veteran Policy, 2013b; Washington, Davis, et al., 2013). This raises concerns about meeting the unique healthcare needs of women Veterans in community settings, where providers may not be trained in the specific health care needs of this population. (Street et al., 2009). VA settings are also potentially inadequate for women Veterans’ mental health needs, due to the historical precedent of treating male Veterans. Women Veterans have a 30% rate of attrition within the first three years of entry into VA care, which may reflect women Veterans’ perceptions that VA care has been historically tailored for male Veterans (Hamilton, Frayne, Cordasco, & Washington, 2013). As a result, women Veterans may perceive a lower quality of care in VA settings, although there have been recent changes in the delivery of care to women Veterans in the VA (Hamilton et al., 2013; Kimerling, Gima, Smith, Street, & Frayne, 2007).

Studying how women Veterans decide to access care in VA, private or community based healthcare services, can help us to understand their perceptions about mental health outpatient care and assist in creating services that are gender-sensitive and appropriate for their Veteran status. Furthermore, although there has been research on the prevalence of mental health conditions in women Veterans, there is a paucity of research on women Veterans’ perceptions of outpatient mental health services and if it meets the needs they identified as important to them. Therefore, the purpose of this study is to understand women Veterans’ experiences when using
outpatient mental health services and factors influencing their utilization of those services. This study utilized the theoretical framework of symbolic interactionism, constructivist Grounded Theory, Sofaer and Firminger’s conceptual model of patient perceptions of care, Andersen-Gelberg’s model of Healthcare Utilization for Vulnerable populations to address the following specific aims:

**Specific Aims**

The specific aims of this study are:

1. To examine women Veterans’ decision-making process regarding entering mental health outpatient services.
2. To examine women Veterans’ experiences utilizing mental health outpatient services.
3. To identify aspects of mental health outpatient services that are important to women Veterans.
4. To develop an explanatory framework to explain the processes used by women Veterans in their access and utilization of mental health outpatient services.

**Significance**

Exploration into women Veterans’ perceptions of mental health outpatient care is critical for the creation of gender specific mental health services. Women’s mental health must be understood within the context of their psychosocial, cultural and biological circumstances in order to design interventions that address their unique needs (Judd, Armstrong, & Kulkarni, 2009). Discovering women Veterans’ perceptions is one way of gaining insights into the contexts of how, why and the process of women Veterans interaction with the mental health outpatient system. Constructivist Grounded
Theory methodology can provide a grounded analysis in women Veterans’ lived realities and truths, to explore their values and behaviors in a meaningful way (Charmaz, 2014). Constructivist grounded theory methodology is used as the basis to explore the nature of women Veterans’ interaction with the healthcare system in regards to their mental health, and the symbols vital to that interaction. By understanding the process of entering and moving through care this study identified points of effective intervention for women Veterans at risk for attrition and negative health outcomes. Therefore understanding women Veterans’ perceptions will improve the understanding and implementation of mental health outpatient care for this growing patient population. This exploratory research can lead to future interventions on appropriate models of mental health care for women Veterans.
CHAPTER 2- Literature Review

Introduction

This literature review will utilize the Gelberg-Andersen Behavioral Model for Vulnerable Populations as a method of organization of literature related to women’s mental health care and specifically veteran women’s mental health care. The Gelberg-Andersen model is a major revision of Andersen’s original 1968 model, which purports that health services utilization is a function of the individuals’ predisposition to use services, factors that inhibit or facilitate use, and the individuals’ need for care (Andersen, 1968; Andersen, 1995). The Gelberg-Andersen Behavioral Model for Vulnerable Populations modifies this original framework with the conceptualization that elements that make populations vulnerable will also influence health services utilization (Gelberg, Andersen, & Leake, 2000). This literature review will use the three components of the Gelberg-Andersen model that describe population characteristics that enable or impede care: Predisposing, Enabling and Need (Gelberg et al., 2000). The population in this case will be vulnerable groups of women, with an emphasis on women Veterans. These three components are further delineated into traditional and vulnerable domains, to consider issues that are specific to vulnerable populations (Gelberg et al., 2000).

The Predisposing traditional domain consists of demographic characteristics, including gender, marital status, and Veteran status, while the predisposing vulnerable domain includes social structure characteristics such as acculturation and childhood characteristics (Gelberg et al., 2000). The Enabling traditional domain encompasses personal/family resources such as insurance coverage, and availability of care, while
the Enabling vulnerable domain includes the availability of social services and competing needs to health services use (Gelberg et al., 2000). Finally, the Need traditional domain includes subjective and objective determinations of healthcare need. In this context of predicting mental health outpatient service use and its subsequent outcomes, mental health conditions are in the Need vulnerable domain, rather than the Predisposing component (Gelberg et al., 2000). The Need vulnerable domain also includes subjective perceptions and objective evaluations of need for conditions relevant to vulnerable populations, such as sexually transmitted infections (STI's), and premature delivery (Gelberg et al., 2000).

For the purposes of this study, women Veterans are considered a vulnerable population due to the burden of mental health conditions compared to Veteran men and civilian women. Compared to civilian women, women Veterans are significantly more likely to report frequent mental distress (12.3% vs. 16.3%, respectively), depressive disorders (20.5% vs. 27.4%), and anxiety disorder (16.3% vs. 19.5%) (Lehavot, Hoerster, Nelson, Jakupcak, & Simpson, 2012). Although women Veterans experience an excess of mental health conditions, mental health in is not effectively managed in Veterans Administration (VA), military, or community based primary care environments (Freedy et al., 2010). This places women Veterans at higher risk for negative health outcomes related to untreated or ineffective mental health care, such as limited physical activity, substance abuse disorders, and risk of suicide (Chapman & Wu, 2014; Lehavot et al., 2012; Zivin et al., 2007). Organizing the literature within the Gelberg-Andersen lens attempts to position the state of science within an accepted theoretical framework. In this way, areas of congruency, as well as theoretical incompatibility can be identified.
Predisposing Characteristics

The predisposing characteristics component describes Veteran women from a demographic perspective, to highlight differences between the populations.

Women Veterans Demographics.

Introduction to the Population. The 2009 American Community Survey estimates the number of women Veterans, as 1.5 million, or approximately 10% of living Veterans nationwide (National Center for Veterans Analysis and Statistics, 2011). Women Veterans comprise approximately 10% of the Veteran population nationwide, and are the fastest growing Veteran population (National Center for Veterans Analysis and Statistics, 2013). Women Veterans, in general, are about the same age as non-Veteran women (ages 48 and 46, respectively), and younger than Veteran men (48, and 63 respectively) (National Center for Veterans Analysis and Statistics, 2011). Black women are overrepresented in the military (19%) compared to the civilian population (12%), whereas Latina/Hispanic women are underrepresented (7%), compared to the general population (National Center for Veterans Analysis and Statistics, 2011).

Women Veterans (WVs) are more likely to have ever been married or partnered than civilian women. The literature estimates 83% of women Veterans report being currently married, divorced, widowed, or recently separated, compared to 74% of civilian women. WVs who do marry tend to wed at an earlier age than civilian women, with 33% of 17-24 year old Veterans currently married, compared to 11% of civilian women (National Center for Veterans Analysis and Statistics, 2011). Conversely, when considering women 35 years and over, civilian women are more likely to be married than Veteran women. Considering socioeconomic status, WVs are less likely than civilian women to
live in poverty (as determined by the federal poverty level); but WVs ages 17-34 had the highest poverty levels within the WV population.

Although women have served in the U.S. military since the Revolutionary War, there have been significant restrictions on the military rank women were allowed to attain and an enlistment restriction at 2% of total forces up to and including the Vietnam War (Murdoch et al., 2006; Street et al., 2009). Female soldiers had a larger role in the Gulf War, beginning approximately in 1990, where women soldiers comprised 11% of total forces and serving pivotal support positions such as refueling fighter planes.

Following the Gulf War conflict, Department of Defense and Congressional legislation eased restrictions on women in combat positions, opening 90% of military occupations to women (Donegan, 1996; Street et al., 2009). Consequences of the expanding roles of women in the military are changes in the level and nature of service. Understanding the era of service among women Veterans is important to the design and subsequent utilization of care (Washington, Bean-Mayberry, Hamilton, Cordasco, & Yano, 2013).

The statistics on younger WVs are relevant to the era of military service, as they reveal disparities that are potentially mental health related. Specifically, these women tend to be Veterans of the Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) conflict.

**OEF/OIF Veterans.** The percentage of OEF/OIF WVs continues to rise as women join the armed forces in record numbers. Approximately 15% of active armed forces, 17% of National Guard/ National Reserves and 20% of new enlistments are women (Meehan, 2006). Women Veterans of the OEF/OIF conflict, lasting generally from October 2001 to December 2011, are exposed to combat related traumatic
experiences more than any other group of women in past conflicts and sustain combat stress levels similar to those of men (Pereira, 2002; Kelly, Skelton, Patel, & Bradley, 2011; Cohen et al., 2012). The increase in combat related exposure is related to the lack of a delineated battle front line and the increased role of women in the military (Kelly et al, 2011; Street et al., 2009). Although women are formally barred from combat roles, the guerilla tactics of this particular conflict translates into women engaging in combat and its repercussions, such as searching for improvised explosive devices (IED’s), and providing security to combat convoys (Mattocks et al., 2011). Unofficially women are serving in support roles side-by-side with male combat soldiers, with an estimated 75% of women soldiers exposed to at least one combat related experience (Dutra et al., 2011; Street et al., 2009). Serving in key roles such in transportation, piloting, intelligence, and mechanics places women at greater risk of combat exposure and experiencing potentially traumatic events than any other era of conflict. These traumatic experiences, such as handling human remains and receiving and returning arms fire, place women Veterans in this conflict at greater risk of psychological distress than women who have served in previous conflicts or during peacetime (Street et al., 2009; Haskell et al., 2011; Kelly et al., 2011). However, the effects of OEF/OIF deployment on women Veterans' mental health remain unknown (Haskell et al., 2011).

**Gulf War Pre 9/11.** The Gulf War or Operation Desert Shield conflict lasted from August 1990 to June 1991 in Saudi Arabia, Bahrain, United Arab Emirates, Iraq and Kuwait (Carney et al., 2003; Pierce, 1997). Women in this conflict are currently an average age of 46, and at the time were the highest percentage of women in the military (Washington, Bean-Mayberry, et al., 2013). Motherhood in the military was very
significant in this period as this was the first conflict where mothers with children were deployed (Bell, Roth, & Weed, 1998). Even in this conflict men and women did not differ significantly in the type of military occupations, environmental exposures, or combat exposures (Carney et al., 2003). However, the types of exposures were different between men and women, but perhaps not significant. Women were more likely to report hearing chemical alarms, being exposed to burning trash and wearing protective gear. In addition, women Veterans reported feeling ill as a result of those environmental exposures more often than men, and (Carney et al., 2003). In terms of combat exposures, women Veterans were more likely to report missiles exploding within a mile of their location and seeing maimed or dead bodies. Significance for each of these exposures was not tested in the study by Carney et al., 2003.

The effects of combat exposure are significant for women Veterans in this period. Active duty women and women with dependent children were significantly more likely to have general health problems, such as insomnia and unintentional weight loss, when compared to National Guard or Reservists (Pierce, 1997). Women who served in the Gulf region were more likely to report gender and mental health related disparities compared to those who served outside of that area (Pierce, 1997). In the four years post military service in the Gulf region, women are significantly more likely to report breast cysts, and abnormal Pap smears, depression and PTSD than those not deployed to the Gulf region (Pierce, 1997).

**Career Military Women/ Women Officers.** Rank is associated with mental health conditions in women Veterans, as women Veterans discharged as officers are less likely (39%) to report a mental health condition than non-commissioned officers
(50%) and lower-enlisted women (53%) (California Research Bureau, 2012b). There are four pathways to becoming an officer in the U.S. military: ROTC programs offered in traditional colleges/universities, Officer Candidate School (OCS) for college graduates with a four year degree, direct commissioned officers who are civilians in specialized roles in law, medicine, and chaplaincy, and enlisted officers who transition into officer roles (Today’s Military, 2014; U.S. Army, n.d.). Nurses are typically included as healthcare officers (Gibbons, Hickling, Barnett, Herbig-Wall, & Watts, 2012).

**Enabling Characteristics**

The enabling component describes personal/family resources and health services resources, such as the organization and structure of care (Gelberg et al., 2000). This component of the literature review will also review patterns of healthcare utilization in multiple mental health services settings, to identify both barriers and facilitators currently available in the literature. Although this is not clearly delineated in the model description, the Gelberg-Anderson model acknowledges some of the components will require modification based on the needs of the vulnerable population (Gelberg et al., 2000).

**Mental Health Services Organization.** This section will describe the organization and implementation of mental health services utilization in multiple healthcare settings relevant to women Veterans: the VA, mental health provided through an insurance plan, and mental health services via public/community health services.

**VA Health System.** Although there is no standard model of mental health outpatient service delivery for women Veterans in the VA, a qualitative study of
healthcare providers and key stakeholders in women’s health services have revealed four arrangements of mental health services for women Veterans, arranged along a spectrum (MacGregor, Hamilton, Oishi, & Yano, 2011). Women Veterans enter the mental health outpatient system through a referral from their primary care provider. The spectrum, at one end, describes a health center where designated women’s only services may not exist or have informal forms of implementation. The provision of specific mental health services for women Veterans at this level is basic and rudimentary. The other end describes a comprehensive, well-developed program for women Veterans mental health. Although four distinct arrangements are described here, most women’s health services do not fit neatly into one description or another. Many VA centers have overlapping aspects of multiple delivery arrangements, which corresponds to the spectral nature of this description (MacGregor et al., 2011; Pirraglia et al., 2012; Sambamoorthi, Bean-Mayberry, Findley, Yano, & Banerjea, 2010). Recent VA initiatives to integrate primary care and mental health services create further distinctions between models of care for men and women Veterans (Pirraglia et al., 2012; Sambamoorthi et al., 2010).

At the least developed level, there are providers within the general outpatient mental health clinics, who have a caseload primarily of women Veterans (MacGregor et al., 2011). These providers are typically women with some sort of specialty in military sexual trauma (MST), but are not formally designated women Veteran mental health providers. So too are women Veterans who enter these clinics routed to these providers from a functional, informal standpoint; the process is not necessarily explicit (MacGregor et al., 2011). The next arrangement of care are women’s mental health
groups, where women-only groups convene within an outpatient mental health clinic or a women’s primary care clinic (MacGregor et al., 2011).

The next service delivery arrangement is women’s-only group therapy sessions, which took place in the general mental health outpatient clinic or the women’s health primary care clinic (MacGregor et al., 2011). These groups were arranged around reentry and mental health conditions such as MST, substance abuse, and parenting and facilitated by a social worker, psychologist, or women’s health primary care provider. Many groups faced challenges in finding an appropriate facilitator specialized in women’s health issues and finding enough people to attend specialized groups (MacGregor et al., 2011). Issues arose not necessarily due to a lack of need, but a lack of availability and transportation issues, especially in rural areas. The 8am-5pm typical clinical schedule was inopportune for women Veterans who work or have childcare needs.

The third delivery arrangement in this spectrum is mental health provider(s) co-located in women’s health clinics. This arrangement was the most common of the VA women’s health settings sampled for this study, with 19 of the 26 settings surveyed reporting mental health outpatient services delivered in the women’s health primary care settings (MacGregor et al., 2011). Group therapy was the most common type of care provided, although individual ongoing therapy was indicated at some sites. The most common type of providers in these settings are social workers and psychologists (MacGregor et al., 2011).

The last and most comprehensive delivery arrangement are established women’s mental health clinics. These settings tended to be in major cities, with a heterogeneous
mix of women Veterans (MacGregor et al., 2011). The settings were designated as women’s mental health centers, separate from the women’s health primary care clinic. These clinics offer a broad range of services, from individual and group therapy to inpatient programs. Clinics are staffed by a mix of practitioners, from psychiatrists and psychologists to social workers and resident trainees. This service arrangement is the most advantageous to mental health outcomes in women Veterans, as women in gender specific integrated primary care mental health services were more likely to be appropriately diagnosed with depression (Sambamoorthi et al., 2010). Although this study is in-depth, to date this is the only study which characterizes the organization of mental health outpatient services in the VA across the VA system. Further research is needed to describe the types of mental health outpatient services available.

**Private/Insurance Mental Health Services.** Primary care providers who serve patients through insurance based sources of care encounter patients seeking services for mental health. Moreover, primary care providers (PCP’s) encounter patients who report somatic symptoms which may be ascribed to a mental health source rather than a physical illness. Thusly, PCP’s in private settings are managing mental health care, whether knowingly or unknowingly (Culpepper, 2002). Although no data is available on women Veteran’s utilization behaviors in private care settings, generalized anxiety disorder (GAD) and major depressive order are the most commonly occurring mental health conditions in primary care settings overall (Kessler & Wittchen, 2002; Wittchen et al., 2002). Compared to depression, GAD is generally underdiagnosed by PCP’s for a variety of reasons, including lack of knowledge of diagnostic criteria for the condition, insurance regulations that exclude payment for mental health conditions which can
downplay the significance of mental health in primary care settings, and the course of the condition, as it tends to arise during times of psychosocial stress and age transitions into adulthood and older adulthood (Culpepper, 2002). Recognition of GAD in primary care settings is relevant to health services utilization, in that GAD is associated with higher use of primary care resources for vague somatic symptoms associated with GAD. Unlike depressive conditions, those with GAD may lack self-awareness that they are experiencing an emotional disorder and are less likely to seek care specifically for that condition (Culpepper, 2002; Kessler & Wittchen, 2002; Wittchen et al., 2002).

The implementation of the Affordable Care Act results in implications for the model of primary care and integration with mental health services as the primary care model is made more robust, an increased emphasis on prevention and wellness, and the swell of people entering the system (Pearlman, 2013; Roll, Kennedy, Tran, & Howell, 2013). The U.S. Department for Health and Human Services estimates more than 32 million people will gain mental health and substance abuse coverage, translating into a demand for PCP’s to effectively recognize and treat mental health conditions in the primary care setting, or have the resources available to facilitate entry into outpatient mental health services (Culpepper, 2002; Pearlman, 2013; Roll, Kennedy, Tran, & Howell, 2013; U.S. Department of Health and Human Services, 2013).

Nursing stands to reconfigure its roles and responsibilities in light of ACA’s changes to improve care delivery and fill the demand for services. The Nurse Role Exploration Project, authored by the California Institute for Nursing and Healthcare, espoused five new roles for nurses with the implementation of ACA (California Institute
for Nursing and Healthcare, 2013). In terms of contact with the patient, three roles have
direct contact with the patient and can provide an additional source for the recognition
and treatment of mental health conditions in primary care settings; that of the primary
care provider, nurse/family cooperative facilitator, and the care coordinator (California
Institute for Nursing and Healthcare, 2013). As care coordinators, nurses are able to
work in mental health settings to create a therapeutic relationship where the patient is
able to understand and respond to the provider. These nurses will also establish trust
with the patient to facilitate access to evidenced based interventions (California Institute
for Nursing and Healthcare, 2013). The nurse as the cooperative facilitator connects
social determinants of the environment to the individuals’ health. The nurse reaches the
patient where they live and work to provide early intervention for mental health
conditions and to facilitate the patient living in the community for as long as possible
(California Institute for Nursing and Healthcare, 2013). The primary care provider in this
instance does not refer to nurses with advance practice degrees, but instead embedded
within clinics to monitor and manage chronic diseases, and in a health promotion and
disease prevention services (California Institute for Nursing and Healthcare, 2013).

Public Mental Health. Initiatives that engage community members,
academicians, and community based services tend to have better patient outcomes in
mental health, especially regarding depression, where persons of color are less likely to
receive appropriate depression services (Chung et al., 2010). As women of color are
overrepresented in the women Veteran population, and are more ethnically diverse than
their male counterparts, care delivery that affects persons of color will also affect
women Veterans and their families (National Center for Veterans Analysis and Statistics, 2011; Swords to Plowshares Institute for Veteran Policy, 2013a).

Persons of color in underserved communities see depression as an issue of collective concern, especially when information is presented in culturally relevant ways (Chung et al., 2010; Doornbos, Zandee, DeGroot, & De Maagd-Rodriquez, 2013; Doornbos, Zandee, DeGroot, & Warpinski, 2013; Wells et al., 2013). Evidenced based programs derived from collaborative care models improve quality of mental health care for those experiencing depression (Chung et al., 2010; Doornbos, Zandee, DeGroot, & De Maagd-Rodriquez, 2013). The 2013 Community Partners in Care (CPIC) study created a community engagement and planning (CEP) intervention for depression care based on screening, patient education, care management and referrals for medication and therapy across agencies in traditional and non-traditional health care settings, such as social services and faith based organizations (Chung et al., 2010; Khodyakov et al., 2014). The interventions built capacity to treat depression with the training of community participants on a CPIC toolkit, with training about collaborative care models, case management, administration of cognitive behavioral therapy, and medication reconciliation (Khodyakov et al., 2014). This model improved mental wellness, an organized life, physical activity, while reducing homelessness and homelessness risk factors (Wells et al., 2013).

**Mental Health Services Utilization.** This portion will describe who, how, and when women Veterans utilize mental health outpatient services.

**VA Health System.** In general, women Veterans are more likely to be VA mental health outpatient utilizers than men (Women’s Health Evaluation Initiative and VHA
Women’s Health Services, 2012). Women Veterans with diagnoses of PTSD and depression were more likely to use mental health services, with depression as the most definitive predictor of mental health service use (Washington, Davis, et al., 2013). The authors used standardized screening tools to prevent gender biases. Screening for PTSD was achieved with a seven item screening scale validated in civilian and Veterans primary care users, with a sensitivity of 85% and specificity of 84% in a test sample of predominantly women Veterans. Depression was measured with the five item Mental Health Inventory (MHI-5) (Washington, Davis, et al., 2013). Mental health is also related to increased health services utilization among women Veterans: In 2010, 38% of women Veteran VA users had at least one mental health or substance use visit, compared to 26% of Veteran men VA users (Women’s Health Evaluation Initiative et al., 2012). Women who utilize VA mental health outpatient services also tend to be frequent users, with frequent use defined as six visits or more in year users (Women’s Health Evaluation Initiative et al., 2012). 15% of women Veteran VA users were frequent users, compared to 9% of male Veteran VA users (Women’s Health Evaluation Initiative et al., 2012). Of women Veterans who are VA users, OEF/OIF woman Veterans have the greatest VA reliance, with 35% of women Veterans in the OEF/OIF conflict using VA healthcare services. This highlights the importance of designing care that is patient-driven and gender specific to meet the needs of women Veterans who are more likely to use these services.

OEF/OIF and Gulf War Veterans are significantly more likely to use both women’s health and mental health services in VA and non-VA settings, possibly resulting from the heightened traumatic exposures and emphasizing the need for
tailored care for women of this era and specialty service (Washington, Bean-Mayberry, et al., 2013). Women Veterans with PTSD have more healthcare visits and are more likely to be VA users than women without PTSD (Washington, Davis, et al., 2013). Women with PTSD using mental services in any setting are more likely to be disabled, have a history of comorbid depression, and were formally diagnosed with PTSD in a treatment setting (Washington, Davis, et al., 2013). Although women Veterans with PTSD were more likely to have experienced military sexual trauma than women Veterans without PTSD (43% and 5%, respectively), military sexual trauma did not predict mental health services use in women Veterans diagnosed with PTSD (Washington, Davis, et al., 2013).

Attrition is also a significant issue considering women Veterans and VA services, with estimates of a 30% attrition rate in the first 3 years of VA use among woman Veterans (Hamilton, Frayne, Cordasco, & Washington, 2013). Women Veterans who stop using VA healthcare tend to be age 65 or older, to have an annual income of at least $50,000, and to have a service-connected disability (Hamilton et al., 2013). In addition, women who stopped using the VA had better overall health than current VA users, and less likely to have served in OEF/OIF, and to experience PTSD or MST. Attrition is relevant to mental health services utilization because most women Veterans are not current VA users (Washington, Davis, et al., 2013).

**Private/Insurance Mental Health Services.** The majority of women Veterans use providers outside of the VA, where providers may not be aware of their Veteran status and susceptibility to mental health conditions (Washington, Davis, Der-Martirosian, & Yano, 2013). In contrast to OEF/OIF women Veterans, Gulf War women
Veterans are only 9% of VA users, inherently meaning these women Veterans are using services outside of the VA (Washington, Bean-Mayberry, et al., 2013). A 2011 survey of women Veterans in California, the state with the largest population of women Veterans with over 185,000 women, claims 30% of women Veterans seek treatment outside of the VA (California Research Bureau, 2012b). As of 2013, 40% of women Veterans in California do not use VA services overall (Buttice, 2014). Of that 40%, 39% of women use their own private insurance, and 36% of women did not know they were eligible (Buttice, 2014). Another measure of women Veterans healthcare utilization estimated that 87% of women Veterans do not use VA Healthcare services (Swords to Plowshares Institute for Veteran Policy, n.d.) (Swords to Plowshares Institute for Veteran Policy, 2013b). Although this figure is from 2005 and may not reflect the influx of OEF/OIF Veterans, this estimate should reflect the reliance women Veterans have on resources outside of the VA system in both public and private systems. For these reasons, the prevalence of mental health service use in the general woman Veteran population is unknown (Washington, Davis, et al., 2013).

There are current estimates of mental health services use of women with PTSD, where the majority use healthcare in community settings. PTSD-positive women Veterans using primary care services outside the VA have a 33.1 predicted probability of receiving mental health care, compared to a 57.4% probability among PTSD-positive women Veteran VA users (Washington, Davis, et al., 2013). Women Veterans with PTSD living above the poverty level and with a regular provider outside the VA have a 21.2% predictive probability of mental health services use, which increases to 69.8% with a comorbid depression diagnosis (Washington, Davis, et al., 2013).
Public/Community Mental Health. Socioeconomic and ethnic disparities exist in the access, utilization and quality of mental health services, and those in underserved communities are more likely to encounter low provider availability and quality of mental health care (Miranda et al., 2013). Therefore, these safety net communities rely on alternative settings to receive mental health services, such as faith-based or substance abuse programs (Miranda et al., 2013). Women Veterans are at high risk of socioeconomic instability due to issues of family identity, reintegration, unemployment and poverty (Swords to Plowshares Institute for Veteran Policy, 2013a). Although Veterans are less likely to be poor, those who are poor are more likely to be homeless (Swords to Plowshares Institute for Veteran Policy, 2013a). Unfortunately, women Veterans are the largest growing homeless population, with a 140% increase from 2006 to 2010 (Swords to Plowshares Institute for Veteran Policy, 2013a). Due to shortages of woman Veteran specific resources, lack of awareness of and/or ineligibility to participate in Veterans programs, many women are using community-based resources, often without knowing they are serving women Veterans (Swords to Plowshares Institute for Veteran Policy, 2013a).

Although no data exists specifically on women Veterans’ utilization of mental health outpatient services, the scientific literature does address general utilization. Multiple studies have demonstrated that persons of color, namely African-Americans, Latinos, and Asians were significantly less likely to utilize mental health services in the past year. When mental health services were received, persons of color were significantly less likely to receive quality mental health services (Alegría et al., 2008; Ault-Brutus, 2012; Doombos, Zande, DeGroot, & Warpinski, 2013)
The 2013 CPIC study used community based participatory research (CBPR) methods to create a baseline assessment of utilization of community based services for depression. The authors found participants had a high prevalence of depression at 33% overall, significantly higher than the 6-20% found in general primary care settings (Miranda et al., 2013). Those with depression used a variety of services, with over 40% of participants reporting a primary care visit for mental health. However, primary care visits only represented 8% of the total number of depression contacts (Miranda et al., 2013). Over 25% sought care for depression in mental health specialty settings, and another 25% in substance abuse settings (Miranda et al., 2013). Therefore, over 67% of mental seeking behaviors were outside of formal healthcare settings, such as senior centers, hair salons, faith-based organizations, and homeless social and housing services (Miranda et al., 2013). This baseline assessment demonstrated that traditional health services partnering with a range of community based services is necessary to identify those with mental health needs and facilitate the transition into care. After a community engagement intervention, mental health inpatient hospitalizations and medication management visits were significantly reduced in a trend to utilize primary care/public health, faith based and park services (Wells et al., 2013).

**Gender Specific Care.** Women Veterans want health care that is tailored to their gender specific needs, such as availability of gynecological services (California Research Bureau, 2012a). In reference to mental health care, this also translated to MST counseling and female providers (California Research Bureau, 2012a).

Gender specific considerations in mental health include age, physical status, housing, family role, the presence and ages of children and socioeconomic status.
Pregnancy can exacerbate a new onset or relapse of mental health conditions; however, little research has focused on care considerations for women in the perinatal and antenatal periods (Judd et al., 2009). Menopausal changes are also a vulnerable period for the development of mental health conditions. Gender differences in the pharmacokinetics of psychiatric medications have not been adequately explored, especially in women of reproductive age, where estrogen and progesterone levels can delay drug absorption (Judd et al., 2009; Kohen, 2010). Use of oral contraceptives or hormone treatments for menopause may also influence the metabolism of psychotropic medications (Kohen, 2010; Robakis et al., 2015).

To be gender specific, therapy based treatments for mental health conditions should be sensitive to gender differences in symptom perception, concepts of illness, coping, and health seeking and utilizing behaviors, particularly interpreted through the lens of gendered role behaviors as it pertains to mental health (Celik, Lagro-Janssen, Widdershoven, & Abma, 2011; Judd et al., 2009). These concepts have not been adequately explored in women overall and less in women Veterans.

Crucial considerations for women Veterans include the impact of pregnancy and breastfeeding on treatment options, especially in terms of medication selection. Seventy percent of OEF/OIF and 44% of Gulf War women Veterans are within reproductive age, where hormonal transitions can increase vulnerability to mental health conditions (Freeman & Zacher, 2013; Washington, Bean-Mayberry, et al., 2013). In looking further down the lifespan women Veterans are raising children, with the tacit requirements of financial stability, housing stability, and time availability. Unfortunately, these factors are significant needs for women Veterans, with 46% of a representative sample of women
Veterans reporting unemployment, 33% reporting homelessness, 30% reporting housing instability and 14% reporting experiencing homelessness some time in their lives (California Research Bureau, 2012a). Gulf War and OEF/OIF women Veterans are more likely to be unemployed than women in other service eras. These housing and income considerations are an integral component to the utilization of mental health services for women Veterans, as financial instability can lead to constrained choices, such as deciding between medications and purchasing food on a limited income (Bird & Rieker, 2008).

Although these works have affirmed the crucial component of gender and sex when considering mental health and treating mental conditions, they lack a consideration of subgroups of women, such as racial/ethnic variation, socioeconomic status, and significant life events such as military service and Veteran status. Exploring the perceptions of women Veterans regarding mental health outpatient services broadens the scope of this theoretical perspective by adding additional nuance and subtlety when considering women and significant life experiences and an added source of social identity with Veteran status.

**Need Characteristics**

The need characteristics component describes the subjective and objective perceptions of mental health needs of both civilian and Veteran women. Comparing civilian and Veteran women highlights the similarities and differences between the two populations, especially considering mental health conditions, traumatic military exposures, and suicide. This component will also delineate the state of the science of
the concept of patient perceptions and why understanding care from the patient’s perspective is crucial for providing quality care.

**Mental Health and Women.** Overall, the prevalence of mental health conditions is similar between men and women in the U.S. (Bird & Rieker, 2008; Judd et al., 2009). However, women are more likely to experience depression and other mood disorders, anxiety, and eating disorders whereas men are more likely to experience substance abuse, antisocial behavior, and suicide (Bird & Rieker, 2008). Depression is twice as prevalent in women as men and a leading cause of disability, yet remains underdiagnosed and undertreated in women (Resnick, Mallampalli, & Carter, 2012). The 50%-100% higher prevalence of depression in women is believed to reflect gender-based differences in health, rather than differences in health-seeking behaviors or willingness to disclose depressive symptoms (Bird et al., 2008). The physiological and psychosocial mechanisms for women’s increased vulnerability to depression are not fully understood (Bird et al., 2008; Resnick et al. 2012).

Women’s mental health can only be understood by considering biological, social, personal, cultural and economic contexts of women’s lives (Judd et al., 2009). Biologically, fluctuations in reproductive hormones are believed to partially account for women’s susceptibility to mental health conditions over a woman’s lifetime. Reproductive hormones transition at key points across a woman’s life span, such as the menstrual cycle, pregnancy, and menopause, in which can result in vulnerability to mood disorders for certain women (Judd et al., 2009; Resnick et al., 2012). Women’s increased risk of mental health conditions is present from puberty to post-menopause, but is most pronounced during reproductive age (Bird et al., 2008). Anxiety and
depression are commonplace during and following pregnancy, particularly in the second and third trimesters (Judd et al., 2009). Infertility is also related to mental health, as women who are infertile are more likely to have depression and anxiety than younger women not experiencing infertility (Freeman & Zacher, 2013). Alternatively, pregnancy can exacerbate an existing mental health condition, such as PTSD, bipolar disorder, and substance abuse conditions (Mattocks et al., 2010). Menopausal changes later in life also place women at higher risk for depression as a result of sleep and comfort changes and increased psychological distress (Freeman & Zacher, 2013; Judd et al., 2009). Menopausal symptoms can be confused with medication side effects or a recurring mental health condition (Judd et al., 2009).

Women are more likely to have the first onset of depression during early adolescence, contributing to a longer depression morbidity and risk of detrimental outcomes over time (Bird & Rieker, 2008; Cyranowski JM, Frank E, Young E, & Shear M, 2000; Faravelli, Alessandra Scarpato, Castellini, & Lo Sauro, 2013). In addition, women experiencing depression are more likely to have co-morbid anxiety than men, who are likely to have co-morbid substance abuse and depression (Bird & Rieker, 2008; Cyranowski JM et al., 2000; Faravelli et al., 2013; Freeman & Zacher, 2013) (Bird et al., 2008). Women experiencing depression are at risk for deficits in physical as well as mental health. Women with mood disorders are more likely to have greater medical and psychiatric comorbidities than men, and may require concurrent medical monitoring (Freeman & Zacher, 2013). Depression in women is linked to higher risk of developing cardiovascular disease, immune dysfunction, and can amplify pain and disease severity though augmenting stress hormone release (Bird et al., 2008).
From a personal and social standpoint, childhood experiences and the social position of women can influence the development of mental health conditions. Abuse and social disadvantages during childhood can affect mental health in the course of the lifespan (Judd et al., 2009). Childhood sexual abuse is approximately three times higher in women than men and is linked to mental health conditions in adulthood, such as depression, anxiety and PTSD (Judd et al., 2009; Stewart, 2007). Social inequalities such as gender based violence, poverty, balancing work and childrearing, and harassment can predict an increased prevalence of mental health conditions in women (Judd et al., 2009; Stewart, 2007).

**Mental Health and Women Veterans.**

*PTSD in women Veterans.* Post-traumatic stress disorder (PTSD) is defined by chronic symptoms that last more than one month and include re-experiencing of a traumatic event, persistent avoidance of stimuli associated with a traumatic event, negative cognition and mood, and persistent symptoms of increased arousal, previously absent before the traumatic event (American Psychiatric Association, 2013). PTSD is linked to a host of negative outcomes, such as suicidal ideation, suicide attempts, increased risk for negative health outcomes, and worsened overall physical health for women Veterans from experiences in the military and reentry process (Cohen et al., 2012; Cougle, Keough, Riccardi, & Sachs-Ericsson, 2009; Kelly et al, 2011).

PTSD is also linked to poorer reproductive health outcomes for women Veterans, as those with PTSD have 1.5-3 times higher prevalence of all negative reproductive outcomes, such as STD’s, UTI’s, dysmenorrhea, endometriosis, abnormal pap smears, and infertility (Cohen et al., 2012). This is one such example of how mental health,
particularly PTSD, affects women Veterans in a gender-specific way. Several reasons are hypothesized for this health burden in those with mental health conditions; namely increased risk taking, avoidance of preventive health services stemming from fear and embarrassment, increased substance use which can lead to risky sexual behaviors, and the symptoms of PTSD itself such as emotional numbing, and lower likelihood of treatment adherence. Interestingly, women Veterans who have comorbid PTSD and depression are at highest risk for a range of poor medical and reproductive health outcomes (Cohen et al., 2012). One telling example is in the case of the outcome of sexual dysfunction, which is 10 times more likely in those with PTSD and depression than women Veterans without any mental health conditions.

The data are mixed regarding gender differences in rates of PTSD between men and women Veterans, with some studies reporting women Veterans are diagnosed more than men, some men more than women, and yet others reporting equal numbers (Kang, Dalager, Mahan & Ishii, 2005; Kelly et al., 2011; Street et al., 2009; Vogt, Pless, King & King, 2005). Resnick et al. (2012), posit one possible explanation for the differences in the literature, albeit one from the general male and female population. They posit that PTSD is twice as prevalent in women versus men, but men have more traumatic exposures than women (Resnick et al., 2012). This is because the type of traumas women experience make them more vulnerable to PTSD (particularly sexual trauma), women have longer duration of PTSD symptoms, and women have a more pronounced reaction to traumas (Resnick et al., 2012). What is definitely known is women Veterans are more likely to have PTSD than their civilian women counterparts,
with a lifetime estimate of 13% and 9.7%, respectively (Haskell et al., 2011; Washington, Davis, et al., 2013)

**Depression in women Veterans.** Post-traumatic stress disorder (PTSD) and depression were identified as the most prevalent service related injury for women Veterans (Resnick et al., 2012), and are generally studied as comorbid conditions (Cohen et al., 2011). Evidence estimates that of women who screen positive for PTSD, 67.1% also screen positive for depression (Washington et al., 2013), and 69.3% of lifetime PTSD cases also meet criteria for depression. Diagnostic criteria includes depressed mood, loss of interest and pleasure in activities, significant unintentional weight loss or gain, and feelings of worthlessness or excessive guilt that lasts for at least two weeks and cause significant impairments in functioning (American Psychiatric Association, 2013). Women Veterans tend to have higher rates of depression compared to male Veterans in the first few years of reentry into the civilian sphere (Haskell et al., 2011; Seal et al., 2009). Furthermore, although there is limited data on depression in women Veterans of OEF/OIF, studies on mixed multiple cohorts of women Veterans revealed the lifetime depression rate is significantly higher amongst women Veterans (29.3%) versus male Veterans (15.9%) (Freedy et al., 2010).

**Military Sexual Trauma (MST).** MST in its narrowest definition in the literature refers to attempted or completed oral, vaginal, or anal penetration through threat or use of physical force that took place on or away from the military base (Zinzow et al., 2007). Other studies broaden the definition to include incidents of sexual harassment while on military duty and/or unwanted physical contact of a sexual nature (Street et al., 2009; Zinzow et al., 2007). MST becomes crucial in studying mental health disorders as
those who experience MST are up to nine times more likely to experience PTSD and up to 18 times more likely to have depression than those who do not (Kelly et al., 2011; Kimerling et al., 2010; Suris, Lind, Kaashner & Borman, 2007). MST is also associated with substance abuse, poorer overall health, more chronic health problems, and economic adjustment difficulty in the post-deployment process (Skinner et al., 2000; Street et al., 2009).

A national, population based study of MST in OEF/OIF Veterans revealed 15.7% of women and 0.7% of men reported MST, although this number is subject to underreporting (Kimerling et al., 2010). In a national sample across military service eras (1910’s- 2000’s), 25% of women Veterans report sexual trauma during their active duty (Skinner et al., 2000). The evidence suggests MST during active duty is more strongly correlated to the subsequent development of mental health conditions than sexual trauma before or after active duty (Himmelfarb, Yaeger, & Mintz, 2006). The reasons for this association are not clear but may relate to feelings of betrayal or loss of trust with fellow service-members, feelings of being trapped during service, and fear of repercussions as a result of disclosure (Street, Kimerling, Bell, & Pavao, 2011).

**Women Veterans and Suicide.** Joiner (2009) asserts that one must perceive themselves to be a burden to others, feel they do not belong, and be physically capable of self-harm in order to attempt suicide (Joiner, 2009). Veterans experiencing PTSD and the situations that cause them may decrease fear of harm, potentiate them to pain and violence, and acquire an ability to self-harm (Joiner, 2009). The literature on women Veterans and suicides considers three outcomes variables: suicidal ideation, attempted suicide and completed suicides (Chapman & Wu, 2014). The mental health disparity in
women Veterans also extends to completed suicides, with a woman Veteran suicide rate three times higher than women in the general population (Chapman & Wu, 2014; Kaplan, McFarland, & Huguet, 2009; McFarland, Kaplan, & Huguet, 2010). Among Veteran VA users, the ratio of male Veteran to women Veteran completed suicides was 3:1, compared to a 4:1 ratio in the general population (Chapman & Wu, 2014; Zivin et al., 2007). These figures demonstrate the gap between male and female suicides is smaller among Veterans and suggest that women Veterans are experiencing some form of distress different from that of civilian women.

Qualitative exploration of perceptions of suicide and self-harm with 19 OEF/OIF women Veterans ages 24-52 years revealed how military experiences influence the ability to complete suicide (Gutierrez et al., 2013). Notably, participants stated military culture reinforces the view that needing help is a sign of weakness and to seek help is to be a burden. The participants in this study valued self-reliance and personal responsibility, and seeking help means they were somehow inadequate in that they could not handle their problems on their own (Gutierrez et al., 2013). Participants also felt like being a woman in the military makes them feel like an outsider in that they are ostracized from the men they served with. Feelings of failed belongingness also stems from their PTSD symptoms, which keep participants from connecting with civilians upon their return (Gutierrez et al., 2013). Lastly, women Veteran participants reported their military experiences led to maladaptive coping mechanisms, physical and emotional pain. This leads to isolation, emotional numbing, substance abuse, and thoughts of engaging in self harm (Gutierrez et al., 2013). Although this study is not representative
of women Veterans as a whole, these findings demonstrate salient issues that impart an acquired ability for suicide in women Veterans.

**Patient Perceptions of Care.** In the 2001 Institute of Medicine (IOM) report, *Crossing the Quality Chasm*, the IOM identified patient centered care as one of the goals for healthcare system improvement (Institute of Medicine, 2001). The IOM broadly defines patient-centered care as “care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring patient values guide all clinical decisions” (Institute of Medicine, 2001). Furthermore, this report calls for customization of care based on patients’ needs and values, with the realization that the patient is the source of control for interactions between the patient and health care system (Institute of Medicine, 2001). The incorporation of patient perceptions as a central component of the quality of care was one of the many highlights of this landmark report, and cemented the study of patient values and interactions between the patient and the healthcare system as an area of inquiry.

A major force driving the development of patient perceptions research is the patient centered care movement, in response to the fragmentation of care and lack of care coordination (Sofaer & Firminger, 2005). The movement toward patient-centered care since the early 2000’s eschews the biomedical model as a standard of care and instead acknowledges the effects of psychosocial and behavioral factors on the presentation, symptomology, and outcomes of illness, the growing diversity of the U.S. population (but increasing standardization of care), and the need for ongoing productive patient-provider interactions as chronic disease becomes more prevalent (Sofaer & Firminger, 2005).
Patient perceptions also have significance from a social justice and accountability aspect. Patient oriented approaches have always appealed to the ethical implications of social justice in healthcare, to ensure equal access and care for all persons. Healthcare designed to meet the needs of the people that use it increases the chance that those in need will access and utilize care. Focusing on the patient also translates into greater accountability and transparency in healthcare. Patient perceptions reveal who the patient regards as responsible for their quality of care, and therefore how and what quality of care surveys should measure. Public reporting of quality measures requires the development of measures from patient perceptions of quality, rather than administrative views of quality (Sofaer & Firminger, 2005).

Patient perceptions have both an intrinsic and instrumental value that define their importance to healthcare (Sofaer & Firminger, 2005). By their very nature patient perceptions have an inherent value, insofar as philosophical post-modern thought and American democracy tends to have a focus on the needs, rights, and values of the individual. Alternatively, patient perceptions are cogent predictors of healthcare decisions and healthcare outcomes, such as choice of provider, adherence to treatment plan, patient complaints, and health and functional status outcomes (Sofaer & Firminger, 2005).

options (Montori VM et al., 2013). From the author’s analysis, it seems as though the Sofaer and Firminger model is aligned with the patient preference literature, although patient preferences seem to address practical clinical approaches to care from a medical standpoint. The Sofaer and Firminger model considers patient preferences from a larger conceptual standpoint, in that it considers health beliefs, expectations, and goals (Appendix B). The literature contemplates patient preferences in the context of patient-centered medicine, which emphasizes patient experiences rather than the pathophysiologic mechanisms of disease (Krahn & Naglie, 2008). The literature acknowledges the primacy of patient experiences in nursing care. Patient preferences represent the values characterizing health outcomes in clinical decision making and health economics (Krahn & Naglie, 2008; Krumholz HM, 2013; Montori VM et al., 2013). Patient preferences also relates to decision making in that preferences can inform healthcare choices.

**Decision-making in women Veterans.** The current literature currently describes women Veterans' decision-making in VA primary care, rather mental health decision making. Decision-making in women Veterans in ambulatory care was explored quantitatively by Washington et al. (2006). This analysis demonstrated women Veterans who choose not to use VA care have significantly more negative perceptions of VA care, in that care through the VA is not tailored to women’s needs, inconvenient VA locations and an unwelcoming VA environment (Washington et al., 2006). Furthermore, those who choose not to utilize VA services have a knowledge deficit in terms of their eligibility for VA services and the existence of VA women’s health services. These results imply that women Veterans are not fully utilizing services for which they are
eligible. However, what is unknown from these results is if and how women Veterans are utilizing other services outside the VA. The proposed research also explored how women Veterans who are not VA users decide to utilize services.

**Mental Health Decision-Making.** Although there is limited literature on mental health treatment decision making in women Veterans, the broader literature on vulnerable women’s mental health decision making provides insight into how and why women Veterans make decisions to enter mental health and highlight gaps to understanding decision-making in women Veterans.

**Personal knowledge.** Personal knowledge, within the domain of women’s decision making, is defined as a woman having thought about her choice in relation to what is best for her (Stepanuk, Fisher, Wittmann-Price, Posmontier, & Bhattacharya, 2013). Stepanuk et al., demonstrated that personal knowledge about healthcare choices is a significant predictor of satisfaction with the decision of taking medications for anxiety and depression during pregnancy among a sample of majority white non-Hispanic women, who are living with a partner, and with incomes above $75,000 (Stepanuk et al., 2013). This concept of personal knowledge is salient throughout the literature on mental health decision making among vulnerable women, in that its presence or absence results in barriers to care and treatment (Alegría et al., 2008; Ebert, Bellchambers, Ferguson, & Browne, 2014; Judd et al., 2009; O’Brien et al., 2008; Stepanuk et al., 2013). I argue this personal knowledge concept is at once a telling predictor of the barriers vulnerable women face as well as a flawed proxy for the structure of the health care system.
Cultural influence. The literature describing mental health decision making among immigrant women, refugee women, and women of color differs in scope from the personal knowledge concept. Cultural beliefs about mental health can keep vulnerable women away from mental health services offered through the healthcare system (Callister, Beckstrand, & Corbett, 2011; Caplan & Whittemore, 2013; O'Mahony & Donnelly, 2010; Pieters & Heilemann, 2010). In this case, a woman may not think about what’s best for her as a person removed from her culture, but within her cultural norms. A woman may be self-aware that something may be wrong, but unaware of her symptoms and what she needs to get better (Caplan & Whittemore, 2013; Pieters & Heilemann, 2010). In other circumstances women may not rely on a formal healthcare system but instead receive support from other women in their social network (Callister et al., 2011; O'Mahony & Donnelly, 2010).

Gender roles. Cultural beliefs are closely intertwined with gender roles, in that women are expected to be strong pillars of the family unit. Women are expected to maintain the household, raise children, maintain a job outside the home, and maintain social relationships (Callister et al., 2011; O'Mahony & Donnelly, 2010; Pieters & Heilemann, 2010). Once again, within this context, personal knowledge is a narrow concept; these women cannot make decisions solely for their benefit, but for the benefit of their spouse and families. From the viewpoint of the woman, to show “weakness” in the form of seeking help could mean the family unit could potentially fall apart. However, a motivator to start treatment is the woman realizing the family unit and social relationships can fall apart if her symptoms are left untreated (Pieters & Heilemann, 2010).
**Other Healthcare Decision-Making.** The literature also describes vulnerable women’s decision making within the context of back pain, cardiovascular care, reproductive health, including abortions and cancers of the reproductive system, maternity care, and overall engagement with the healthcare system. Each of these studies are qualitative, to account for the complex social position of each of these groups of women that can influence how they make healthcare decisions. Despite their differences, there are commonalities throughout that demonstrate relevant factors that shape how vulnerable women make healthcare decisions.

**Power and Punishment.** Across each of these studies issues of power and punishment appeared (Bungay, 2013; Cappiello, Merrell, & Rentschler, 2014; Ebert et al., 2014; Ebert, 2012; Hershberger, Finnegan, Altfeld, Lake, & Hirshfeld-Cytron, 2013; Jackson & McCulloch, 2014; Washington, Kleimann, Michelini, Kleimann, & Canning, 2007). Vulnerable women frequently encountered healthcare interactions where the woman was situated as less powerful than the provider. The provider had the “power” to determine their treatment choices, when and where that treatment can happen, and even to withhold treatment altogether. In situations where the woman lacked regular access to primary care providers, that mismatched power relationship was more pronounced (Bungay, 2013). Women feared “punishment” if they were to violate this power arrangement. Punishment took a different form throughout the literature but they all identified some aspect of a negative action or outcome that served to restrict their healthcare options or their ability to use them. Some feared a violation of privacy, negative judgment by their provider, given less information by their provider, long wait times, limited appointment availability, or being forced into a procedure they may not
agree with. Whether these actions were necessary, safer or beneficial for the woman is seemingly irrelevant, what matters is their perception of the act as a punishment (Bungay, 2013; Cappiello et al., 2014; Ebert et al., 2014; Ebert, 2012; Hershberger, Finnegan, Altfeld, et al., 2013; Jackson & McCulloch, 2014; Washington et al., 2007).

Provider Preferences. Vulnerable women make healthcare decisions within this power and punishment framework. Not surprisingly, the vulnerable women in each of these studies favored healthcare interactions in a non-judgmental setting where providers are able to maintain privacy and “see the patient as a person” (Alegría et al., 2008; Bungay, 2013; Cappiello et al., 2014; Ebert et al., 2014; Ebert, 2012; Jackson & McCulloch, 2014). This continual struggle to have not only the provider, but the general structure of the healthcare system recognize the multi-status (race/ethnicity, SES, geographic place, homelessness, age) personhood and decision-making autonomy is echoed throughout the literature on vulnerable women and health. Generally, vulnerable women who had positive healthcare experiences, determined by the provider approach and perceived knowledge of the provider, were more likely to remain with that provider (Bungay, 2013; Ebert et al., 2014; Ebert, 2012; Kirby, Broom, Adams, Sibbritt, & Refshauge, 2014). However, access and proximity may regulate this relationship. Women who have more provider choices are more likely to seek a new provider when a trusted provider changes locations and becomes less accessible (Kirby et al., 2014; Washington et al., 2007). Women who are limited in their choices, such as homeless women, are more likely to follow a trusted provider out of their comfortable proximity to stay with that provider (Bungay, 2013).
Community and Peer Support. Community, friends, and family contributed to vulnerable women’s healthcare decision making in two different ways. First, some women consulted the opinions of their community and peers to make their treatment decisions (Bungay, 2013; Donnelly, Foster, & Thompson, 2014; O’Mahony & Donnelly, 2010). However, it is important to note that opinion gathering also means disclosure of a diagnosis. Therefore, women tend to gather opinions from others in informal situations where disclosure of a treatment plan or diagnosis is unlikely to result in stigma or negative judgment (Hershberger, Finnegan, Altfeld, et al., 2013; Hershberger, Finnegan, Pierce, & Scoccia, 2013; Kirby et al., 2014). Second, vulnerable women considered the effects of their choices on their community and loved ones as a criterion for decision making, whether it was to minimize potential harm to a child, or to avoid worrying or bothering their family members (Cappiello et al., 2014; Ebert et al., 2014; Ebert, 2012; Jackson & McCulloch, 2014).

Although the study populations are different these studies set a precedent for a similar pattern of behavior in women Veterans. Examining their perceptions of mental health outpatient services revealed a similar set of processes, but also some significant differences. There are some limitations to this literature review, in that a majority of the study populations are white non-Hispanic. This is contrary to the makeup of women Veterans, where women of color are overrepresented compared to the U.S. The result is that we know little about the social, ethical and moral networks of typical women Veterans. This dissertation provided further detail about who women Veterans trust, the crucial conversations women Veterans have with those deemed safe, and how they choose to enter mental health outpatient treatment.
Gaps in the Literature

Although the Gelberg-Andersen model serves as a good template for organization of the existing literature in a meaningful way, gaps emerged from the literature which suggests areas of further exploration.

The author finds an inconsistency in the historical development of patient-centered medical homes (PCMH), namely that their foundations are within medicine and physician practice (Saha, Beach, & Cooper, 2008). The National Committee of Quality Assurance (NCQA) describes the PCMH model as evidenced-based, team-based care that actively engages the patient through easy and open access to services, meeting the patient’s cultural and linguistic needs, and continually improving care to meet the patients’ needs (National Committee for Quality Assurance, 2014). The driver of patient-centered care models was the lack of awareness of the patient as a whole person, more than just an illness but a biopsychosocial and spiritual entity (Sofaer & Firminger, 2005).

The nursing discipline, at its theoretical core, lies in the relationship of the person, nurse, environment, and health (Meleis, 2012). Therefore, nursing has a tacit expectation to pursue patient-centeredness as a standard of care and explore aspects of patient preferences as a method to create and implement patient centered care. Nurses and the nursing profession are in a vital position to create changes in the way outpatient and mental health outpatient services are delivered through research and advocacy on behalf of the needs and preferences of the individual.

Furthermore, there is a dearth of qualitative research regarding the woman Veterans’ experience as it relates to patient centered care. Qualitative methods allow for in-depth exploration of abstract concepts such as meanings, needs, and values, which
may not be adequately described by quantitative methods. The majority of studies done on women Veterans health are performed in the VA system, but research policies can bar direct access to women Veterans for interviews, or delay the recruitment process up to a year or more. As a result, the qualitative studies that relate to women Veterans health are typically done with providers are performed with providers, who are easier to recruit and interview (MacGregor et al., 2011).

Exploration of mental health needs through considerations of gender and Veteran status will add complexity to the development of gender specific care. The gender differences in symptom perceptions, mental health seeking and utilizing behaviors are likely different between civilian women and Veterans women, due to differences in need and the evolution of gendered behavior as a former soldier. Gender specific health care considers socially constructed gender roles differences between men and women in all aspects of care (Celik et al., 2011; Gijsbers van Wijk, van Vliet, & Kolk, 1996). This stance is supported by the notion that women have different health problems than men, or experience the same illness differently. This overall concept does not take military service into consideration, where men and women were considered soldiers with equal roles and assignments. How does this concept of socially constructed gender roles apply to situations where men and women are working side by side in military service? And how does that change once these gendered social roles are reinforced in the civilian world when a woman transitions out of the military?

The literature lacks an exploration of the reasons why women Veterans enter mental health outpatient services, what factors facilitate the service utilization process and what impedes the process. Although the literature addresses barriers for women
Veterans, these barriers are to medical care and do not address outpatient mental health service utilization. Furthermore, current quantitative measures of patient experiences with care fail to capture the needs of persons with mental health conditions, both male and female (Francis, 2013). This qualitative grounded theory dissertation explored the patients’ experiences, from a woman Veteran’s perspective to better understand the context these women are living in. Understanding this process can improve the structure of mental health outpatient services to improve patient outcomes.

**Summary**

The Gelberg-Andersen model represents the sum of Predisposing, Enabling, and Need components, in that these three components influence health behavior (Gelberg et al., 2000). Health behaviors consist of personal health practices, such as adherence to care and use of health services (Gelberg et al., 2000). The Gelberg-Andersen model is lacking in this area related to women Veterans, as there is a dearth of information on the mental health outpatient service health seeking behaviors among women Veterans. Furthermore, the literature lacks a sufficient explanation of women Veterans’ trajectory through the mental health outpatient system. Creating a model of how women Veterans access and utilize mental health outpatient services will identify areas of improvement for the health system, women Veterans’ mental health needs, and areas of intervention to improve mental health outcomes.
Chapter 3- Philosophical Underpinnings and Theoretical Frameworks

Philosophical Underpinnings

Due to the burgeoning nature of research with women Veterans and the research gap of suitable knowledge about the perspectives of women Veterans, constructionist/constructivist philosophies are the most appropriate underpinnings for this phenomenon.

Constructionism

Constructionism is a philosophical orientation that is an alternative to an empiricist approach in performing nursing research. The constructionist view denies the empiricist notion of an objective reality and instead purports that humans construct their reality and social world based on shared languages, understandings and practices (Berger & Luckman, 1966; Gergen, 2009; Latimer, 2010; Schwandt, 2003).

Major Tenets of Constructionism

The first of three main tenets of constructionism refers to our understanding of the world, and how our descriptions of it are not bound by an external, fixed reality, or “what is” (Gergen, 2009). In other words, our description of the world does not depend on the inherent nature of things, but the opposite is true, our description of the world shapes the nature of things (Gergen, 2009). Describing the world in alternate ways opens up dialogue and discourse between different groups of people who may not ascribe or belong to the dominant worldview (Gergen, 2009).

The second major tenet of constructionism deals with the way we describe and explain the world through outcomes of social relationships (Gergen, 2009). The tool of the individuals’ description of the world is through language, to put our experiences into
a communicable form (Gergen, 2001). However, the basis of language comes from human relationships, specifically the societal agreement that certain words denote certain aspects of the world individuals see (Berger & Luckman, 1966; Gergen, 2009). Therefore, the use of language is predicated on the basis of the relationships that create its structure and disseminate its use (Gergen, 2001; Gergen, 2009). Extending this concept not only includes descriptions of day to day life but also abstract terms like “T/truth” and objectivity (Berger & Luckman, 1966; Gergen, 2009).

Words gain meaning through a set of language games, to achieve a picture of reality through the use of language in action and interaction (Gergen, 2001; Gergen, 2009; Strathern, 1996). Like a chess game, the use of language follows a set of guidelines with tacit social expectations (Gergen, 2001; Gergen, 2009; Strathern, 1996). Words gain meaning as small pieces of a complex language game and because of the rules of the game. Furthermore, the use of words outside of the game itself is meaningless, similar to a chess piece independent of the board (Gergen, 2001; Gergen, 2009; Strathern, 1996). For example, the use of the words “Hello, how are you”, fit within the context of a “greeting” language game. If these words were uttered outside of the context of a greeting or as an outburst without any social interaction, the sanity of the person would be in question (Gergen, 2001; Gergen, 2009).

The third tenet of constructionism involves the significance of social constructions derived from its social utility (Gergen, 2009). The social worlds that groups construct are a function of their utility within that cultural tradition and how accurately it describes the conventions of that group (Gergen, 2001; Gergen, 2009). The social constructions then help its members in organizing, navigating and interpreting the world in ways
meaningful to them (Berger & Luckman, 1996; Gergen, 2001; Gergen, 2009). A vital component of this tenet in the constructionist tradition is the fluctuating nature of “T/truth” and how it changes depending on its usefulness in a cultural tradition or socially constructed environment (Gergen, 2009).

**Epistemological Issues**

The constructionist tradition does not attempt to create or verify the modernist notion of one, unified, objective “Truth”, nor does it seek to establish the truth of its own predilections (Gergen, 2009). Constructionism as a philosophical tradition acknowledges that constructionism itself is a social construction (Gergen, 2001; Gergen, 2009). These standpoints have far reaching implications on epistemological issues for research. Reliable knowledge is considered a co-construction of the viewpoint and experiences of an individual or group existing within a socially constructed world, and the researcher within their own socially constructed world (Berger & Luckman, 1966; Gergen, 2009; Latimer, 2010). Constructionism purports that the responses of the individual to the researcher is not purely objective information, but is influenced by language, non-verbal communication, environment, and interaction of the two social worlds (Berger & Luckman, 1966; Gergen, 2009; Latimer, 2010). The source of knowledge is what an individual learns, values, and knows to be true within their socially constructed reality. In constructionism there are co-knowers: the individual, or to a larger extent the social group, and the researcher (Berger & Luckman, 1966; Gergen, 2009; Latimer, 2010). Constructivist principles acknowledge every woman Veterans’ social world may differ, even though they all have served in the military.

**Influence on Knowledge Development**
Based on the central tenets and philosophical standpoints of constructionism, qualitative methods are best suited for nursing knowledge development. The goal of research in this tradition is to understand multiple realities of individuals and how their realities are constructed (Gergen, 2001; Gergen, 2009). Considering the constructionist view of multiple realities, using an empiricist questionnaire or survey with multiple people would discount the different realities individuals are living in (Latimer, 2010). Therefore, the results achieved are indicative of someone else’s reality, namely the researchers (Gergen, 2009). In contrast, qualitative interpretive methods rely on interviewing or observations to identify what the individual, or the group, identifies as “T/truth” within their reality (Latimer, 2010). However, constructionist tradition acknowledges that scientific knowledge is a social construction; the researcher is not static, or removed from the research process (Gergen, 2009). Whether intentional or not, the researcher brings their socially constructed world, values, and sets of language to the scientific process and this influences the participant and research setting, resulting in the aforementioned co-construction (Gergen, 2001; Gergen, 2009; Latimer, 2010).

**Theoretical Framework**

The philosophical underpinnings of Grounded Theory lie in pragmatism and its offshoot, Symbolic Interactionism (Charon, 2010; Corbin & Strauss, 2008). The influential pragmatists, John Dewey, and George Mead placed an emphasis on problem-solving action, interaction and behaviors in creating knowledge. Specifically, knowledge arises through the actions, and interactions of self-reflexive individuals in response to a problematic situation (Charon, 2010; Corbin & Strauss, 2008).
Pragmatism also asserts a subjective view of reality, rather than an objective one, but still maintains a notion of truth (with a lowercase t), that is liable to change over time. Some other major assumptions of pragmatism deal with the meanings of actions, and how one action can create multiple meanings that can apply to the past, present, and future; as well as the notion of a developed self that partakes in all these meaningful actions (Charon, 2010; Corbin & Strauss, 2008).

**Symbolic Interactionism**

Symbolic Interactionism (SI) refers to a particular type of interaction within pragmatism that was promulgated by Herbert Blumer. This school of thought looks primarily at the nature and essence of interaction itself, and the people, or “actors” that perform these interactions (Charon, 2010). The notion of an interaction relies primarily on symbols, things in the world created by humans with agreed upon meanings that are used to refer to our social reality (Charon, 2010). Symbols are the tools in human interaction, without which no interaction could occur. The use of symbols refers to one of the major assumptions of SI, that humans are social individuals in “ongoing, constant, lifelong” interaction that guides our actions and behavior (Charon, 2010). Another major assumption deals with the nature of reality. SI takes the subjective reality and extends that concept by asserting that not only do humans directly perceive their environment, but they in fact define the environment they are in. An objective world may exist somewhere but the way humans define it is the important perspective to understand (Charon, 2010). Overall, symbolic interactionism purports that understanding social interaction between actors, their subjective perspectives of the situations they are in,
and their patterns of thinking about the present and future are necessary in understanding human action (Charon, 2010).

**Assumptions.** The use of symbols refers to one of the major assumptions of SI, that humans are social individuals and it is “ongoing, constant, lifelong” interaction that guides our actions and behavior (Charon, 2010). This orientation eschews psychological factors like personality in understanding behavior, as well as the notion that a collective “society” causes human behavior. In fact, SI maintains that the individual is not only created through interaction, but society itself is created and maintained through interactions (Charon, 2010).

Another major assumption deals with the nature of reality. SI takes the subjective reality and extends that concept by asserting that not only do humans not directly perceive their environment, but they in fact define the environment they are in (Charon, 2010). An objective world may exist somewhere in reality but the way humans define it is the important perspective to understand. Furthermore, this definition is formed through ongoing social interaction through the use of symbols, tools used purposefully to represent social objects and concepts in reality to communicate with others (Charon, 2010). Language is a special class of symbols that is unique in its role to communicate between individual actors as well as internally within the actor, as the self becomes a social concept to be acted upon. Spoken and written words are used to describe the tangible physical world in the past, present, and future as well as what the actor thinks and imagines (Charon, 2010). Therefore, symbols are used to represent and communicate to others their definitions of the world as it is, and as it could be.
Interaction occurs not only with others but within the self, through an active, lifelong process of thinking (Charon, 2010). This SI assumption highlights the concept that human beings are entities that are constantly and deliberately observing, thinking, appraising, and comparing, ultimately to maintain and preserve the self-concept. The formation of a “self”, self-perceptions, and a self-concept is through interaction and subsequent action within the individual actor (Charon, 2010). The self becomes a symbol that the individual can act upon; and like other symbols relies on social interaction.

**Applying Framework to Phenomena of Study.** Grounded theory is an appropriate method of inquiry into this research problem and specific aims because of the emphasis on knowing a process and developing a theory to explain it. Women veterans are a unique minority population within United States military veterans, with a different set of health needs, health preferences, and healthcare patterns than the male majority (Washington, Bean-Mayberry, Riopelle, & Yano, 2011). Furthermore, women veterans are a diverse cohort within their population. Women of color are overrepresented in the women veteran population compared to the civilian population, as well as marked differences in combat versus non-combat roles and tour of duty (National Center for Veterans Analysis and Statistics, 2011). Women Veterans low numbers relative to the majority group place women veterans at risk for marginalization and invisibility within the VA system and scientific research (Washington, 2004). Women veterans are typically underrepresented in clinical research, leading to inaccurate depictions of their healthcare needs, treatment and healthcare related decision making (B. Bean-Mayberry et al., 2011; Washington, Bean-Mayberry, et al., 2013). As a result,
current behavioral, cognitive, or psychosocial models used on a women veteran population may be inadequate or insufficient to describe current behavior and predict future results. From a Symbolic Interactionist standpoint, this means the perspectives, meanings, actions, and roles women Veterans share are qualitatively different than other Veteran cohorts or civilian women. A grounded theory approach seeks to illuminate the perspectives of this specific group, with the notion that a theoretical model will be more specific, thorough and comprehensive in appraising, describing, and ultimately understanding certain aspects of women veteran's lives. From a Symbolic Interactionist standpoint, this means the perspectives, meanings, actions, and roles women Veterans share are qualitatively different than other Veteran cohorts or civilian women. Using a grounded theory methodology can explicate and delineate those different interactions, selves, and meanings in relation to mental health and utilizing mental health outpatient services.

**Influence on Knowledge Development.** Based on the central tenets and philosophical standpoints of constructionism and SI, qualitative methods are best suited for nursing knowledge development in women Veterans and perceptions of mental health outpatient services. The goal of research in this tradition is to understand multiple realities of individuals and how their realities are constructed (Gergen, 2001; Gergen, 2009). Considering the constructionist, symbolic interactionist view of multiple realities, using an empiricist questionnaire or survey with multiple people would discount the different realities individuals are living in (Latimer, 2010). Therefore, the results achieved are indicative of someone else’s reality, namely the researchers (Gergen, 2009). In contrast, qualitative methods rely on interviewing or observations to identify
what the individual, or the group, identifies as “T/truth” within their reality (Latimer, 2010). Furthermore, the constructionist tradition acknowledges that scientific knowledge is a social construction; the researcher is not static, or removed from the research process (Gergen, 2009). Thus, whether intentional or not, the researcher brings their socially constructed world, values, and sets of language to the scientific process and this influences the participant and research setting, resulting in the aforementioned co-construction (Charmaz, 2014; Gergen, 2001; Gergen, 2009; Latimer, 2010).

Incorporating SI and constructionism in conducting research in this phenomenon acknowledges the researcher and is involved in the co-construction through the process of interaction (Gergen, 2001; Charon, 2010). The researcher and participant are communicating using symbols, like language, to elaborate on more than just a fixed reality, but on personal values, feelings, and beliefs. Using qualitative methodology can explicate and delineate those different interactions, selves, and meanings in relation to mental health and accessing mental health outpatient services.

**Gelberg-Andersen Behavioral Model for Vulnerable Populations**

Although qualitative methodologies are most appropriate for this area of research, a sensitizing theoretical framework can assist in creating a starting point for qualitative methodology, in terms of substantive topics to explore in qualitative interviewing and basis for comparison within women Veterans and between women Veterans and the general civilian population.

**Assumptions.** The Gelberg-Andersen model functions under the assumption that health services utilization is shaped by the individuals’ predisposition to use health services, the individuals’ subjective and objective evaluation of their need for care, and
factors that bar or facilitate use (Gelberg, Andersen, & Leake, 2000). The revisions in 2000 added a domain of vulnerabilities to the model, recognizing that factors that contribute to the vulnerability of a population may also contribute to health status and health behaviors (Gelberg et al., 2000; Swanson, Andersen, & Gelberg, 2003).

Applying Framework to the Phenomena of This Study. The original iteration of Andersen model, rather than the Gelberg-Andersen revision has been used to a limited degree in research on women Veterans health. These studies maintain the predisposing, enabling, and need components as determinants of health services utilization, albeit the additional vulnerable domains are not included. A 2013 study by Hamilton, Frayne, Cordasco and Washington used Andersen’s Behavioral Model in a cross-sectional study of women Veterans who leave VA care and the reasons for their attrition. The authors used Andersen’s model to hypothesize that women Veterans who leave VA care were significantly different in their need characteristics than women Veteran VA users, specifically in terms of individual characteristics and perceptions of VA care. Indeed, the authors found that women Veterans who left VA care had significantly negative perceptions of VA care (Hamilton et al., 2013).

In another 2013 cross-sectional study Washington, Davis, Der-Martirosian and Yano used the Andersen model to understand factors integral to mental health service utilization to women Veterans who did not use VA services. The objectives of this study were to determine the prevalence of PTSD in women Veterans in the general population, characterize mental health service use among women Veterans who screened as PTSD positive, and identify attributes that may predict mental health services use (Washington, Davis, et al., 2013). This study modified the original
Andersen model by including Veteran specific predisposing, enabling, and need factors, acknowledging practitioners in community settings may not recognize Veteran specific experiences among general women Veterans populations. Veterans-specific predisposing factors include military service era, combat, and MST exposure. Veterans-specific enabling factors include a military related disability, awareness of VA services for reentry (Washington, Davis, et al., 2013). Lastly, Veteran-specific need factors were screening tests for mental health conditions, substance abuse disorders, disability status and overall health status. The authors organized their results in terms of general and Veteran specific factors, demonstrating that barriers and facilitators to mental health outpatient treatment exist at multiple levels of the healthcare system, all of which warrant systematic research (Washington, Davis, et al., 2013).

**Influence on Knowledge Development.** However, a qualitative study, from a constructionist and QI standpoint would be the most appropriate method to address the relationship between women Veterans and mental health services utilization, as there are incomplete areas of the Gelberg-Andersen model. Gelberg-Anderson lacks consideration of the importance of interaction between individuals, and does not take power dynamics, gender, trauma, and combat stressors into account, issues very relevant to women Veterans. Lastly, the assumption of a healthcare provider as a member of the interpersonal environment that exerts influence over the individual is only one aspect of a dyad, which is better explained with SI. SI broadens analytical thinking regarding interpersonal dynamics and establishes that the individual influences larger society, and vice versa (Charon, 2010). Although this model stands as one possible explanation for the utilization of mental health outpatient services among women
Veterans, for the aforementioned reasons this model may not apply in its entirety to women Veterans considering their unique set of circumstances.

**Sofaer and Firminger’s Framework for Patient Perceptions of Quality**

Sofaer and Firminger created a framework for understanding patient perceptions of quality (2005) (Appendix A). This model states that patient perceptions of quality are based on responses to healthcare experiences, either once or over time, and are typically implicit rather than explicit (Sofaer & Firminger, 2005). Perceptions are a result of the interaction of the patient’s expectations and their actual experience. As individuals apply their own criteria of quality to the interaction then patient perceptions arise (Sofaer & Firminger, 2005).

**Assumptions.**

**Patient Perceptions versus Patient Satisfaction.** One of the few studies studying women Veterans perceptions of care is authored by Kimerling, Pavao, Valdez, Mark, Hyun, and Saweikis (2011). This is a cross-sectional study of the association between patient satisfaction and MST status in a representative sample of over 150,000 men and 5,500 women Veterans with and without MST. The authors measured certain aspects of satisfaction, including overall satisfaction, overall coordination, continuity, access, courtesy, education and information, emotional support, patient preferences, visit coordination, and specialist care (Kimerling et al., 2011). They found women’s overall satisfaction to be relatively high at 72.3%. However, women who experienced MST had significantly lower scores in overall coordination and education and information subscales (Kimerling et al., 2011).
When comparing the findings of Kimerling (2011) to that of Sofaer and Firminger (2005), Kimerling uses satisfaction and perceptions interchangeably, which according to Sofaer is not conceptually aligned. They are often used interchangeably but actually describe different aspects of patient perceptions (Sofaer & Firminger, 2005). Satisfaction is one of many examples of patient perceptions, and not a necessarily strong example because satisfaction does not infer superior service, but only adequate or acceptable service. Satisfaction is also a relative concept, what can satisfy one may not satisfy another (Crow et al., 2002). However, patient satisfaction is the predominant term in studies assessing quality of healthcare services. In fact, literature reviews are critical of the concepts of patient satisfaction as it lacks theoretical development, standardization, reliability and uncertain validity of measures (Crow et al., 2002; Morales, 2001; Sofaer & Firminger, 2005). Francis (2013) also asserts that experiences and the perceptions of those experiences are not synonymous with satisfaction. Satisfaction addresses an outcome, whereas experience describes the journey to an outcome (Francis, 2013). The dimensions mentioned in Kimerling are actually not dimensions of satisfaction but instead dimensions of patient perceptions as a whole. Therefore, the current literature is not sufficient in describing patient perceptions of care from a conceptual level. Hearing perceptions and concerns in the patients' own words will clarify existing models (Sofaer & Firminger, 2005).

Applying Framework to Phenomena of Study. The left side of this conceptual model (Appendix B) describes factors that influence patients' expectations: the reputation of the provider; the needs of the patient, specifically the nature, number, and severity of their needs; the extent of healthcare choices available to them; previous
interactions with the healthcare system, and in this case the mental health outpatient services system; the patient’s own personality and attitude; social/cultural norms; and the extent to which the patient knows what she can expect out the intended mental health outpatient interaction (Sofaer & Firminger, 2005).

The right side of the framework compares the actual experience of seeking and using services with the expectation of that interaction (Sofaer & Firminger, 2005). Experiences are relevant in two ways, in terms of shaping expectations and interpreting what actually transpired from that patient’s point of view. Patient satisfaction is purposefully omitted from this model, as the authors do not consider it a useful way to gather information on patient perceptions (Sofaer & Firminger, 2005).

This framework both enriches the Gelberg-Andersen model and adds theoretical depth to the exploration of women Veterans perceptions of their mental health care. Women Veterans’ needs, personal characteristics, and the social/cultural norms of military life, Veteran reentry, social standing as mothers, wives, etc., and their expectations of what will happen during their interaction with the mental health outpatient system are all included in this theoretical approach. The unique experiences of women Veterans, from combat, MST, and mothering while on active duty will be incorporated through this framework. As women’s mental health is understood by the multiple contexts that women occupy, this framework considers those frameworks as crucial aspects that shape the interaction with the mental health outpatient system.

**Influence on Knowledge Development.** This framework is compatible with Constructivist Grounded Theory, in that it considers one aspect of interaction, in this case intrapersonal interactions of healthcare expectations and actual experiences.
Constructivist Grounded Theory and SI are the broader philosophical and theoretical bases on which the patient perceptions model is built. Qualitative inquiry is necessary to identify robust descriptions of women Veterans' interactions with the mental health outpatient system that relate to the concerns of woman Veteran, using the woman Veteran's own language (Sofaer & Firminger, 2005).
Design

This study followed a qualitative design, specifically a constructivist grounded theory approach as articulated by Charmaz (2014). Unlike a deductive approach which takes an existing theory and applies it to a phenomenon, the theory itself is “grounded” in the thoughts, perspectives, and experiences of the participants experiencing the phenomenon (Creswell, 2013; Guba & Lincoln, 2005; Lincoln & Guba, 1985). The goal of a grounded theory study then, is to learn about the world and establish a theory to develop an interpretive portrayal of the studied world (Charmaz, 2014). Grounded theorists aim to fit emerging categories with the data, and create the basis for emerging hypotheses that spark new research (Charmaz, 2014).

Sample Population

Inclusion criteria. Participants eligible for this study were women ages 21-65 who served in the regular armed forces or a member of the National Guard or Reserves who had been called to duty. Considering the age range for eligible women Veterans, it was expected that women would typically have served in the OEF/OIF, Gulf War/Pre 9/11, and Vietnam eras. Women Veterans must have had at least one mental health outpatient service visit in the past twelve months. Although women in the National Guard or Reserves are not active duty military, those who are called to service tend to have similar military experiences than women in active duty (Helmer et al., 2007).

Exclusion Criteria. Participants were excluded if they were currently hospitalized for a mental health diagnosis, under the influence of drugs and alcohol, or under psychological distress. Being under the influence of substances and under
psychological distress was determined through an inability to articulate experiences and
judged in conversation. This study also excluded current active duty military personnel,
VA employees, including VA work study students, women Veterans who are mental
health providers, and nursing home residents. Active duty women have not experienced
the reentry process and are not eligible for VA services. VA employees, mental health
providers and work study students may have insight into healthcare system that could
make them overly sympathetic to or critical of how mental health outpatient services are
designed and implemented. Nursing home residents are unable to access mental health
outpatient services because of advanced illness.

In order to accurately assess psychological distress I completed two trainings on
suicide prevention: Suicide Prevention Gatekeeper approach, and the other Applied
Suicide Intervention Skills Training (ASSIST). These trainings also provided the
necessary clinical assessment and skill level for a response in the event of any suicidal
ideation or intent expressed by the women during the interviews.

Recruitment

The women Veterans recruited for this study were women Veterans who used
mental health outpatient services in community based, insurance based or VA services.
From previous literature an estimated 50 women would need to be approached to
obtain a sample of 10-25 needed for theoretical saturation (Washington, Yano, Simon,
& Sun, 2006). I estimate I approached at least 500 women Veterans through a
combination of in person and online recruitment methods. Of those I estimate half were
ineligible due to age or mental health use criteria. I approached approximately 30
women in person, all of whom were eligible to participate, and 24 refused. In total, 6
women were recruited through in person recruitment through women Veterans outreach
events, and the other 6 were recruited via electronic means such as email list-serv
distribution, and Facebook posting.

Recruitment took place both online and in person. In person sites included: a
Veterans Center in Gardena, CA, Veterans service organization events, and Veterans
resource office on a college campus. Veterans Centers are satellite centers that provide
mental health and reentry support services. They are appealing to some Veterans
because they are open for extended hours on afternoons and weekends and have
multiple centers throughout the community. Although VA patients are frequently referred
to Veterans Centers, they are not under the same jurisdiction and supervision as VA
medical centers. The women Veterans support groups, offered the first Saturday of
every month have an attendance between 10-20 women Veterans that meet eligibility
criteria.

Both in person and email based recruitment occurred though Veterans Service
Organization events and emails. Some of the Veterans services organizations that
have agreed to distribute recruitment materials via email are the National Veterans
Foundation (NVF), Military Women in Need (MWIN), the Department of Veterans Affairs
in the City of Los Angeles and in the County of Los Angeles, and Iraq and Afghanistan
Veterans of America (IAVA). The NVF email list-serv consists of approximately 50
persons, with at least half of the group identifying as women Veterans. The IAVA
reaches at least one hundred women Veterans through their website, email listserv, and
monthly events. The City of Los Angeles and County of Los Angeles reach
approximately 30-50 women every month during their networking events. The
researcher created and fostered key connections in each of these settings to ensure visibility of recruitment materials and management buy-in with the specific aims of the study. Women Veterans who are interested in the study provided contact information to the researcher to schedule an interview screening. Another key site for recruitment was via women Veterans Facebook groups. I created a separate social media profile just for the purposes of this study and joined three groups: Women Veterans of California, Women Veterans of Los Angeles, and Cal Vet Women Veterans. I gained permission from the site administrators to post my recruitment flyer on their page and invited women Veterans to participate.

Although the ideal study parameters were to recruit and interview one at a time, I found that this group of women were difficult to access and recruit due to reticence to share mental health experiences, and lack of mental health service use within the past year. To reach theoretical saturation, four of the interview participants were recruited collectively and interviewed individually from the same location, a home for sober living. Because of program guidelines their schedules were set by the program, and not independently. This was necessary to ensure access to these women who provided a unique perspective on use of mental health services by women veterans and remain amenable to their considerable schedule restrictions. Within this context, to schedule interviews over four separate visits would be a strain on the resources of the program, who set and manage the women’s schedules within and outside the home.

This strategy follows Charmaz’s recommendations to remain flexible, preserve participant dignity through establishing rapport to conduct interviews and maintain positive relationships (Charmaz, 2014). In the circumstances of accessing women
through substance treatment centers, the rapport must be established with the program staff as well as the individual participants. Also, considering the traumatic histories for the research participants, respect for their personal boundaries and space was of the utmost importance.

**Setting**

Interviews took place at coffee shops, on a college campus, and within private conference rooms at the participants’ place of employment. The women recruited from the sober living home were interviewed in a private room in the residence. No interviews took place on a VA campus or within a treatment setting.

**Sampling**

Grounded theory begins with initial sampling following the inclusion and exclusion criteria. According to Charmaz (2014), and Clarke (2005) theoretical sampling occurs once an initial stage of analysis is completed, and subjects are selected not to represent the target population nor satisfy a set sample number but to flesh out themes and categories rising from the initial interviews. The process of theoretical sampling contributes to building the open and axial coding to contribute to the eventual theory (Creswell, 2013). Once initial sampling is achieved theoretical sampling will proceed later in the analytic process once categories are established (Charmaz, 2014). Memo writing throughout the analytic process will establish a basis for identifying incomplete categories and analytical gaps. Then, data collection can proceed with the intent of constructing robust categories and clarifying relationships between those categories (Charmaz, 2014).
**Initial (Purposeful) Sampling.** Purposeful sampling is used in qualitative research, meaning the researcher selects research participants for a study because they can purposefully inform an understanding of the research problem and the phenomenon under study (Charmaz, 2014). The intention of sampling in qualitative research is not for generalization of large amounts of data, but to elucidate the specific, by collecting extensive detail on a limited number of participants and research settings (Charmaz, 2014; Creswell, 2013). According to Corbin and Strauss (2006), qualitative theoretical saturation may be achieved with between 10-25 participants in developing a grounded theory. Theoretical saturation occurs when the collection of new data no longer sparks new analysis or reveals new properties of the emergent categories. In this study, purposeful sampling was used as an initial sampling strategy as a way to begin data collection. Sampling criteria were established before entering the field.

For this study, I sought to sample women Veterans to represent a range of demographics, including ages, service eras, military branches, and maternal status. After each interview, I documented my observations from the field in fieldnotes and impressions of the interview data in a memo, a written document used to actively engage with the data by capturing insights about the data, making connections between the data, and articulate analytical development. I then used analytic techniques (described later) to engage with and analyze transcript data, then reviewed my findings with my faculty advisor. After interview 7 (“Lola”), I moved into theoretical sampling under the advisement of my dissertation chair.

**Theoretical Sampling.** Theoretical sampling is a type of purposeful sampling derived from analytical categories and theoretical concerns of the particular study
Theoretical sampling purports to enrich theoretical and conceptual development, not to represent a target population or to make the results statistically significant. Following the principles of constructivist grounded theory (Charmaz, 2014); the sampling procedure followed initial purposive sampling with theoretical sampling. From coding, analyzing, and memoing interviews 1-7, I noticed frequent and significant codes relating to: significant trauma; the dynamic process of changing, rebuilding, and negotiating identity within and outside the military; transitions in space, role, and sense of self marked by the movement into and out of the military; and lastly the position of the military and other circumstances as sorts of structure to provide stability. From there, I specifically sought women who were experiencing transitions. I carefully considered, through reflecting, journaling, and memoing, on the definition of and concept of transitions. I consulted the literature, particularly Meleis (2012), in her interpretations of transitions: notably the individuals’ incorporation of new knowledge, changing behavior, and the subsequent development of the definition of self. I considered transitions in the forms of health/illness, situational, and spatial when searching for new participants (Meleis, 2012). I found with interviews 8-12 that the conceptual hunches in my analysis were developing, becoming refined, and given depth and dimension with these subsequent interviews. I shared my data analysis and developing categories with my advisor, who supported my claims of broad depth and range of category formation. Therefore, for this study, theoretical saturation was achieved with 12 participants.

**Study procedure**

Women responded to the flyer by contacting the principal investigator by phone, who then screened each woman to determine eligibility (Appendix C). During the
eligibility screening process, the PI described the eligibility criteria, purpose of the study, and the expectations for research participants. If the potential participant met eligibility criteria, the investigator scheduled a time to meet in person to complete the consent form and conduct a recorded interview between 45-90 minutes in length. At the in-person meeting, the investigator ensured participant confidentiality and privacy, the voluntary nature of the study, and the risks and benefits of study participation. Potential participants were informed that participation or refusal to participate in the project would not affect their current health care services in any way.

After consent was obtained, contact information and basic demographic information was collected including: age, self-reported ethnicity, rank at entry and discharge, maternal status and marital status. The participant was also informed they would be assigned a pseudonym, which was the name they were called in this analysis. The participants were aware that a pseudonym would be assigned, but they did not know what that pseudonym would be. Although participants were notified of the interview length, they were also advised that they could decline to answer interview questions or end the interview at their discretion and comfort. They were assured that their eligibility or use of services in any context was not influenced by their participation, or lack thereof, in the study. Interviews were guided with a semi structured interview guide with questions based on military experiences; views of mental health, mental health service history, and mental health provider preferences (see Appendix F). The participant was given a $25 gift card as compensation at the end of the interview. The content of the questions changed based on the advisement of the principal investigators’ advisory committee to explore and fulfill possible theoretical categories.
Debriefing. After the interview was completed and recording ended, I debriefed with the participant as to how the interview went for them, how they felt about it, or if there is anything they would recommend to change or add about the interview process. These opinions were added to the study field notes for potential modification for future interviews.

Due to the sensitive and traumatic nature of the interviews, I performed an intrapersonal debriefing to prepare for the next interview. In these situations I used field notes to debrief and included significant feelings in the analytic memos, as that mindset may alter or change the nature of analysis or conceptual formation. In addition to fieldnotes, I kept a personal journal of my thoughts, feelings, and responses to interviews and throughout the interview and analysis process. To maintain my psychological well-being, I used services through the Counseling and Psychiatric Services (CAPS) provided on campus. I also attended a dissertation writer’s support group, offered by CAPS, which met weekly to discuss significant positive and negative aspects to the dissertation experience.

Privacy and Safety. Interview transcripts and participant identifiers were stored in a locked file cabinet which only the principal investigator has access to. The investigator received approval from the UCLA Institutional Review Board (IRB) to conduct interviews and maintain participant privacy.

There were two resources available in case the participant expressed emotional instability or need to hurt self or others, she could be referred to the Veterans Crisis line, which is available via at 1-800-273-TALK (8255), option 1 and via text message to the Veterans Crisis Lifeline at 833255. Depending on the emergent nature of the crisis,
emergency services (911) would have also been alerted. All participants were offered a list of mental health services resources compiled from the Veterans Resource Book authored by the California Department of Veterans Affairs.

As a safeguard, I established contact with emergency and outpatient psychological services for participants expressing desire to harm self, others, or other emergent psychological distress, and created a partnership with an expert psychologist, Dr. Perry Nicassio, that served as an on call mental health provider if a woman Veteran expressed psychological distress, or suicidal ideation or intent. No women expressed intent to hurt themselves or others during screening, consent, or data collection.

Timeline

Due to the unique nature of constructivist grounded theory, recruitment occurred throughout the interviewing and analyzing process. For this study, initial sampling took approximately 6 months, from August-December 2015. Theoretical sampling took place from January- March 2015.

Data Analysis

Description and Analytic Strategies. Consistent with Charmaz’s (2006) description of gathering grounded theory data, emerging analysis was shaped by simultaneous data collection and analysis. Therefore, my analytical process began by crafting a semi-structured interview guide with prompts that were open-ended and in depth to gain an understanding of women Veterans’ insights and range of experiences, particularly in terms of mental health and accessing mental health services. Interviews were transcribed verbatim by an independent transcription service, with identifiers
Next, the transcripts were coded by the principal investigator with line by line and section codes to summarize actions, experiences, and feelings within interviews.

**Analytic Techniques.** Data collection and analysis occurred simultaneously, with interview transcripts as the object of data analysis and using coding to summarize and “select, separate, and sort data” (Charmaz, 2014). By using line by line and focused coding strategies I was able to see similarities, differences, and gaps between and within interview participants. I would ask questions of the data, use my own personal experiences to make connections or establish relationships in the data, look for processes within the data, and write my findings within a memo (Corbin & Strauss, 2008). My doctoral chair served as second lens for consensus on focused and theoretical codes.

In the midst of interview coding I would alternate between coding that remained close to the data while also using analytic techniques described by Corbin and Strauss (2008), to raise analysis to a theoretical, interpretive level that spanned between and within interview participants. I used the analytical tools of ‘looking at language’, ‘using various meanings of a word’, and the ‘Flip-Flop technique’ to help me answer the overarching questions of, “What is happening here?” and “What is the meaning of this word, phrase, or passage?” (Corbin & Strauss, 2008). For example, one woman described her mindset toward her MST experiences as “[Y]ou took something from me, but I’m not going to let you keep it” (Interview 2 “Yolanda”). I used the “various meanings” strategies to determine any other meaning of the words “keep”, and “it” in this passage, and the “flip-flop” strategy to ask myself, what would be the implications if she did let the “you” (i.e., the perpetrator) “keep it.” Furthermore, her use of the word
“let” in this passage can denote a sort of power or permission that she claims to have. In my analysis, I connected this statement to constructivist issues of multiple subjective realities and a potential power relationship between the participant and her perception of the perpetrator and the trauma she endured. I collected my thoughts, ideas, potential connections, and questions related to analysis in the form of memos. I advanced the analysis through memoing by reflecting back on completed interviews while coding future interviews and applying the questions, concerns, and analytical hunches from previous memos into the transcript currently being coded and documenting that analytical synthesis into a new memo. This in turn generated more questions, cemented or altered the nature of theoretical relationships already established and overall heightened abstraction.

Considering the sensitive study topics and complex issues that arose from the interview data, the analytic strategies of ‘looking at language’, ‘using various meanings of a word’, the ‘Flip-Flop technique’, and asking questions of the data were crucial in understanding and engaging with the data. Certain passages of data, although short, required lengthy consideration. An example of this was from Interview 11 “Gwen”: “It’s a lot of my reason why I was using. It stemmed from the main incident. And I started becoming that person that they kept saying I was after the incident. And it’s just unhealthy.” For this passage I used the techniques of questioning and looking at language as described by Corbin and Strauss (2008). Considering the significance of this passage in terms of its emotional complexity, I asked theoretical questions of the data as to why her “using”, “the incident” and her “becoming” were linked and interrelated. Her substance use could be an extension of the attitudes of the “they”, and
her adoption of that behavior indicates a severe degradation in power and self-concept that may have occurred after “the incident.” This incident was so powerful that it possibly changed, or transitioned, her self-concept (identity). In regards to language, I took note of how the language she used showed her insights and conceptualization of her experiences (Corbin et al., 2008). Notably, she referred to her substance abuse as “using”, (rather than “smoking” or “drinking”), her trauma as “the incident”, and her assailants as “they.” I memoed on this use of indirect, vague language and how it may symbolize a sort of distance, or hesitance to approach the actual words, and by proxy the tangible experience. It is possible that, using indirect language became a way to avoid the actual details, which for her are traumatic and potentially paralyzing to encounter at once.

**Situational Mapping.** To further raise the level of abstraction, I utilized Clarke’s (2005) methods in creating two kinds of abstract situational maps: a messy and ordered version. Following Clarke’s (2005) recommendations I used my position as the research instrument to place the concepts, people, objects, places, and abstract discourses relevant to women Veterans and mental health on paper. For the messy map, I chose an anchor, or starting point, and created a series of relationships between this anchor and the other map elements, answering the statement “The nature of the relationship between the anchor and another entry is….” I created these maps by hand and within Atlas Ti software to have multiple standpoints for data analysis and remain open to the insights that can come from using each method (Appendix G; Appendix H). For the ordered version I used the same elements and ordered them based on their attributes and inherent properties from the data.
(Appendix I). Using these methods to manipulate abstract data concepts revealed connections between seemingly unrelated factors and deepened attributes of a category in a formative stage. Entries that were deemed less relevant to the map were removed, and I memoed about my reasoning behind relationships, dimensions and omissions in the maps.

**Engagement with Social Worlds.** To enhance data collection and data analysis, I engaged with the research participants’ worlds and the interview data in a variety of ways. To engage within women Veterans’ social worlds, I attended at least two women Veterans focused events per month. These events included the Los Angeles County Women Veteran’s Program though the LA Department of Military and Veteran Affairs, a statewide collaborative phone call and seminar through the California Department of Veterans Affairs, the LA Veterans Collaborative through the University of Southern California (USC) School of Social Work Center for Military and Veteran Families, Military Women in Need, women Veterans support groups at Gardena Veteran Centers, and the Women Veterans Support Group through Holman United Methodist Church.

At each of these events, I focused on making connections with women Veterans, and speaking to them honestly and candidly, without having an expectation that the women will be recruited into the study. I slowly gained trust and developed rapport among the small women Veterans community in Southern California, and the social services providers that support them. Over time, the faces at these events started to look familiar. Some of the women at these events were eventually recruited into the study, while others declined. I still maintain positive relationships and support for this
study among women Veterans and supporters within this network. In fact, I was
encouraged to join the military service organization titled National Association of Black
Military Women as an associate member, and still I actively participate in the LA
Veterans Collaborative in the Healthcare, and Faith-Based services Working Groups. I
completed fieldnotes after each event on my observations on the social context that
women Veterans live within, and any notable conversations or stories that I overheard
or took part in. I would also journal my personal thoughts and experiences about each
event, and connected the experiences I was having to my personal gauge of feelings
and emotions.

In addition to in person meetings, I also reviewed women Veterans Facebook
groups 2-3 times per week. Although I would post my flyer to the group pages,
reviewing group posts was separate from active recruitment, and was an observational
activity to see how women Veterans communicated with one another and to gain insight
as to what was important to women Veterans. They spoke to one another in ways that
reflected humor and also frustration with aspects of their lives, such as health and
finances. They also shared articles and jokes that were specific to the military
experience. Engagement with the social worlds enriched the analytic process of
memoing and mapping and contributed to the development of a robust constructivist
grounded theory.

Constructivism & Reflexivity. Constructivism, as one of the underlying
philosophies of CGT, asserts multiple subjective realities and conditional truths based
on the positions one occupies in time and space (Charmaz, 2009; Charmaz, 2014).
This influences CGT methodology because it encourages the researcher to
acknowledge their place in the construction of data and to remain aware of their circumstances and the social circumstances of participants. Constructivism also purports knowledge is not objective, but is instead shaped and interpreted with pre-existing social constructions (Charmaz, 2009). Researchers utilizing CGT recognize that the research process can reinforce social constructions and power structures and is not an objective, neutral procedure. This constructivist assumption implies that researchers practice reflexivity throughout the research process to ensure these constructions are not simply reinforced in their foray to create new knowledge.

Reflexivity & Bias.

One way in which I remained reflexive throughout data analysis was to recognize and address my own bias. Constructivist grounded theory (CGT) acknowledges the researcher as an integral part of the data collection and analysis, as the data obtained is in fact a co-construction between the researcher and the participant (Charmaz, 2009; Charmaz, 2014). Therefore, the researcher should not only be aware of biased interview data, but even own their biases in doing data analysis. I realized that my continued interaction with women Veterans in a social capacity enriched data analysis, but could also introduce bias during my data analysis. The analytic process presented a sort of “check” or “tollgate”, through which I could gauge my opinions toward the data and ensure that I did not adopt the women Veterans’ social viewpoint as the only way the data could be understood. Through memoing, I was able to recognize my personal bias against the U.S. military as a patriarchal, authoritative, secretive system where personal liberties and personal identity expression are diminished, if not mitigated altogether. Upon reflection I realized particular codes would reflect this inherent bias,
and in my messy mapping the relationships I created were based on the notion that the U.S. military was somehow repressive. For example, one relationship I mapped was between women Veterans and Veteran men, with the crux of the relationship being that Veteran men perpetuate mental health related stigma and gender based harassment, a negative connotation. Although that relationship was present in the data, I realized I failed to take into account that Veteran men can also be positive influences in the lives of women Veterans. Another bias I recognized was the presence of trauma in women Veterans’ lives. I recognized in this analytic process that I assumed trauma, especially MST, to be omnipresent in all women Veterans’ stories. Although women in this sample disclosed experiencing MST, there are a plurality of stories and experiences before, during, and after the military, and MST may not be a part of it. Recognizing biases made my analysis more sensitive, as I was more aware of ensuring my abstractions were derived from the data and not my opinions.
CHAPTER 5- Results

Introduction

The purpose of this Constructivist Grounded Theory study is to understand women Veterans’ experiences in accessing and using mental health outpatient services and determine factors that influence how and why women Veterans seek mental health outpatient services. The specific aims of this study were to: (1) describe women Veterans’ decision-making process regarding entering mental health outpatient services, (2) describe women Veterans’ experiences utilizing mental health outpatient services, (3) identify aspects of mental health outpatient services that are important to women Veterans, and (4) ultimately, to create an explanatory framework of the processes used by women Veterans to access and utilize mental health outpatient services. The final goal of this research study is to develop a substantive process, grounded in the words of women Veterans’ themselves, of the ways in which women Veterans form their views of mental health and mental health care, how they decide to enter care, and what their experiences are once they have entered mental health care.

Twelve interviews were conducted and analyzed following constructivist Grounded Theory articulated by Charmaz using the constant comparative method to reach theoretical saturation. Four major categories, emerged from the data as formative factors related to mental health decision making, experiences using mental health and value formation related to mental health: (1) Transitions, (2) Identity, (3) Structure, and (4) Trauma. Although these categories are integral in relation to understanding each of the specific aims, together they form a broader conceptual model and Grounded Theory descriptive of the complex processes used by women Veterans to understand
process trauma such that they are able to develop a reconstructed sense of self in concert with seeking mental health services following discharge from the military. The military experience adds to the complexity of identity transitions and trauma.

**Participant Demographics**

**Sociodemographic.** The sociodemographic information of the 12 women interviewed is presented in Table 1. The average age of participants was 43 years at time of interview (min=25, max=65). This is slightly younger than the national average age of 48 (National Center for Veterans Analysis and Statistics, 2011). Four (33%) of women sampled were unemployed at time of interview, with another 4 (33%) as full time students, the last 4 (33%) had full time employment or were retired from full time employment. The majority (66%) of women used VA healthcare benefits as their primary form of health coverage. One woman also used VA as a secondary form of coverage to supplement her insurance from her employer. Only 3 (25%) women in the sample did not use any VA health services at the time of interview.

Three (25%) women were married at time of interview, while the rest of women were not partnered (divorced, single, or widowed). In terms of income, the women interviewed were in two extremes, with 5 (41%) women reporting low income ($0-$20K/year), and 4 (33%) with yearly incomes greater than $60K. The majority of women (7, or 58%) were mothers, with the rest reporting not having children at time of interview. In regards to ethnicity, half (n=6) of the sample were racial/ethnic minorities: 3 black (n=3), Latina (n=2), and Asian/Pacific Islander (n=1). One woman declined to state her ethnic background, one woman described herself as mixed race (black and white/Caucasian), and the rest (4, or 33%) self-identified as white/Caucasian. These patterns differ
somewhat from national statistics. Black women are overrepresented among women Veterans (19%), compared to the general population (12%), and are overrepresented in this sample (25%) (National Center for Veterans Analysis and Statistics, 2011). Latina women are generally underrepresented among women Veterans (7%), but are overrepresented in this sample (~17%) (National Center for Veterans Analysis and Statistics, 2011).

**Pre Military Context.** The majority of women Veterans interviewed for this study described a pre-military situation or context that was somehow unstable, dysfunctional, or maladaptive. The range of experiences described included childhood emotional, sexual, or verbal abuse, coming from a low-income neighborhood, substance abuse/addiction, and intimate partner violence. Only one woman of the 12 interviewed mentioned a stable, supportive household in which she felt she had access to socioeconomic viability and did not disclose patterns of abuse. Context served as the foundation for joining the military and unfortunately those women who disclosed pre-military trauma (N=9; 75%) also experienced traumatic events during and after military service.

**Military Service.** Table 1 presents information on military service and mental health service use. The Army, Navy, and Air Force had similar representation throughout the sample. Interestingly, the sample included one Coast Guard woman Veteran. Coast Guard soldiers represent 2.1% of the total military, 1.7% of active duty soldiers, and 1.4% of Veterans. Of Coast Guard Veterans, women Coast Guard Veterans comprise 0.9% of the total Veteran population, so her participation is a unique feature of this research study (National Center for Veterans Analysis and Statistics,
Eleven women (91%) served as enlisted soldiers during their military service. Of those 11, eight served as Non-Commissioned Officers (NCO). NCO’s are enlisted soldiers, but who are typically given supervisory roles over other enlisted soldiers. Half (50%) of the sample served in the National Guard/Reserve after active duty service. Guards and Reservists have civilian career and military responsibilities, and can be called to service depending on State and Federal Needs. Reservists can only be called to duty by federal order, whereas Guardsmen can be called to serve based on state and federal needs (Bureau of Labor Statistics, 2014a, 2014b). Lastly, military service periods are evenly distributed from 1980-2014. This includes active duty and Reserve/Guard service. None of the sample was called to active duty from Reserve or Guard status.

**Mental Health Service Use.** Table 1 describes the healthcare service use for the study sample. Seven (58%) of women have been in mental health treatment for greater than one year. While using mental health outpatient services in the past year, six (50%) of women have seen both a psychologist and a psychiatrist, five (41%) were seeing either a psychiatrist or a psychologist at time of interview, and one woman used her informal social support network as a form of mental health treatment in the months immediately post military service. None of the women disclosed that they used other mental health provider types, e.g., mental health nurse practitioner, therapist, or a social worker. Four (33%) of women were recruited from a substance abuse rehabilitation program for women Veterans, hence they each endorsed a history of substance abuse.
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<tr>
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</tr>
<tr>
<td>During Post-Vietnam Era (May 8 1975-Sept 7 1980)</td>
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<tr>
<td>Between Vietnam War and Persian Gulf War (Sept 8 1988- Sep 17 2001)</td>
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### Mental Health Outpatient Service Use Characteristics

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<th>Psychiatrist</th>
<th>Other</th>
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<tr>
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#### Time in Treatment

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<td>6-9 months</td>
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<td>Greater than 1 year</td>
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Individual Profiles of Women Veterans

Telling each woman Veterans’ story in her own words honors each of the women who participated in this study, and the powerful stories they shared. The profiles of each of the 12 women interviewed also provide evidence for the conceptual model (Figure 5-1). Each woman will be referred to by the pseudonym assigned at time of interview. All demographics and information provided is at the time of interview, and significant identifiers have been redacted. In addition to quotes, I described significant pre, intra and post military service experiences, which sets a precedent for the description of the Grounded Theory (Appendix J).

Theoretical Model of Women Veterans Perceptions of Mental Health Outpatient Services

Description of Overall Model. Figure 5-1 describes the overall conceptual model for women and the process by which they reconstruct and reclaim their identity and sense of self when confronting traumatic histories illustrating the linkages between the emergent concepts of identity, transition, structure and trauma within the context of having served in the military. Women Veterans perceptions of, experiences with mental health outpatient services, and aspects of using mental health outpatient services that are important to them are also included within this process. Then, these results will address each of the specific aims. Finally, this section will explore final stage of reclaiming sense of self.

The data collected not only revealed the process in which women Veterans perceive and use mental health outpatient services, but also a process in how they create and maintain their sense of self after leaving active duty in the military. This is a
process that is continually moving forward, rather than cyclically or on a pendulum. Looking back or fixating on military service often means confronting a traumatic and painful history, which they are actively trying to leave in their past. Instead, these women Veterans are focused forward on what they have the potential to accomplish.

**Categories.**

**Trauma.** Each of the women in this study reported some sort of trauma throughout the course of their lives, from their childhood to the present. This trauma took different forms and had differing levels of intensity, but all events created instability for the woman in terms of her security, trust, sense of worth and view of the world. For this sample of women, trauma does not just describe an instance of rape or assault, but also describes harassment, threatened assault and/or harassment, and unwanted sexual advances. Types of trauma varied from combat trauma (n=3), childhood abuse (n=9), domestic abuse, military sexual trauma (MST) and repeated instances of rape and harassment. Nine women disclosed more than one instance of trauma throughout their lifetime. In describing repeated harassment, one woman remarked:

Yeah that was one of the many scenarios that happened other than like with people trying to get me to drink or I’ll say no I’m not going to do that or other men trying to advance on me and stuff like that. (Brandy)

Another woman also comments, “And then um, my dad who I have issues with as far as abuse, not physical abuse but mental and emotional abuse” (Lola). The pervasiveness of trauma infiltrates all parts of this conceptual model (Figure 5-1), hence its placement at the top of the model and its connection downward from home situation to the end of the model at sense of self. It is the context in which this process takes place. The
trauma that took place in their lives created disruption in their self-identity coupled with the identity formation inherent in becoming a soldier. Trust had been destroyed and is never fully regained after.

**Transitions.** Transitions in this model (Figure 5-1) refer to the changes in the structure of the environment and identity that propel these women forward toward the recognition of a need for assistance in reconstructing their sense of self. One of the first transitions these women report is joining the military and the changes in environment that can occur with duty station assignment, military occupation, potential deployments and the tight structure of military life. The next major transition is out of the military and back into the civilian world, where women Veterans must transition into housing, employment, and in a larger sense, the role of a woman in larger society. Because of the overarching nature of trauma, this process is achieved with varying levels of success. Women Veterans use mental health outpatient services to facilitate this transition into stability once they have reached the civilian world. As one woman stated, “I’m now pushing 50, got rehab, managed to get help, and it took a really horrific, horrible thing to happen to me to be able to do that” (Jessica). Another woman describes how stability keeps her connected with her provider, “I do know that I need to have a little bit more of rela-, of relationship with my-my therapist because I know that that keeps me grounded” (Yolanda).

Transitions also occur within each of the components of the model. In addition to the larger transitions in physical location and occupation that occur when joining and discharging from the military, identity, structure, and sense of self are themselves in
transition as the woman Veteran moves forward in the model. Women discussed setting their own priorities and even the health transitions they may anticipate for the future:

I’ve got to get my life back in order. And get back on track. And yeah, I’ve got goals and things like that I want to accomplish. And I need to definitely stay sober to accomplish anything. I’m useless to this world, to myself, to everybody if I’m drinking. But I’m productive when I’m not. So if I stay sober, that’s one big huge chunk out of the puzzle you know right there. Then I can work on things…I want to be a contributing factor to society, not be a leech basically. (Mary)

Another participant also discussed her potential health needs as follows:

But one day it’s nice to know kind of in the back of my mind like, one day when I’m you know, I don’t know 45 years old or something and like these issues, this, this knee injury I got while I was in the military since it’s service connected that um, that if it starts bothering me that the-the VA or the military will cover it. (Delia)

Even at the conclusion of the model, the sense of self is not a static, fixed entity. It is one that is reshaped by the woman Veteran, and she uses mental health outpatient services as a tool to reconstruct her identity by confronting and coping with trauma.

Identity. In considering transitions of status, there are also transitions and changes in identity. Upon joining the military the woman assumes the identity of a soldier, which is engrained during the arduous process of basic training. Notions of gender in the military are often reframed, as women are in the minority. Exposure to a male dominated field and MST influenced how the women Veterans interviewed portrayed and communicated their feminine selves:
Because all the other girls were, I’m sorry, but they were sleeping around with all
the guys on the ship and on the base because we were still in port. So when they
see one that stands out, oh nobody’s been with her, well that makes you a target.
And I didn’t want to be with anybody. I was in the military. I wanted to serve, not
to be with all the guys in there. (Mary)

Once re-entering the civilian world, the status as a soldier is lost and the role as a wife,
mother or nurturer is assumed. A participant describes her childbearing experiences
once leaving the military as:

So all these different aspects of my day just… And I was a mother only. And I
do value motherhood. I think it’s very important for ourselves and our country
and our world. But it was just hard letting go of all those other things. (Carmen)

Part of the reclaiming and restructuring sense of self is not only creating a positive
identity and behaviors in the face of trauma, but also is creating a sense of self separate
and unique as a civilian.

**Structure.** The last major concept in this conceptual model is structure, in that
the participants reported actively seeking out the stability inherent within structures such
as the military, “When I was in the military, for me it was the parenting that I never got. It
was highly structured. It was organized. I could advance through my own merit. You did
the work, you advanced” (Jessica). Structure also refers to what happens when a sense
of structure is absent. Structure seeking can happen as early as adolescence, where
many women in this sample join the military to get away from a traumatic household or
maladaptive behavior, such as substance abuse and addiction. One woman shared,
“It’s just, I joined getting away from crack. I said, I’ll join the foreign legion” (Kim). They
seek out a system like the military to gain a sense of structure that was absent in the home situation they came from.

**Underlying Trajectory.**

*Home to Military to Civilian.* With trauma as the larger context there is an underlying trajectory shown in Figure 5-1. This describes the change from home/pre-military situation, to military, and back to being a civilian. This movement through different sectors throughout the participants' lives generally triggers changes in the major concepts of transitions, identity and structure. The final stage of a restructured sense of self occurs at the civilian stage of this conceptual model, which represents the summation of experiences over the life course so far.

**Trauma Grounded Theory Process Model**

Data analysis revealed a detailed grounded theory process model of how the major concepts were related. These women Veterans experienced trauma, transitions, identity reformation and eventually used mental health outpatient services to reclaim their identity and take ownership of, not responsibility for, their traumatic experiences. As a result, they were able to incorporate military experiences into their reformed identity. They are able to renegotiate the place of trauma from a position where they accept the blame and shame of what happened and reframe their trauma in terms of the example they can set to others, and their pride in what they have been able to overcome. This process model incorporates each of the major concepts in some way.

*Traumatic Event.* This refers to the traumatic incident or incidents in their lives that shattered their views of the world and personal identity. Some women had one instance of sexual assault or rape, while others unfortunately suffered multiple incidents.
Combined with this, nine women experienced childhood trauma as verbal, emotional or physical abuse within their families, along with poverty and low socioeconomic viability in their neighborhoods.

**Instability.** As a result of trauma and their diagnosis women Veterans talked of entering a period of instability, which lasted from months up to ten years. The participants who reported having PTSD and other mental health symptoms indicated that their ability to form meaningful relationships, stable housing, and to maintain sobriety was impaired. Some women become involved in multiple abusive relationships, substance abuse, and may experience homelessness. A notable component of this model of trying to recreate stability reported by the women was the encapsulation of trauma. As a means of survival, women reported emotionally locking away their trauma and their reactions to it. This phenomenon, which the author has called “Soldiering On”, is a means of managing stress by regaining some stability to be able to continue to move forward, and to perform even with significant trauma (Shkurti, 2011). These women reported doing this in order to maintain a household, job, or sense of sanity as they move through the world and threatening spaces, “Because it-it… And I think I don’t really realize how I felt when I was in the military ‘cause I just put up this strong front and I kind of just block everything out when I’m walking through there” (Keisha).

Their military training had effectively taught them to dissociate from the harsh and potentially violent exposures that can happen during their service and lock it away. They talked of continuing to use this skill when they re-entered the civilian world to dissociate from their trauma in order to function in civilian life. In describing her attitude, one woman shares “You know you suck things up; you don’t cry about it and whine
about it. You just do it you know” (Barbara). Although they have consciously locked away their trauma (“safe”), the negative repercussions manifest themselves in their lives as instability:

So, a lot of that stuff, you know, plays back in your mind. I mean you try to not to think about it, but it’s still there. And it happened, you know. So, uh, from that, I ended up getting divorce...because all of this was, you know, playing in-in the back of my mind. (Yolanda)

However, as these women told their stories it became evident that this encapsulation, combined with the hypervigilance, emotional numbing, and triggering that are symptoms of PTSD became increasingly difficult to manage over time, and eventually degraded the woman’s ability to maintain the life she has established post military:

And I feel like they took that from me or something. But I don’t know if that’s possible. But it just like since I have not been able to dissociate, I have completely isolated. I have stopped like having a life like I used to. I used to be social and outgoing and optimistic. And my whole like personality has changed like 180 degrees.....because I’m looking at the reality of the situation as opposed to the fantasy of it. You know, I've always been really optimistic. But now I’m not. Now it's just like okay I'm dealing with it. I'm going to go with it. I'm going to keep fighting but like it doesn't look good. (Lola)

Some women described relapsing as a result of their mental health, as the woman who said, “But then I lapsed. You know depressed. Why does it make you go back to that again? Never again” (Kim).
The women who were mothers reported lack of an emotional attachment to their children during deployment and after return, as their symptoms made it difficult to bond with their own and their children’s emotions:

Yeah um, ‘cause you know and I had always hoped that I would be very close uh, that my son and I would be very close...You know but I think a lot of it had to do with the fact I was never around...From the time he was eight on... ‘Cause I was in the military. I was always gone.... (Barbara)

**Tipping Point.** Over time, women reported reaching a tipping point, where they had exhausted their coping resources and reached a point where they realize they needed resources to help them re-establish a post-military, post-trauma identify in order to move forward with their civilian lives. The participants interviewed reported incidents that included conflict with a work supervisor or spouse, incarceration, or a perceived overload of responsibilities. Some tipping points were expressed as internal realizations, while others were triggered by additional trauma or violence:

[I]t was a situation where I was kind of backed in the corner...And it was the fight… the flee or fight type syndrome you know and I had just started [OCCUPATION] the year before, And I had not gotten past my probation yet and it was like okay, one of us... you know something’s gotta give...You know and so I decided to go into treatment and I’ve been in treatment ever since. (Barbara)

“Interestingly, uh, our first interview, you know, she goes through all the background questions, like did you experience trauma as a child, are your parents divorced, did you experience drugs, did you experience violence and all this stuff. And I answered yes to like every single question she asked me. And
she's like do you realize that you went through like every traumatic [LAUGH] she didn't say it in those words, but basically she said that. Do you realize how much trauma you've faced as a person? And I just like no, I guess I haven't. You know, and she was like congratulating me to be where I'm at, you know, having gotten through all that stuff. But then I walked out of that-that session, I'm like holy cow; I did go through a lot. (Carmen)

At this time these women Veterans reported seeking and willingly entering mental health treatment. This decision to enter mental health was described as an individual choice that is not generally discussed with the woman’s social network. When deciding to enter mental health services, the women Veterans interviewed remarked they felt isolated, and had difficulty establishing trust with others. Sharing a personal decision like entering treatment would mean becoming vulnerable to those in her surroundings of whom she may be suspicious especially if a woman Veterans comes from an abusive or traumatizing childhood/ home situation, which they return to once they are civilians. As one participant shared, “Yeah. Because I didn't want to let my friends know I was going” (Sharon).

Re-establishing identity with Mental Health Treatment. The women Veterans interviewed told of confronting painful traumas from childhood to their present. Women talked of being unable at first to approach their trauma, having kept it locked away for so long:

And I'm still addressing it but it's been hard because it's hard to talk about. But at first, I didn't know where to turn to and what avenues to go through. So maybe
that’s on my own part too just feeling you know what I mean, like worried about going through it. (Gwen)

Another participant remarked keeping her pain locked away for quite some time, “But, you know, twenty years later. This is inside of me. So, I-I finally dis, discussed it with her” (Yolanda). Some of the women reported that it was difficult to separate the trauma from the context in which the trauma occurred, “Yeah, it still haunts me a little bit today, but I think about it when I have to. I don’t think about it anymore because I know it will make me mad sometimes” (Brandy).

Over time, women expressed being able to process their trauma through significant and meaningful partnerships with mental health treatment providers. They felt that they became aware and conscious of their symptoms, triggers, and the relationship between their traumatic histories and their distressing behaviors. Continued use of mental health outpatient services was reported to result in the ability to better manage their mental health symptoms, enhanced ability to form relationships, and ability to re-integrate into large systems such as healthcare, employment, and education. One woman described a time where she had to rely on her provider to help her with her education:

I check in and I know that I can call (doctor’s name) who’s my psychologist if I’m having a really bad time, which I did last quarter. I had a really, really bad time. I almost quit school. And I called her and we had a couple of appointments. She helped me to get reprocessed and she did an outstanding job. (Lola)

**Regaining Stability and moving forward.** At this stage, the women Veterans interviewed were taking active steps to move their lives and goals forward, such as
finding and maintaining employment, starting post-baccalaureate education, and securing stable, safe, housing, and entering substance abuse treatment. One participant shared her outlook for the future as follows:

   I’m going to do what I’m going to do you know, within reason. Luckily, the things I want to do actually aren’t robbing and stealing and killing and bad things. They’re just build my little—I’m doing what I need to do to make the kind of money that I can relax and enjoy the fact that it poured down rain and oh, it’s nice and bright and sunny and warm now. It’s time for sun banners on the beach. (Lola)

Another woman described the support she receives from the substance abuse program as a motivator to continue treatment:

   Um, the program and the counselors here keep us motivated and on track because I didn’t care before you know. I just had the case of the F-it. It’s like whatever you know. I’m going to go use. I’m going to get drunk. And I didn’t care. (Gwen)

The participants reported still experiencing symptoms and encountering triggers, but felt better able to handle their symptoms because of a rebuilt sense of identity, “There’s certain triggers that I have and so, um, I feel like I’m getting really good care at the V.A. as far as like, understanding who I am” (Keisha).

   Some women Veterans, expressed that the natural process of aging brought perspective and scope to their experiences, in that they were able to separate their trauma from the other experiences in their lives. Although women participants like Barbara and Kim describe MST and harassment, they also have fond positive memories of their military experience, as one woman described, “Yeah the camaraderie is what I
miss most about the service” (Barbara). Another participant broadened her worldview through her service:

Yeah so you could get 30 days a year vacation you know, so I’d take a week here and a week there. And I made a lot of friends. I have four friends who had restaurants, two Germans and two Italians that have restaurants. We’d go there and eat all the time. They’re sweet, sweet people. They’re good people. They’re aggressive but sweet. They’re from the heart. But it was just a great experience, and a lot of it I brushed it off. (Kim)

Finally, women Veterans told of forming stronger ties with women Veteran peers, and a small group of friends and family members. Ties to other women Veterans provided an outlet for experiences to be easily understood, without explaining oneself. The ties are a crucial social aspect of women Veterans lives:

“It was camp [NAME] that we were deployed at so we became kind of like the [NAME] sisters and we were like a good support for each other and um, the three of them were bridesmaids at my wedding and we got together, we try to get together every two years with our families and everything. (Delia)

Although these women took significant steps forward in confronting their trauma, restructuring their lives and re-establishing an identity, some women Veterans reported still feeling isolated during this time. Trusting relationships can be formed, but it’s a slow, deliberate, conscious process on behalf of the woman Veteran. For that to happen, the relationship must be nurturing to her and lack any expectations back as a result of forming the relationship whether social, monetary, or romantic. The women Veterans interviewed wanted an environment in which they can feel safe and
understood, rather than one that is overly expressive or focused on emotional sharing, “I have my friend (name) who, she doesn’t judge me. She listens to me. She’s had a couple kids removed from her so she knows. And we just we grieve a little bit together” (Lola). One woman describes the suspicion that comes with change and her concerns in new spaces:

Um, i-it’s-it’s new people. It’s a new area. It’s, um, am I gonna be able to thrive here? Am I gonna do okay? And so, safe, to me, is not just like, ‘Oh, there’s violence.’ But, safe is just like, do I trust the people around me? (Keisha)

**Re-establishing Identity, Owning Experiences.** In this culminating stage, the women Veterans interviewed are able to reclaim their identity and reframe their traumatic experiences. They are able to separate themselves from the shame they experienced and realize they were not to blame for their trauma. They are able to separate the traumatic experience from the other positive experiences within that context. Women Veterans in this sample at this stage were able to talk about their MST, but also talk about the positive experiences in the military, such as socioeconomic stability, international travel, and ability to learn a skill. Finally, they can “own” their experiences, in that they can see the potential to educate other women Veterans and share their stories. They frame their stories of MST and past traumas as a story of survival and ability to maintain a positive outlook:

“And then be able to talk about it and-and realize that, yeah, this-this happened, but I’m not gonna allow you to take my life away from me just because you d-, you caught me. You know, it’s the same as, you know, even if someone cut me with a knife. The scar’s always gonna be there. And it’s gonna be a reminder of,
but I’m not gonna allow that cut take away my arm, you know? So, and that’s just one of my analogies, and it works for me” (Yolanda)

Addressing Specific Aims

This section will describe each of the first three specific aims in relationship to the overall conceptual model (Figure 5-1). The women in this study discussed their decision to enter mental health, their relationship with their provider and the larger healthcare system, and what about their experiences using mental health are important and matter to them. From engaging and interacting with the data it was determined that these aspects are not separate from Figure 5-1 but are in fact an in-depth exploration of one part of the model, the transition into using mental health outpatient services.


Independent Choice. The decision to enter and utilize mental health services is one made independently and without consulting others. Some women lack trusting, nurturing relationships to share that sort of decision, without fear of stigma or judgment. For others, it is a reflection of their resolve to finally advocate for themselves:

Well, I mean, for going to CAPS, I didn't really consult with my husband. It's-it's on campus. It's not out of the way. You know what I mean? And that's fine. But, you know, making a big decision about bringing in our child, you know, I of course spoke with him about that stuff. And I don't… I don't think I talk to him about things I address at CAPS before I address them. But I'll give him the debrief. (Carmen)

Other women asserted their choice to enter decision mental health in the following ways, “'Cause I’m a... you know I live by myself so it’s me, myself and I so...When it
comes to making decisions about-about me or anything else you know I have to rely on myself...And nobody else...” (Barbara). Another woman states simply, “No, because I knew I wanted to do it so I just did it” (Sharon). Yet another woman was more assertive about her choice and was undeterred, “So it was not a matter of if it was a matter of I need to. And how soon do I get in and what do I need to do. I told her straight out, I don’t care what I’ve got to do” (Gwen). When discussing who she talks to about mental health, one participated stated she does not talk to anyone about her mental health, “I don’t. Well not for mental health. Maybe physical health, but not mental health” (Brandy).

**Perceptions of own mental health needs.** The participant’s perception of their own mental health needs, as well as their assessment of their resources is another factor that influences decision making. Delia, who did not access a traditional mental health provider, had a positive perception of her support system and resources available to her. However, the other participants did not have this same perception, and instead favored an approach in which the person is continually engaged with a provider. If not, the woman could suffer psychologically:

I, I mean like I said it’s maybe it’s the support system back home, maybe it’s just you know, our prior experiences kind of set us up for how we deal with things in the future and-and maybe you know just coping mechanisms personality differences I don’t know ‘cause it’s like you-you experience the exact same things. (Delia)

Another woman discusses her perceptions of her recovery and considers how her use of services affects her holistically:
True recovery is all encompassing. It’s your heart, your mind, your spirit and your body. So you take care of your medical needs right…. You go to treatment. But treatment does not just stop when you leave this room and you had a group. No. You have to live it 24/7 because if you’re not living it, you’re going to go back out. What about the dying on the inside? The guys and women that went overseas, they’re going to be coming back with more than just wounds. They’re going to becoming back with a lot of internal wounds. So psychological wise there’s a lot to be said for it because if we don’t take care of our psychological. We can take care of our psychological and our body will do okay you know. We can deal with a lot. But if our psyche is all messed up, the whole person just starts deteriorating. (Gwen)

**Timing of decision.** The fear of negative repercussions or to be treated differently can influence when these participants make the decision to enter mental health outpatient services, and who to share that information with. As women Veterans enter civilian systems they also fear that stigmatizing reputation may follow them, “‘cause there is like the stigma like you, you’re not strong enough to handle this or you’re not you know, or you’re weak if you know, you need help or something” (Delia). One woman also fears loss of privileges that come with military service:

And, through answering that, okay this is probably very pertinent to your study now, [LAUGHS] uh, in my head I answered yes. Even though I put no on the paper. Because, at that time, there was still this stigma that if you say “yes” to these things, you lose your clearance, you know, and you’re probably not gonna be doing your job anymore. (Carmen)
Another aspect of timing is the public perception of Veterans and the stigmatization that participants perceived by being Veterans:

> And if you start to do your research, there are people, you know people know you’re a veteran and you have PTSD or this and you say any kind of thing, your ass is going to get locked up. And that is part of the media issue that I’ve spoken out against. It’s part of the VA’s policy to brand you as a psych problem and a threat if you go in and assert your rules and rights as a veteran to demand proper care or to refuse a certain type of treatment or to question or challenge a psychiatrist who wants to just give you a handful of drugs. That is reprehensible.

(Jessica)

Women also describe a perception that services for Veterans are only for men, which can delay the access and receipt of mental health services:

> Like I wasn’t aware that there was a woman’s health clinic, especially just for women, you know what I mean. That they don’t see men. It’s designed to use our process which is great you know. And just be nurturing to them because sometimes it’s devastating and hard to seek treatment and even just general health you know because you’re worried about like having them view you in certain ways. It’s great for them to be non-biased. Just because like it’s just a stigma. Like it’s a men’s military. (Gwen)

**Peer Networks.** The participants did not use their social networks to make the decision to enter mental health services, but did use their social networks when seeking out information on providers. Participants also remarked that once in mental health treatment, communication with other Veteran peers, both male and female, can keep one accountable to a treatment plan and suggest treatment options: “Um, the-they
might think about it, um, or if somebody who knows a veteran, once again, might say, “Hey, you know, you should check this out” (Keisha).

Women Veterans in this study also desire a colleague who can be supportive, but also recognize when they may be trouble:

But also, you know, have that friend that is there for you and doesn’t judge you. But then you also need that security check. You need somebody that’s going to tell you I think you’re a little bit off. Or I think you need to be maybe checking on this or that… (Lola)

Other social support comes in the form of treatment recommendations:

“Only in the sense of don’t go to this doctor; go to this doctor. You have a problem with that one? Who are you seeing? Is she any good? Is she trying to shove drugs down your throat? I mean that’s the only talking to my other veterans I would say. Or if I’m asked questions or somebody says to me—because now I’m a little big known on campus for having come out to say hey I have these issues but I was able to manage and achieve. And I’m starting to have people come and want to interview me, you know some interest. So I will meet people and they will ask me and I try to give them the best information I can. Say well this person worked for me and here’s why. This person didn’t work for me and here’s why. And you know at least to know where to go for the resources. (Jessica)

Veterans also find networking with other Veterans about benefits and claims are also beneficial:
I think that networking with people is huge too. Networking with other Vets and finding stuff out. I’ve told people stuff that they had no clue they could get. They’re like I can get that at the VA, I’m like yeah. I even tell them, depending on the VA, I can tell them where to go, who to talk to. I can give them the phone number. You need the phone number? Which is cool because people can get the help that they need they never even knew. (Mary)

**Specific Aim 2: Experiences Using Mental Health.** This section organizes participants’ experiences using mental health care in different settings and treatment models.

**VA Healthcare.** Experiences with VA providers are positive, and the woman Veterans interviewed do acknowledge providers have met their needs as Veterans:

I’ve used the-the VA more because they have been more receptive to-to some of my needs, not all, but they’ve been pretty-pretty receptive to some of the stuff that my civilian healthcare would not be as quick as reacting to as the VA has.

(Yolanda)

Alternatively, another woman remarked, “There’s certain triggers that I have and so, um, I feel like I’m getting really good care at the V.A. as far as like, understanding who I am” (Keisha).

However, once women are linked to care, the built environment can be uncomfortable and threatening, specifically because of male Veterans:

And if you’re a female and you still walk into the VA hospital in (location) you will still get, are you somebody’s wife…and I get that every time I walk into the VA campus even though I’m flashing my VA card. And then also you lay on top of
that a lot of male veterans are not friendly towards females at all which makes it also difficult in triggering issues. (Jessica)

Some women report that gender based harassment continues when accessing VA services:

“I’m just so tired. I hate, I hate going to the VA. The doctors are great, but I hate going up there. I hate it. It’s nothing but men. I was verbally assaulted with one of the guys that works in the cafeteria” (Kim)

These experiences add to the perception that the VA system is only for men:

Sometimes it’s hard because I feel like it’s an all men’s military at times you know what I mean. And just because of the trauma that I experienced like I didn’t even want to have to use the healthcare they provided at first you know what I mean. But um, now that I’m working with it and with people that have also experienced it, it’s easier (Gwen).

On the opposite of the spectrum, women Veterans who are long time users see the improvements the VA has made over time, particularly in terms of trauma:

I’ve been going to the VA since I got out of the military. And they haven’t had services really so much for women. They’re just now starting to get into it and they’re just now starting to get into MST issues. PTSD is just kind of rolling out there too. They’ve known it for a long time but they’re starting to address it more. But the MST, like when they documented it for me, they put it down as just PTSD, not MST. And I was told they’re two totally different things. (Mary)

**Patient provider interactions.** Overall, women Veterans have positive experiences with their providers, in VA and non-VA settings. The providers’ history in
treating Veterans also gives provider legitimacy and can enhance that interaction. In situations when the participants’ trust is impacted they are still able to establish and maintain relationships with providers. Women Veterans in this sample describe what makes a quality provider in multiple ways. One woman appreciates when it feels like her provider who knows more about her than what is in her chart:

Um, she didn’t… She remembered more than just what was written… In my file, so, um, I was really comfortable with her. Um, my psychiatrist, I-I really like her. I trust her, um, and then, again, she also remembers little bits about me, so, um, as far as my doctors go, I feel comfortable. (Keisha)

Another woman describes experience with treating Veterans as a valuable quality, “So luckily my psychologist has been treating Veterans for 25 years and has learned and she’s a smart lady—she gets what works and—when I speak to Veterans who have seen her, they’re like yeah she’s pretty good” (Jessica).

Being personable, affable, and kind are also valued by women Veterans in this sample, “Well I was, somebody referred me to them. And they’re patient with me and they always talk kind.” (Sharon)

**Groups vs. individual.** The type of mental health treatment the woman Veteran receives can determine the type of experience a woman Veteran may have. The participants favored one on one, rather than groups, as their primary form of contact with the provider. Groups can be implemented, but along with a one on one system:

So, I sought a mental health clinician at [LOCATION] myself once. And, hmm, I don’t know why I didn’t feel like I should return. I went to a support group for the first time and I didn’t think the people that were in my support group were similar
to me. Like, I think I was kind of insensitive to the things that they were saying. Or, we were just at different places. Like I said, you know, before I left I kinda knew to expect to see really bad things and these people were like, complaining about seeing really bad things. In my mind, I’m like, well duh, you knew you were gonna see that. Like, you’re going to war. You know what I mean? So, in my head I’m like, I don’t have time to listen to other people, you know, go through this. Like, it’s important for them to grieve and to talk through it, yes, but I don’t feel like I need to be in this support group, you know. (Carmen)

“Gwen” describes a one-on-one provider interaction as a way to keep her progress on course as she begins treatment:

Um, I’m both a visual person mainly, but I like one on one communicating you know what I mean. Like if I feel comfortable with a person, it’s great. But right now, like I said, I’m new at this, so like just staying on track and having reminders and stuff is great for me because I was in solitary for 7 months and I was just used to programming by myself. (Gwen)

Another participant favors one-on-one treatment over groups because she can receive personalized direction:

I’ve never had a one on one with anyone. It’s always been a group setting. And so you don’t always feel comfortable revealing everything about what’s going on with you. And it’s not as intimate. You can’t talk back and forth. They can’t really spend too much time with one person at a time. So it’s not just me, but then there’s other people that are missing out if they spend too much time with me. So
groups are great but I really want to have my one on ones to work on things because in here that’s what we’re doing. (Mary)

Specific Aim 3: Important Aspects. The third specific aim discussed important aspects of mental health care that are important and meaningful when using mental health outpatient services:

Trust and time. Establishing and maintaining a relationship with a mental health provider takes both trust and time to develop. If a provider can maintain that regimen, the participants interviewed will feel satisfied in the care provided:

In a positive provider relationship, the provider hears her story and takes it seriously:

“Yeah, it’s really hard for me to trust. Um, I think that goes along with, um, with the PTSD, um, and so them remembering my story. And then, um, when I tell them… Like, when I told the-the psychiatrist about, um, my symptoms, she took it really seriously. Um, my doctor has-has gone above and beyond, like, um, she went in to run some labs to see if I was anemic. And she called as soon as she got the results. And she called me directly. I’m never r-really having anyone else call me, but they call me themselves. Um, and then, giving me their-their direct line, so that I don’t have to call and get like an operator…. (Keisha)

Another aspect of the relationship is open two way communication, where the patient feels valued and not dismissed, “Um, it goes both ways. Me being honest with them and their addressing all my concerns and needs. Not feeling put out because of military issues, you know what I mean? And being able to be honest and open” (Gwen).
**Expertise.** The women Veterans interviewed want to see some evidence of the providers’ expertise. The women know what they want from their provider and are actively watching the provider to demonstrate that knowledge to continue with the therapeutic relationship:

”Um, uh, and I don’t like when, um… I don’t like when procedures are done and they don’t tell you why it’s being done or when. They’re just like, “I’m gonna give you this medication.” And-and the doctor, um, him or herself, doesn’t explain what it means. Like, I know the pharmacist can do it, but I want you to tell me what’s gonna happen. And I want you to be looking to see… looking to see what other medications I’ve already told somebody else that I’m talking… To see if there’s gonna be any negative side effects. And maybe even talking about how the medications will react with each other. (Keisha)

The women Veterans interviewed indicated that appropriate and complete assessment skills are also important components of evaluating clinical expertise:

She was thorough. She did my pap smear, everything. And everything came out great which was awesome. And she seemed interested in my health and it was good. We communicated. She asked the appropriate questions and she was thorough you know. And I appreciated that. I didn’t expect to have a pap smear done the first time and all that stuff. Yeah. I asked, I was like why? And she said well it’s your first time here and we just want to check and cross all the T’s and dot all the I’s. (Gwen)

Expertise is also demonstrated by objectivity, as one woman states:
That they do listen to your problems. I also like that you know they don’t take
tsides, but they do listen which I like you know, having a listening ear. I like how
they suggest what else is going on even though I might not be interested in it. So
that tells me that they’re doing their job. (Brandy)

**Medication Aversion and Holistic Treatment.** The women Veterans
interviewed were averse to taking psychiatric medication at the onset of the relationship
with their mental health provider. Many (n=8) disliked the side effects, in that the women
felt medications altered their identity, “And I’m doing it through my sessions more so
than, you know, meds. I don’t want the meds. ‘Cause the meds, all they do is numb”
(Yolanda).

Providers who rely on medication too heavily can also trigger distrust in the
women interviewed:

Because I remember not sleeping well or sleeping too much because I’m on
medicine or how much dosage they gave me. Or when doctors tell me oh you
have to take medicine for the rest of your life, don’t believe that crap you know so
Yeah, especially for mental health. It screws up with your brain a lot. You know,
you’re not you. (Brandy).

Use of psychiatric medications may have a particularly negative connotation because of
gender specific issues. Medications are seen as a way to manage reproduction, as well
as personality. As “Lola” describes:

No. I started the aversion to medication because of the fact that they had gone
through these great lengths to take my child when I had always been compliant.
And I didn’t have a kid in the military. I was married, and I had a good marriage
but he wanted babies and I kept getting deployed, and I didn’t want to do that. So I waited and I waited and I waited. I was almost 30. And I made sure that I was compliant. I had been on medications for like 2 years straight. And I prepared for that pregnancy. I prepared for my child because I needed that. Because of a mental health history, they would be extra speculative. And so I had tried to be extra cautious. And it didn’t matter. Like it didn’t matter. So that being said, I kind of rebelled a little bit because I’m so hurt….Right and you guys still did this.

(Lola)

Medications are also seen as a way for a provider to avoid treating and confronting the actual problems:

“No. I don’t think that somebody should be fed a handful of drugs to deal with their PTSD or you know—I have some focus problems that are you know chemical problems due to my brain injury and you know, so I take Ritalin as PRN to help me when I really need to focus. And I have (prescription drug) that I take PRN or when I have amounts of anxiety attack or I’m triggered, which helps calm me down. This woman thinks that I should be taking (prescription drug) every day, and out of my mind and taking (prescription drug) at night to sleep and you know…it’s just crazy. And when you talk to other veterans and you look at the number of prescriptions that they’re on, it’s because of the psychiatrist, like (doctor name) who just sit there and check on a list and say ok, I’m just going to feed you pills because then I don’t really have to deal with what your issues are.

(Jessica)
Instead, the women interviewed offered holistic treatments as an alternative, especially with physical activity:

Maybe some expressive therapy, like art or arts and crafts, not just yoga I guess. Uh, meditating helps too like tai chi….they help, but it would be nice to have something different. I think art work helps a lot. Seeing colors, making stuff kind of….or even writing, journal type of thing. Uh, which I do. (Brandy)

Other interviewees added,” I bike ride a lot. I do yoga sometimes. They’ve just recently come up with these holistic classes at the VA so I’ve started that” (Lola). “I walk sometimes for exercise and bicycle ride every day” (Sharon).

**Loyalty.** Starting a new relationship is draining and re-traumatizing to explain ones trauma again. Therefore, once a connection is made the participants will attempt to maintain it:

“So, after that, I’m like, really, I don’t know if, I don’t want to open up my can of worms again and again. So, when I went to, um, meet with the-the lady that did my evaluations for my psych eval, I-I really had a very good connection with her. And after all of that was said and done, I have done follow ups with her. Cause she has been a little bit more consistent in my life. (Yolanda)

Once the participants have established a relationship with a provider, they prefer to stay with that provider, even if it is no longer convenient to see them:

So the distance is a little bit of a diff… uh, a difficulty. So, um… Yeah, but I prefer to still see her. I mean, she’s not so far away that I can’t… Go and see her and that’s why I chose to see her on Monday instead of switching doctors. (Keisha)
As women establish a relationship with a provider, they can grow to become very attached:

I like my primary doctor. I’ve been going there since 90 something. I’m attached to her. She’s understanding you know even though sometimes they do try to prescribe you narcotics and I tell them no. I don’t want anything to make me loopy…Dr. (name), that’s my baby. I love her. (Kim)

**Patient-Provider Partnership.** The women interviewed mentioned themes alluding to a partnership that is patient centered and responsive to their needs. One woman Veterans’ experience is not akin to another, so their needs may vary drastically. However, the goal is for the woman Veteran to reach her goals and manage her health herself, not to be dependent on the provider. Attrition can occur if the woman does not perceive a partnership, “So, um… Yeah, I just… I-I like the-the personalized care and so if I feel like it’s just like, you know, a templ… a template format… Then I just won’t follow up. I won’t go back” (Keisha). Instead, women encourage providers to start goal planning with Veterans, and not to perceive Veteran needs as one size fits all:

Okay. So, if-I think if-if providers try to just kind of set things up in the future, maybe a good consideration is, what are your goals? Not just saying, “Okay, these are the goals.” But, then asking a veteran what are your goals. Because, then they could be in different states of transition. I guess when they’re coming in to, um, you know, the civilian world or going to school, or whatever the case may be. Their goals may-your-your goals may be drastically different. (Carmen)

Other participants assert that patient-centered care can empower women Veterans to care for themselves:
I guess someone who knows what they’re supposed to be doing in a therapeutic session and that the therapy session is about the client and finding the best way for the client. That listens…that’s not trying to sit there and say you should do this or you should do that. But instead asks the client, what do you think is the best way and this may possibly work you know, figure this out to do that. But also being able to assess the client’s emotional issues and by actually listening can say yeah, I know what’s going on. I know this, this, this….you know…Because it helps the person examine what those issues are so they can better be self-aware to manage themselves, manage what’s going on. (Jessica)

**Culminating Stage**

**Reclaiming Sense of Self.** The culminating, but not final stage of this process, and indeed the goal of using mental health services, is for the woman to reclaim her identity and her story for herself. She wants, and indeed will assertively claim, that she deserves her own safe spaces, opportunities for socioeconomic advancement, and to define her relationships as she sees fit. She controls the story of what happened to her, instead of continually being a victim to it. This stage is also in transition as the woman shifts her priorities and those of her family. It is important to note that this is an ongoing, changing stage that does not end with this model. As women reclaim and renew their identities, their lives continue to move forward as the woman Veteran grows, adapts, and changes. This moving forward can be sobriety and a renewed focus on wellness:

That’s the thing that if we don’t get that treatment and we have to want it. Like I want it like the air I breathe you know. If you want it that bad, it’s going to work
because you’re going to make work. You’re going to do everything in your power.

(Mary)

For others, it can be new opportunities to make career advancements and use their innovative skills:

*Jessica:* “It was only after I was in the pitch session and the investors were asking me about this…well how did you know to come up with this and I’m like well I was a cryptographer in the Navy. And then it became ok for me to say, oh yeah by the way I’m a Veteran and this is what I did, and this is how I used my knowledge. And I didn’t tell anybody that I was a Veteran when I first won. And I only did after because they were like, no it’s really cool for you to be a Veteran now. It’s to your advantage to tell people you’re a Veteran. And I was like oh, ok. I guess I’ll start using that card now.”

In summation, “Yolanda” clearly expresses her feelings about her priorities and what she sees for her future:

“And it’s about me now. You know, I-I don’t, I don’t let, uh, my work or other people’s need drive me. My needs are more important. And I gotta take care of me before I can take care of anyone else. So, I’ve decided that it’s all about me.

(Yolanda)
Chapter 6- Discussion

Implications for Research

This study contributes to the body of new knowledge regarding women Veterans’ mental health, mental health service use, and how women Veterans process trauma from their pre-military situation to their post-military life. Furthermore, this study is, to the authors’ knowledge, the first constructivist grounded theory study that specifically addresses women Veterans’ perceptions of their mental health and experiences using mental health services.

Sample Comparison to other women Veterans. This study has a number of similarities and differences when compared to the literature. In terms of similarities, women Veterans self-report of trauma is similar to other estimates in the literature. 100% of women in this study experienced some type of trauma in their lifetime, compared to estimates of 81%-93% in the literature (Escalona, Achilles, Waitzkin, & Yager, 2004; Freedy et al., 2010; Yaeger, Himmelfarb, Cammack, & Mintz, 2006; Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, & Frueh, 2007). In terms of differences, seven of the twelve women (58%) reported MST, which is higher than general estimates (30%-45%) in the literature (California Research Bureau, 2012a; Zinzow et al., 2007). However, the prevalence of MST in this sample (58%) is similar compared to samples of women Veteran VA users who access mental health services (55%) (Turchik, Pavao, Hyun, Mark, & Kimerling, 2012), or have a substance use disorder(64%) (Davis & Wood, 1999).

This sample of women Veterans is far more diverse than other studies of women Veterans. Half (50%) of the women in this study were women of color, compared to
estimates that range from 50%-80% white/Caucasian in the literature (Duggal et al., 2010; Escalona et al., 2004; Mooney & Weeks, 2007; Washington, Bean-Mayberry, Mitchell, Riopelle, & Yano, 2011). The average age of women in this study (43), is close to the national average age of women Veterans (48) (National Center for Veterans Analysis and Statistics, 2011). In terms of service use, the women Veterans in this study have higher usage of VA healthcare (66%) than the overall prevalence (Buttice, 2014; California Research Bureau, 2012b). Considering Veterans of all genders who use VA services are more likely to have more severe medical and mental illness, this reflects in the high reports of trauma in this sample (Turchik et al., 2012).

Sample comparison to other vulnerable women. Comparing the results of this study to the groups of vulnerable women described earlier in the literature review revealed areas of overlap as well as areas of significant difference. Considering the majority of women in this study were VA service users, they too held negative perceptions, but it related to their negative interactions with male Veterans and lengthy claims process, not necessarily toward the services or providers themselves.

The women Veterans in this study demonstrated a great deal of personal knowledge; defined in the literature as a woman considering her choices in relation to what is best for her (Stepanuk et al., 2013). For each of the women, they considered the choice to enter mental health outpatient services as a positive action that would benefit her and her family. A potential bias in this study is that the women sampled all considered using mental health services as positive, and were able to eventually overcome barriers to service use. It could be that this concept of personal knowledge can range throughout women Veterans with mental health conditions, and that barriers
to mental health service use are more difficult to overcome among women Veterans as a whole. However, this study shows the experiences, behaviors, and decisions of the women who were able to use services, and could serve as an example for women who have not yet accessed care.

Similar to other groups of vulnerable women, cultural influences and gender roles were salient issues for this group of women Veterans, but unlike other women military experiences permeated each of these concepts. The women Veterans interviewed did not discuss their ethnic/racial background as significant factors in their decision to enter mental health services or important aspects of their experience using mental health services. Instead, gender based and military based influences and roles were important intertwined factors in their decision making and experiences. Help-seeking, for a time, was contrary to the “soldiering-on” behavior learned and reinforced during military service. Similar to the literature, the realization that relationships can degrade is a component of the “tipping point” that leads the women in this study to mental health service use (Campbell & Raja, 2005; Pieters & Heilemann, 2010).

In comparing the patient-provider interaction between this study sample and the broader literature on vulnerable women, the notion of power and punishment in the patient-provider dyad was not discussed in this sample of women Veterans. This was possibly regulated by socioeconomic status. Seven of the twelve women sampled (58%), have an income over $20,000, with four of the twelve (33%) making above $60,000. Even though this group of women disliked changing providers, it is possible that a higher income theoretically means more access to other providers or healthcare resource, even if they do not act on those resources. Furthermore, a higher income can
also mean perceptions on each side of the patient-provider dyad that the patient is on equal footing with the provider. Therefore, a power imbalance is less likely to occur.

Alternatively, the women with incomes less than $20,000, especially those in substance abuse treatment, were less likely to have a range of choices available to them. Therefore, when they found a trusted provider they were more likely to stay with that provider, despite distance or feeling uncomfortable in the healthcare setting, such as the VA. This factor enhanced the hesitancy to switch providers among the overall sample.

Finally, peer support is a salient issue shared among different groups of vulnerable women, although the extent to which this study sample used the input of their support system differed from the literature. Although the women sampled may consult other Veterans for their opinions about certain providers or types of treatment, the ultimate decision to enter mental health services is theirs alone.

**Study Limitations and Future Directions.** Difficulties in recruiting women Veterans for this survey can constitute a study bias. Participants had to opt in to the study, rather than refuse to participate. It is possible that the women in this study are significantly different that the majority of women who did not participate. Considering thirty percent of the women in this study were from a substance use treatment facility, and eighty percent were VA users, it is also possible that these groups of women have experienced significantly more trauma and are more have a more severe mental health condition than women who are not.

Although this study was able to sample some women who were not VA users, and statistics indicate the majority of women use care outside of the VA system, there
were still difficulties to find and recruit women Veterans outside of the VA system. Although I made connections with women Veteran serving organizations outside the VA system, the potential bias in service use could also be influenced by these same organizations. Possibly, women Veterans who participate in these groups assume a Veteran identity, and therefore more likely to feel that they are entitled to use VA services. Therein lies a paradox with women Veterans recruitment, in that women who use VA services are easier to find, but also more likely to have chronic illness and differ from women Veterans overall. Attempting to recruit women Veterans who are not VA users can be more difficult, because they are intertwined with larger samples of women, both civilian and Veteran. Women Veterans are less likely to be recognized as Veterans and given the esteem from that position, so there is less incentive to call oneself a Veteran (California Research Bureau, 2012a). As a result, they may not consider themselves Veterans or close to Veterans issues, so attempting to pique their interests through a Veterans-centric strategy may not be effective (California Research Bureau, 2012a). However, women Veterans reintegrating from the OEF/OIF/OND conflict are using the VA more than any other period in military history, so in time VA based samples may become more representative of women Veterans overall (Duggal et al., 2010).

Areas of Intervention

The women in this study came to a “tipping point”, or point of realization that her current situation was maladaptive and she needed help to maneuver through it. For some women it was an act of abuse, but for others there could be a period of escalating time where the tipping point could be abated or avoided. This period is an area for
potential intervention by service providers, to reach women before that tipping point is reached. Alternatively, for the women who experience trauma, services can be made more readily available and appropriate to their gender and the trauma they experienced. Refining these areas of intervention has implications for practice and policy, insofar as both individual practice and structural policy are influenced and changed.

**Implications for Practice**

This study also has best practice implications for nurses and other healthcare professionals. These study findings combined with the current literature strengthen the need for evidence based programs to address the needs of women Veterans.

**Gender Specific Services.** The needs of the women of this study combined with the current literature support the need for gender specific services in both VA and civilian settings. This need extends to mental health services, which should address gender based violence and its repercussions, as well as trauma throughout the lifespan. Women Veterans are more likely to endorse a lifetime history of trauma than male Veterans, so addressing a lifetime history can be a gender specific issue (Kelly, Skelton, Patel, & Bradley, 2011; Zinzow et al., 2007). Although the literature suggests many women Veterans prefer a female provider, giving women Veterans options to select provider gender can also empower women Veterans who may have a differing opinions (Washington, Bean-Mayberry, et al., 2013; Yano, Haskell, & Hayes, 2014). This call for gender specific services also extends to primary care, in that providers should understand the far reaching implications of trauma for both physical and mental health. This can manifest in the somatization of mental health symptoms in primary care.
settings, that can lead to lower patient satisfaction with care because of perceived unaddressed health needs (Escalona et al., 2004).

**Creating Safe Spaces.** Based on the findings from this study and from the literature, women Veterans are in need of safe spaces within healthcare that respects their privacy and personal boundaries. In addition to the benefit of making the woman feel safe, this can give the woman Veteran the time and protected space needed to be vulnerable and safely encounter trauma with a mental health provider.

A key aspect of these spaces is that they are meant for women (and their children) only (Buttice, 2014; MacGregor et al., 2011). Many women Veterans group events and VA women’s health treatment settings are for women-only and have the tacit expectation that these spaces are not for men, even if their intentions are well-meaning (B. A. Bean-Mayberry et al., 2003; MacGregor et al., 2011). VA women’s clinics also have a separate waiting room that is private and partitioned into a separate area, just for women Veterans. The purpose of this is to mitigate the potential trigger or uncomfortable circumstances of a man being close to them in a vulnerable place like a provider’s office. The idea of safe spaces also extends to training and preparation of staff to talk and relate to women Veterans, as the VA healthcare workforce tends to have a male-centered stance toward Veterans health issues (deKleijn, Lagro-Janssen, Canelo, & Yano, 2015). The VA healthcare system has implemented some culture change through environmental rounding and gender sensitivity training, but considering these study results and the high attrition rate among women Veterans who use VA services (30%), the VA can benefit from further review into the design of clinical space and staff training (deKleijn et al., 2015; Hamilton et al., 2013).
Similarly, non-civilian settings can adapt their services to be sensitive to the needs of women Veterans, in terms of understanding military culture and the mental health disparity among women Veterans. A RAND Corporation study on the quality of mental health services for Veterans in community based settings showed that only 13% of providers met “military cultural competency” criteria, which includes understanding of the social mores, language and culture of the military and used treatment that addressed military related mental health needs (Tanielian et al., 2014). Inherent in this study is the overall understanding of military culture, which is typically male-centered. Understanding the mental health needs of women who have served in the military is potentially lower among civilian providers. Although web-based and in-person trainings are available on military culture through the Department of Defense (DOD), and other academic centers they typically do not discuss the depth of women Veterans issues or women Veterans increased service use outside of VA settings. Further specialized training in this area of need have the potential to reach and impact more women Veterans than efforts solely within the VA system.

**Quality of Patient-Provider Interactions.** This study demonstrates two salient factors in the development of a therapeutic relationship and a positive perception of the provider from the woman’s perspective: giving time to develop the therapeutic relationship and forgoing psychiatric medication administration until a trusting relationship is established. The literature also notes tenacity and patience as critical factors to establishing and maintaining therapeutic relationships with patients who have a prolonged mental health diagnosis (Schout, de Jong, & Zeelen, 2010). To the authors’ knowledge, this study is the first to qualitatively explore women Veterans’ perceptions of
the care experience and how and why they establish trust with mental health providers. Future studies can explore patient-provider relationships with other types of providers and define areas of quantitative exploration of the mental health provider relationship.

This study, to the author’s knowledge, is one of the few to explore attitudes toward psychiatric medications, and the first to explore attitudes among women Veterans. The other study exploring attitudes toward psychiatric medications specifically tests for stigma toward psychiatric medication in a group that is 90% male (Boyd, Juanamarga, & Hashemi, 2015). Boyd, et.al (2015), report that 90% of the sample perceive their medications to be helpful, but over half the sample feel ashamed or embarrassed that they are taking medications, or that they would be judged if they were to disclose psychiatric medication use to others. In contrast, the women Veterans in this study did not perceive psychiatric medications to be helpful, and frequently mentioned the mind and personality altering effects of medication as reasons to avoid psychiatric meds. Alternatively, they did want to explore holistic treatment options with their providers, and have enthusiastic perceptions of alternatives like yoga, acupuncture, and physical activity. This distinction can be further explored in future research, and can be used by mental health providers to inform their practice on when and how to introduce psychiatric medications as a treatment option for it to be accepted, and using holistic treatments in the treatment plan.

Implications for Policy

Finally, this study combined with the appropriate literature can serve as a basis for policy exploration and redesign in light of new data that reflects the experiences of women Veterans before, during, and after military service.
Women Veterans Statistics. Once again, the predominant number of women Veterans outside the VA systems prompts the need for data collection on Veteran status in systems outside the VA. One movement that has already begun is the “Have You Ever Served in the Military?” awareness campaign designed and implemented by the American Academy of Nursing (AAN), in partnership with the Bob Woodruff Foundation and the Joining Forces campaign established by First Lady Michelle Obama and Dr. Jill Biden (American Academy of Nursing, n.d.; Collins, Wilmoth, & Schwartz, 2013). This approach empowers healthcare providers in all settings to simply ask each of their patients if they have ever served in the military. The premise of this campaign is that Veteran health disparities can be mitigated if Veterans are identified and appropriately linked to care at their first interaction with the healthcare system (American Academy of Nursing, n.d.; Collins et al., 2013). This wording takes into account that some patients may not consider themselves Veterans, but instead acknowledges the broader term of “served”, which can encompass Veterans at all service levels and military occupations. This campaign is particularly geared towards nurses, who are generally frontline providers and gatekeepers to other referral sources or sources of care based on healthcare need. The “Have You Ever Served in the Military” campaign also developed posters to display in visible areas and pocket cards, which have a short summary of relevant questions providers can ask to determine Veteran status. Campaigns such as these can extend further by advocating for a mechanism so healthcare systems can track Veteran status and determine pertinent health strategies in their Veteran populations.
**Employment and Socioeconomic Status.** Experiences that women Veterans are more likely to have pre, during, and post military are also correlated with higher levels of unemployment (Hamilton, Williams, & Washington, 2015). 11.2% of a nationally representative sample of women Veterans was unemployed, compared to 9.4% for male Veterans, and 8.3% for civilian women (Bureau of Labor Statistics, 2014). Women who reported having a mental health condition, joining the military to leave a negative home environment, and those who felt their military service was misunderstood were more likely to be unemployed (Hamilton et al., 2015). Conversely, women Veterans who felt their employer respected their military service had the greatest level of satisfaction with their care (Business and Professional Women’s Foundation, 2007). The women in this study have a range of experiences across this spectrum, which highlights the need for focused programs that prepare women Veterans for successful, steady employment and employers to adapt to the needs of women Veterans that have experienced trauma. One such program is the “Veterans Employment Leading Practices: Tools for Engagement”, the result of a partnership between the Institute of Veterans and Military Families at Syracuse University, and General Electric (GE) (Syracuse University, 2015). This partnership has created a toolkit of resources to promote the value of hiring and retaining Veterans, to prepare the Veterans for entry to the workforce, and ways for employers to appropriately engage Veterans, especially when addressing mental health and its associated symptoms (Syracuse University, 2015). An offshoot of this program is V-Wise: Veteran Women Igniting the Spirit of Entrepreneurship, a training program that provides women Veterans with a business and entrepreneurial curriculum to prepare them to lead successful
businesses (Institute for Veterans and Military Families, 2015). Programs such as these have demonstrated successful engagement of women Veterans to lead financially stable business and harness their military training for economic viability (Institute for Veterans and Military Families, 2015; Syracuse University, 2015).

**Veteran Support Services.** The women Veterans in this study and in the literature often experience difficulty in accessing a range of resources that often serve as significant determinants of health, such as housing, legal services, and parenting assistance (Swords to Plowshares Institute for Veteran Policy, n.d.; Washington et al., 2010). Early intervention in these areas can prevent periods of homelessness and negative consequences like incarceration or loss of custody of a child. Although successful programs like Swords to Plowshares, University of California, Los Angeles (UCLA) Nathanson Family Resilience Center, and the City of Los Angeles have women Veteran focused programs that assist women with free legal aid, family counseling, and housing placement, many women Veterans report they do not know where they can get the services they need upon return from active duty (California Department of Veterans Affairs, 2013; California Research Bureau, 2012b; Swords to Plowshares Institute for Veteran Policy, 2013b). These programs require further engagement with the social networks that surround women Veterans as they return, which tend to be family members and spouses. Partnering with military families can be a necessary step to link women Veterans to the services they need.

**Conclusion**

In conclusion, constructivist Grounded Theory principles, supported by the Andersen-Gelberg Behavioral Model for Vulnerable Populations and the Sofaer and
Firminger model of patient perceptions of quality guided the inquiry and analysis of women Veterans decision to enter, experiences using, and important aspects of mental health outpatient service use. As a result, a substantive constructivist grounded theory was generated that not only described the process by which women Veterans use mental health services, but also a broader process of experiencing and dealing with trauma, of which mental health service use is one component.

The findings of this study, combined with the pertinent literature indicate the pervasive presence of traumatizing events throughout the life of women Veterans, the mental health disparity these women experience, and the importance and centrality of their military experience in molding their identity and sense of self.

Despite the male-centered military and Veteran culture, women Veterans are joining and transitioning out of the military more than any other time in history. Their presence demands recognition of their experiences, and treatment that respects their service history, gender, and mental health needs. The development of the major concepts of “Trauma”, “Transitions”, “Identity”, and Structure” offer another aspect of understanding the social worlds and significant interactions that shape the lives of women Veterans. These concepts give voice to their powerful and impactful stories have been silenced or ignored, and lay the basis for further research, practice, and policy change that can positively impact the lives of women Veterans and their families.
Figure 5-1. Women Veterans Reconstructing Self After Trauma Grounded Theory Process Model
Appendix A. Gelberg-Andersen Behavioral Model for Vulnerable Populations

[Diagram of the Gelberg-Andersen Behavioral Model for Vulnerable Populations]
Appendix B. Conceptual model of development of patient perceptions of quality.
Appendix C. Screening Script to establish eligibility

ENROLLMENT/SCREENING SCRIPT

Women Veterans’ Perspectives of Mental Health Outpatient Services

Lindsay Williams, RN, BSN, PHN
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Email: lwilli@ucla.edu

<table>
<thead>
<tr>
<th>Purpose of Screener Question</th>
<th>Question numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish eligibility</td>
<td>1, 3, 9</td>
</tr>
<tr>
<td>Stratify into appropriate group</td>
<td>2 (period of service)</td>
</tr>
<tr>
<td>Screen out non-veterans misrepresenting themselves as veterans</td>
<td>2 (inconsistent dates), 5, 6, 7</td>
</tr>
<tr>
<td>Characterize participants</td>
<td>4, 5, 9</td>
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<table>
<thead>
<tr>
<th>Number of Interviews</th>
<th>Number of women veterans to schedule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-25</td>
<td>40</td>
<td>Woman veterans who are currently utilizing mental health outpatient services</td>
</tr>
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TO BE ELIGIBLE:

• Respondent must speak English well enough to participate in an interview
• Respondent must be a female veteran of the U.S. armed services
  • Reservists are eligible if they were called active duty.
• Respondent must no longer be serving on active duty in the armed services [current service in the reserves is ok if they previously served on active duty, and otherwise meet the other eligibility requirements]
• If the respondent has problems hearing or understanding the questions you ask, cannot speak clearly, or seems very confused, suspend the screener and do not attempt to schedule an interview
SCRIPT:

Hello, I am XXXXX from the UCLA School of Nursing. I would like to ask you a few questions in order to determine whether you may be eligible for a research project about Women Veterans and their use of mental health services. I would like to ask you about your military service and if you have used mental health services before. Before I begin I would like to tell you a little bit about the research.

This research study, seeks ways to improve mental health care for women Veterans. If you qualify for the study, we will ask you your opinions about mental health care, your life experiences, your health, and the healthcare you receive. If you are eligible, your participation in the research will involve participating in a 60 to 90 minute interview.

Would you like to continue with the screening? The screening will take about 5 minutes. You may feel uncomfortable answering questions about your military service or mental health. You do not have to answer any questions you do not wish to answer and you may stop at any time. Your participation in the screening is voluntary. A decision whether or not to participate in the screening will not affect your relationship with the Department of Veterans Affairs or your current healthcare providers. You will not directly benefit from the screening.

Your answers will be confidential. No one will know the answers except for the research team.

If you do not qualify for the study, your answers will be destroyed. If you qualify for the study, your answers will be kept with the research record if you decide to participate in the research study activities.

Would you like to continue with the screening? If so, please answer the following questions:

ALL QUESTIONS EXCEPT A3 ARE OPEN-ENDED.

1. Have you served in the United States military?
   
   _____ No  → [Thank, Terminate, and Tally]
   _____ Refuse  → [Thank, Terminate, and Tally]
   _____ Yes  → [Continue]
   _____ Yes, still serving on active duty  → [Thank, Terminate, and Tally]
   _____ Yes, serving in the reserves  → [If reserves, then ask …]

   Have you ever served on active duty?
   
   _____ Yes (prior active duty)  → [Continue]
   _____ No (no prior active duty)  → [Thank, Terminate, and Tally]

2. When did you serve in the military?

129
[Record response. If date range given, then ask in which war era or peacetime period(s) they served. If war and/or peacetime era(s) given, then ask for date range. If multiple periods of military service are given, then record all of them.]

Date range 1: From ____________________ To ____________________

Date range 2: From ____________________ To ____________________

Date range 3: From ____________________ To ____________________

Period of military service (circle all that apply):

01 During WWI (04-06-1917 to 11-11-1918)
02 Between WWI and WWII (11-12-1918 to 09-15-1940)
03 During WWII (09-16-1940 to 07-25-1947)
04 Between WWII and Korean conflict (07-26-1947 to 06-26-1950)
05 During Korean conflict (06-27-1950 to 01-31-1955)
06 Between Korean conflict and Vietnam War (02-01-1955 to 08-04-1964)
07 During transition to Vietnam War (1961 to 08-04-1964)
08 During Vietnam War (08-05-1964 to 05-07-1975)
09 During Post-Vietnam Era (05-08-1975 to 09-07-1980)
   i.e., Between Vietnam War and Persian Gulf War
10 Between Vietnam War and Persian Gulf War (09-08-1980 to 08-01-1990)
11 During Persian Gulf War (08-02-1990 to 02-28-1991)
12 Between Persian Gulf War and 9-11-01 (03-01-1991 to 09-10-2001)
13 From 9-11-01 to present (War in Afghanistan) (09-11-2001 to present)

NOTES: The 1961 to 1964 period is considered to be the pre-Vietnam Era by some ("between Korean conflict and Vietnam War"), and the Vietnam era by others (labeled “transition to Vietnam”), therefore either response is acceptable.

There are two date ranges for the post-Vietnam peacetime period (the period between the Vietnam War and Persian Gulf War), to identify the 9/7/80 change in length of military service requirement for VA healthcare eligibility.

Eligibility Screening Instruction:
If inconsistent dates and eras of military service, then do not enroll. For example, if respondent states that she served during the Vietnam War from 1976 to 1978, then do not schedule. Thank, Terminate, and Tally.

If R is still serving in the military [response option 13 in Q2], ask Q3, otherwise skip to Q4:
3. Are you still serving on active duty?
   _____ Yes, still serving on active duty ✔ [Thank, Terminate, and Tally]
Serving in the reserves, but not on active duty
   → [If prior active duty military service, then Continue]
   → [If no prior active duty service, then Thank, Terminate, and Tally]
No, not serving on active duty   → [Continue]

4. What branch of the service were you in? ________________________________
   1. Army
   2. Navy
   3. Air Force
   4. Marine Corps
   5. Coast Guard
   6. Women’s Army Auxiliary (WAAC)
   7. Women’s Army Corps (WAC)
   8. Women Accepted for Voluntary Emergency Service (WAVES)
   9. Navy Nursing Corps (NNC)
   10. Air Force Nursing Corps (AFNC)
   11. Women’s Air Force Service Pilots (WASPS)
   12. Coast Guard Women’s Reserve (SPARS)
   13. US Merchant Marines
   14. Military Reserves
   15. Other (specify) ________________________________

5. What was the highest rank or rating you achieved? ________________________
[Response could be either a term such as “Lieutenant” or “Petty Officer” or it could be a letter followed by a number, e.g., E4 or O3. The letter can be E, O, W, or WO; the number should be no higher than 11. If respondent does not know, then thank, terminate, and tally. ]

6. Where did you take your basic training? _________________________________
   [If respondent does not know, then thank, terminate, and tally.]

7. What was your Military Occupation Specialty? ____________________________
   [If older (pre-Vietnam) Respondent needs clarification, then ask “What was your job?” Response should be what they did in the military, e.g., nurse, pilot, infantryman, ambulance driver, truck driver, etc. If respondent does not give a specific job title or does not remember, then thank, terminate, and tally. ]

8. What is your current age? 
   ______
9. Have you ever worked or volunteered for the VA?

_____ YES ➔ [PROBE WITH NEXT QUESTION]

_____ IF YES When did you work or volunteer for the VA? _____________

IF GREATER THAN 3 MONTHS AGO SCHEDULE

IF 3 OR LESS MONTHS AGO THANK, TERM AND TALLY

_____ NO ➔ [Schedule an interview]

Thank you for answering the screening questions.

IF ELIGIBLE: We would like to set up a time and date for the interview (RECORD contact information)

1) What time is convenient for you to interview and complete the questionnaire?

2) What is a specific place that is private and quiet where you will be comfortable being interviewed?

IF INELIGIBLE: You do not qualify for this study because you do not meet the requirements of the study. But thank you for taking the time to answer our questions.

Do you have any questions about the screening or the research? I am going to give you a couple of telephone numbers to call if you have any questions later. Do you have a pen? If you have questions about the research screening, you may call Lindsay Williams at 310-569-2897 she will answer your questions.

If you have questions about your rights as a research subject, please call the UCLA Office for Protection of Research Subjects at 310.825.5344.

Thank you again for your willingness to answer our questions.

Name: _____ Contact #1:
Fax or Email: ___________________________ Contact #2: ___________________________
Address: _______________________________________________________________________
City/State/Zip: ___________________________________________________________________

Interview time: ______________________

Interview Location: ___________________
Appendix D. Recruitment Flyer

- Are you a woman who served in the military?
- Have you seen a mental health provider in the past year?

A UCLA School of Nursing study seeks women who have served in the military for a study on women Veterans and their experiences using mental health services in a clinic or other outpatient service.

Why should I participate?
- Your participation will tell healthcare providers and administrators how to better treat women Veterans’ mental health needs

What do I need to do for this study?
- Participate in one 60 to 90 minute interview about your mental health treatment preferences in a private setting that you choose, with a short follow-up interview as needed.
- Fill out a short questionnaire.
- You will receive a $20 for your participation

What makes me eligible for this study?
- You must be a female non-active duty military Veteran or reservist ages 18-65
- You must not be a current VA employee or mental health provider

To find out if you are eligible, please contact:
Lindsay Williams, RN, BS, PHN
Doctoral Student, UCLA School of Nursing
Lwilli@ucla.edu or 310-569-2897
Appendix E. Individual Profiles of Women Veterans

Individual Profiles of Women Veterans

Barbara. Barbara is a recently retired African-American Navy Veteran that describes a childhood of “abandonment”, and MST during her service. Her story, exemplified in the quotes below, describes experiences of conflict, trauma, military gender issues, identity formation, her mental health tipping point, coping strategies, and connections with other women Veterans:

“Tipping point to enter treatment post-military”
“It was me, my supervisor or my job. So it-it was-it was a situation where I was kind of backed in the corner...And it was the fight... the flee or fight type syndrome you know and I had just started at (location) the year before...And I had not gotten past my probation yet and it was like okay, one of us... you know something’s gotta give... You know and so I decided to go into treatment and I’ve been in treatment ever since so...”

Military identity
“You know um, because I’ve always been... well people say I’m a strong individual but because... Of the military uh, w-w-you have to fight for everything, especially as a woman. You know you have to prove yourself, so rather than give in to stuff I just keep going. Whereas maybe I probably should have stepped back at some point...You know uh, but it took that one incident at work...To kind of push me over the edge.”

“Just suck it up and keep on going. Um, you know because that’s what we were taught to do. You know you suck things up; you don’t cry about it and whine about it. You just do it you know. So uh, that can be good, that can be bad.”

Identity
"'cause I’m able to detach myself...From stuff and I think that’s one way that I’ve always...Protected myself is by being able to detach. You know but that’s uh, that’s the shell. That’s my protection...That I have built up over the years. And it just... it’s still there.

Trauma
Q: I can imagine though that having that was beneficial when you were in the military. Barbara: Oh yeah, big time yeah because even... you know I was raped three times in the military. And um, it just... uh, you know I don’t belabor the point you know. Uh, I don’t let it shape...Who I am.”
**Yolanda.** Yolanda is a married Latina woman that served 24 years the Army. Part of her story deals with the MST she endured in the military, and the burden of blame placed on her to take responsibility for her trauma. She encapsulated her trauma and used her femininity as a means of protection from future trauma. Through using mental health services, she makes a powerful statement on her future and reclaiming her identity:

**MST**

“I think it’d been, it was there all along. I just not, you know, really facing it. Uh, I married when I, while I was in service, and I did suffer Stand it was kinda like thrown under the rug ‘cause I was young and I didn’t real, realize that-that I was exposed to MST. You know, I, uh, I-I told on the person that did it and it was like, oh, you was just asking for it. And one of those when you were young and you really don’t know. And they said, well, you went out partying with these people. And so-so what if you said no. You-you already opened-opened, you know, the window up. And so, it happened more than once.

One when I was actually in basic training. And-and, you know, it happened to me at [LOCATION]. I guess it was the norm. At the time that I was training and it was, like, literally, it was happening on a daily basis. And it was like if you tell, you, you’re gonna be sent home. And it, it’s kinda like they punking you into, you know, keeping it. And all the women that were involved in it, we-we talked about it and it’s like, oh, it was kinda like part of training. It didn’t happen repeatedly, thank god, you know. It only happened once, well, but, it happened. And it happened to a lot of us.”

**Female identity**

“And so, I became a very nurturing person. And-and I married in the military. My hus-, my first husband was in the military. And, um, he had two children. He had gotten custody of his kids. And, uh, when I was born, I was a preemie, uh, baby, and I was told that I couldn’t have kids. So, you know, when I met him, I fell in love with his kids. And they in, uh, like I was telling you, because I didn’t want to have any issues with, you know, being promiscuous or anything like that, but I was nurturing with the child. So, I became really close with the kids to the point the kids fell in love with me. I fell in love with him, and I married. So, I became more of a provider and in an enabler or, you know, giving, constantly giving. So, I was more like I needed to be needed, you know? So, and I think that’s why that I would’ve failed marriage because I was constantly giving and giving and giving and thinking okay this was taken away from me. Now I’m going to give so this doesn’t happen to me…”

**Identity and transition**

“And I tell them that the way I deal with it is, I’m the bigger, better person. That, you know, though they took something away from me, I’m not going to allow him to keep it. And I think that that’s how I’ve gotten over it. Because if I let you take this pen from me...”
and I let you keep the pen, it's no longer mine. I don't, I'm not fighting back for you to give it to me. And that's the way that I've-I've approached it. You took, you know, a night away from me. You took a moment away from me. But I'm not going to continue to allow you to keep taking every night away from me. And I think I learned this through, you know, going through therapy and in self-reflection.”

Carmen. Carmen is a married mother, Latina, and an Air Force Veteran. She describes the changes in her identity from soldier to mother and student that was the starting point of her usage of mental health services. She also experienced an incident of sexual assault in her childhood at age 14, and joined the military to further her career opportunities:

Transition

“Like, I know the transition for student veterans to education is difficult. Especially if you come from disadvantaged backgrounds. Which a lot of us do. It’s partly a lot of the reasons why we joined the military, you know, to-it's a social ladder, you know.”

“Ah… It was horrendous. I couldn't study in my bedroom, because the baby would wake with the turn of a page. You know, and I couldn't study in the dining room 'cause they're talking and watching TV. The student lounge that they have at University Village, either one, it was always packed or number two, it was so silent, you can hear people drinking their coffee. [LAUGH] Like the movement of their throat, you can hear. So it was, it was not a suitable place. And I was still breast feeding, so if I stayed on campus, I would have to pump and carry around this huge bag and worry about storing my milk. And where am I gonna pump and all that stuff. And then it was just really hard to study. So I started facing, you know, stress from having to adjust to living with my in-laws, adjusting to living to L.A., adjusting to the program, adjusting to being working Mom. So it was tough.”

Carmen also refers to an interesting sort of identity development among the women in this sample, that of an “outlier”; someone who does not fit the model of a “typical Veteran.” Education and financial concerns closer to that of a civilian are part of the “outlier” identity:

“I don't know how much of a typical vet, women veteran I a.m. mean… An example of how not typical I might be is… this week, I was, I was asked by the General of the State of California to research the economic impact the California National ha-... Guard has on the State of California. Because I am one of the few that's pursuing, I don't even know... I don't even know if I'm one of the few. But I because I'm studying sociology in a doctoral program, like that is a reason they reached out for me.”
“I think our needs are more similar to common needs of a middle class person now. You know, um, trying to find a suitable mortgage, you know, interest rate, and adjusting to family life. You know, normal civilian type stuff. Not necessarily like, okay, I’m a military person, I’m going on deployment and, you know, how am I gonna have my family? You know, support it. You know. But, it’s like, okay, so now I’m back. I still need support. But-But, in different kinds of ways.”

**Delia.** Delia is also a married mother, and reports her ethnicity as white/Caucasian. Unlike Carmen or the rest of the women in this study she served as an officer in the military, specifically in the Army Nurse Corps. Her story is an anomaly from the other women in some ways, but she still describes the same major concepts of transitions, identity and structure. Her trauma is from combat, and she did not disclose any gender based violence:

**Military identity**

“So in the military even if you have days off I mean you’re technically 24-7 a soldier and they have to be able to get a hold of you anytime any day, any place so they have to know where you are at all time and also you’re just you’re accountable”

**Trauma**

“one guy came in and-and I mean you know I was kind of like the triage nurse and I kind of look and he has like a hole where his nose is but the whole head of his, back of his head’s blown out and like he has no brains you know what I mean? That kind of thing, so, so then I was like, I was like can I, I’m a nurse can I, you know like what do I, you know obviously then they get put into the one you know kind of pile area we had and then I had to determine like who goes you know who goes into the hospital, who’s like you know emergent, who’s you know not, who’s kind of like walkable you know you can kind of fix ‘em outside kind of thing so, anyway so kind of after that day like when I-when I kind of trudged back to the tent with like blood on my boots and everything then I was um, I was like oh my God this can happen like, you have no control where it comes from.”

**Projected identity**

You know you have to kind of just face that like, you have to be ready to go at any point you know like you have to be, you have to be good with yourself and ready you know I-I was kind of telling you know like if you want to get spiritual or whatever like one of my friends was you know she’s like I’m good, I’m good with Jesus I’m, you know. He and I said, I’m I said, I need to get married, I need to have, I need to have babies like I-I mean my, my mission like my purpose in life is to be a mother like I know this so I need to, like
I need to stay like I don’t care what plan God has for me, I need to get back home and have babies and get married.”

Delia’s form of mental health and coping came from her social support of friends, spouse, and family, which is absent in the lives in many of the other participants. They were supportive of her decision to join the military and understood her challenges:

Pre-military context

“No, I mean it was you know and I had my husband for support. I mean, I have a really good support system. My father’s retired military um, I have a really good supportive immediate family and extended family you know they’re all supportive of my service you know I mean, like I said I grew up in a military family with my dad.”

Keisha. Keisha is a Navy Veteran in her early 30’s of mixed race. She is a single parent and full time student. The major concepts of trauma, transitions, identity, and structure all arise in discussing her home situation and pathway into mental health treatment:

Trauma and pre-military context

“Um, so I grew up in San Bernardino, California and, um, I grew up in a really pur-poor area and I joined the military, basically, to leave my neighborhood.”

“Um, I have PTSD that wasn’t… didn’t start in the military, but the military didn’t exactly help. Um, it started… They h… The other word for it is, or the other term for it is, Hood disease.”

Military

Yeah, and then I think the-the military kind of fostered that, um, and I don’t think I realized that, um… Well, I didn’t know that I had it until a few years ago. Well, my understanding of it then was that I was just overreacting. And that I was just being kind of dramatic about-about everything. Um, my understanding now is that, you know, I-I know a lot of… I know a lot of coping skills now.”

Entering mental health services

“Um, well, I actually… I went to g… I got screened for having ADHD. Which I never got diagnosed with when I was a kid….When I initially met with the doctor and was going through one of those long questionnaires, um, that’s wh… Um, got to that point, so I think I… And we didn’t even really focus on the ADHD, once I went in. We focused more on the anxiety because that just opened up a whole dialogue and I think I was going through a depression at the time. So, focus on the anxiety and the
depression and then, that’s when I learned that the feelings that I was having, um, uh, were anxiety attacks.”

In terms of her regaining stability, she mentions that she does not have a good relationship with her son, but it is building that connection while coping with her own issues:

Building stable structure

“He still looks at me like, the authority figure. Um, so, i-it is something that I would like to work on. But right now, he’s actually living with my sister while I’m getting used to, um, the first year of grad school. So, um, my family is really supportive of me and I… My sister knows how I am with change, so she has him this first year. So our-our relationship is getting better because he’s at a distance. “

Brandy. Brandy is the youngest woman interviewed in her 20’s, and reports Asian racial/ethnic background. Although she was in the military for a short time, she has a powerful story of her traumatic experiences in the military and post-military after a car accident. In her story she is able to separate the positives of the military from the negative gender based MST she experienced. In fact, for this woman the military gave her the tools to cope with the trauma she experienced while in the military:

Trauma

“[Y]ou know when it’s like you’re the one girl of 300, even if you’re probably not the most decent looking girl, you’re still going to get attention. Okay. And unnecessary attention. So like that’s a problem in the military still and I wish something would be done. I don’t like that some of these men are still in. But in a way I’m thankful because I get disability but you know I lost… I remember having to hear about the outcome what they thought about losing my military job. I remember all of that you know. I was really crying in front of my parents and I was like, all that stuff I worked for. All the care benefits, all the stuff to travel, all that career I worked for is all going to go down the drain you know what I mean? So I literally thought that was the end of the world for me you know at that time.”

Identity and transition

“But that’s, I think me being exposed to that really made me tougher and being exposed to a lot of men too. Like I think I used to be very light-hearted and used to be around my parents you know when it came to guys and what not. But now I’m completely in a different environment, like I’m by myself. I don’t have that protection. So I had to learn to
toughen up and be like no, you can’t come to my dorm. No, you’re not getting this or whatever they’re trying to ask for."

“Um, I think it did help me a lot. It helped me learn how to be on my own. To grow up fast. To take on the world without fear. That’s something I’m proud of. And there’s nothing wrong with being a woman to do so. So that’s what I believe. And if a woman wanted to go combat, she has every right to do so.”

“Um, I remember moving here a year and a half ago. Like I stopped doing figure skating? Which is one of my hobbies because money was an issue. So I got back to doing that. And it was very stressful with roommate situations, now I live by myself. So like you know sleeping well is helpful, getting a job, getting back on track. So I had to take another class to bring my grade up so that was helpful too. It took a little while but I got there.”

**Lola.** Lola is an Air Force Veteran and divorced mother in her 30’s who declined to state her racial/ethnic background. Her interactions with the outside world are greatly influenced by her mental health and traumatic history. Her complicated mental health history is linked to abusive relationships:

**Non-military trauma: Intimate Partner Violence**

“Uh, well, the guy that told me originally to go get checked, he ended up being abusive after I got my head checked and I was diagnosed, he ended up getting arrested for strangling me. And he was drunk but it doesn’t matter. I was separated from him and that was that. And then um, my dad who I have issues with as far as abuse, not physical abuse but mental and emotional abuse, he always brings it up you know. If he doesn’t like something I did or he doesn’t think I’m doing what he wants me to do or whatever, then he’ll bring up like oh you need to go and take your meds or whatever. So it’s kind of derogatory and I feel like it’s always hung over my head by men. I’ve never had any of my, well, I’ve had one female bring it up but I didn’t actually know her. And she was my ex-husband’s ex-girlfriend so. She said something on the phone as far as you’re crazy. You need to take your meds or something like that…yeah”

She also experienced trauma in the military, but she declined to specify the type. Whatever happened, she did not understand the implications until she lost custody of her child, when she was unable to continue encapsulating her emotions:

**Loss of custody and effects of therapy**

“The trauma started in the military but didn’t have a big effect on me until 2013. So I basically have this ability to disassociate and like escape from my reality. I can pretend
things aren’t as bad as they are. So when they took my daughter, the therapy that I was in to get her back helped open me up to the entire trauma. And then when I opened up to it and I disclosed it, I wasn’t able to actually dissociate anymore. So I’m left with actually dealing with the pain of it. So I think that there was too much therapy required of me with the CPS. They required too much and it caused me to flare up and make my situation a little bit worse….I was mentally suppressing it as a survival mechanism. And the amount of therapy I was in caused it not to, can’t do it anymore.”

Despite her setbacks, she is steadfast in her resolve to regain custody of her daughter and change the complicated legal system she’s embroiled with in this custody process:

Identity of Resolve

“And I don’t stop trying. I don’t give up. I guess that’s why I’m still here is because I’m not going to give up ever, on my kid or I’m not going to give up on helping the system to change for the better you know, to improve it.”

Jessica. Jessica is a single white woman with no children in her late 40’s. Her story is one of trauma, but is a powerful example of what women Veterans have endured throughout their lifetimes:

Trauma

“And I’m like no I’m fucked up because somebody beat my head in with a pipe and the cement on the ground to carry the front load and rape me for 16 hours…and I had three other rapes that happened when I was in the military that was undiagnosed…not to mention the fact, combat PTSD from the shit that I’ve seen. That was undiagnosed for 20 years until 2009.”

Coming from an abusive household, she joined the military looking for structure, but also likens the military to gangs, in both the presence and absence of order, structure, and purpose:

Seeking Structure

“So the military in a sense is a gang you’re joining to find someplace to be. When I was in the military, for me it was the parenting that I never got. It was highly structured. It was organized. I could advance through my own merit. You did the work, you advanced. Well you take that same psychology and you apply it to a female gang member, it is the
exact same thing. Gangs aren’t highly structured in the sense that you need to be at this
place at this time or you know, homies don’t punch a clock. But they do have the other
aspects of it which are, wow, you’re a part of something. We’re all in this together. We
are going to do this mission together. We are going to go do this thing. And if you follow
orders and you put in your work, which in homey language, it is actually called “putting
in the work,” then you can advance.

“And so for a person to be able to get out of that, and when you get out of the military,
you go right from having that—and it’s very similar to what I read about homies leaving
the gang—you’re lost. All of a sudden you were cut off from all the people that you know
that supported you. And now you’re in a system that is completely foreign to you and
you’re dealing with the VA or you’re trying to get your benefits and then you’re getting
thrown into UCLA via thousands. There’s nobody there. So you can see why people go
back in? Or you’re trying to get a job and the way that you have learned and how to do
a job, which is you take accountability, you show up, you do your job, you work hard.
And the rest of the world doesn’t operate like that? And then you weigh in the emotional
problems that you have because you’re carrying around undiagnosed PTSD and
that…there’s a lot of similarities.”

She also discusses her identity as an "outlier":

“I am an outlier in the sense that, I’m now pushing 50, got rehab, managed to get help,
and it took a really horrific, horrible thing to happen to me to be able to do that. I mean,
so I’m not your typical Veteran in that sense. I’m an outlier.”

Kim. Kim is an older African-American woman and Army Veteran. She joined the
military as an adult, but joined for the same reasons as other participants, to gain
security and structure separate from a turbulent situation at home:

Substance Use and Structure

“. But I was getting away from drugs. I had a drug dealer get me involved in drugs and
crack. And I never knew. If I had known…because this was not in my family at all…if I
had known, I never would have even tried it you know. But I trusted him. And I didn’t
know it would grab me like that.”

“But you know what, I still would tell anybody, if you’re on the street, if you’re not doing
nothing and you don’t have an education, go to the military. It will give you some
structure. You can go in on a two year program, then get the hell out.
Women Veterans’ Perceptions of Mental Health Services

This is one reason why MST is so devastating for these women, none of them joined with the expectation that they would be abused, and the trauma that some of them escaped would be perpetuated and in fact, enhanced during their service:

**MST and Shame**

“I was raped. And I was so ashamed I didn’t report it. I didn’t report it. That was at my first duty station. And so, I was so ashamed of and um, my husband was wondering what was wrong with me. Anyway, we ended up getting divorced. I didn’t want him touching me and just different things you know. And I never told him. Never told him. We got divorced. He went his way and I went mine. And then I had my tubes tied. I said I’m not having any children because my father didn’t even acknowledge me. And he was married to my mother. So I said, I don’t want any children you know.”

She recently moved away from her partner, who is also a Veteran. This came with her need for peace and nurturing:

**Need for stable structure**

“ But I said, I want me a Marine. Be careful what you wish for. Because when I came here, he had blackouts. He’s the reason I came here. He was having blackouts and just weirdin up on me, yelling at me all the time. Get out get out! I didn’t mean for you to stay gone, I just wanted you to get out then! You know….Yeah, up and down all over the place. And I never saw him like that. He scared me. And so I think that was one of the final things that took a toll on my brain you know. And it just felt like if I hear a whole lot of loud noise and people yelling and stuff. Yeah, it triggers. It’s like I don’t know if I’m supposed to fight for my life or what. But I just can’t take that. I need peace in my life. I’m 64 years old. I need peace. You know if I make any noise it’s going to be me making the noise okay. But I don’t need anybody screaming and yelling at me like I’m somebody’s stepchild. And I’m not having it. So he’s got his place to lash now. And I’m trying to find a place but I have a cat. And I’ve had her since 2002.”

**Sharon.** Sharon is a single African-American Navy Veteran in her 50’s who’s tipping point centered on her alcohol addiction, which was a way of managing her mental health symptoms:

**Mental Health Symptoms**

“I was hearing voices and having trouble sleeping. For about a year or two. About 2 years.
Substance Abuse

“Because I was drinking beer every day. And I got tired of just sitting around drinking... Um, just waking up and just you know...doing the same thing every day and not having no input. Just talking you knows...just socializing over the alcohol you know. It' just got boring. Well I wasn’t going nowhere with my life. And I was wasting money too. I wasn’t eating right, sleeping right. Just hanging out and partying too much. And I just got tired.”

Sharon does not disclose MST or other trauma, but instead describes the leadership structure that made her occupation enjoyable:

Military Structure

“Oh, I had like a sergeant immediately over me and then we answered to a master chief. And he answered to a lieutenant. It was kind of like a crowded office. But it was alright because they had meetings like every Friday. They'd go over what’s going on. So it was okay. So they really had like step by step leadership. 

SPEAKER: Ok. Can you talk a little bit more about step by step leadership? Well they had an E4 and I guess she was like a sergeant or whatever. And she trained you. And then the master chief was over her. And he was taking training from the lieutenants. And so he answered to the master chief. So whenever you had a question, you’d go to her. And if she couldn’t answer it, she’d go to the master chief. If he couldn’t answer it, he'd go to the lieutenant. And we all walked around and did our little part. “

She describes her new outlook and advice to women Veterans who are seeking care, which invokes the encapsulation that some women Veterans perform, and the social support necessary for coping:

Using Social Support

“Not to hold things in and let them know I’ll be there to talk about with them...mainly learn how to release your feelings. Well when something’s bothering you, instead of ignoring it, talk to someone else about it so you can express your feelings and get their opinion so you can solve whatever's bothering you.”

Gwen. Gwen is a divorced mother in her early 30's of white/Caucasian ethnic background. She’s an Air Force Veteran who has had a long journey into sobriety and making goals for her life, after an incident of MST left her incapacitated and using substances to cope. As a result, she actually spent time in jail related to her addiction:
MST

“Like that’s why I got out like something happened to me, and then I was around this person and ended up getting in trouble for it, and I was too scared to seek help in there. I did seek help first, and then, but I was still around this person. And then like he just made my life a living hell and his comrades did. So it wasn’t worth it for me to stay in you know.”

MST and Substance Abuse

“: Uh, yeah I had a situation happen to me in the military. And I’m still addressing it but it’s been hard because it’s hard to talk about. But at first, I didn’t know where to turn to and what avenues to go through. So maybe that’s on my own part too just feeling you know what I mean, like worried about going through it. . .: It’s a lot of my reason why I was using. It stemmed from the main incident. And I started becoming that person that they kept saying I was after the incident. And it’s just unhealthy.”

Using Mental Health for Recovery

“It’s different. I’m taking it a day at a time. But I need this program to deal with a lot of my issues and to get a better foundation for my future. I just did 17 months in jail. And my life was very unmanageable so… My head’s more clear, but it’s still a day to day thing.”

At her level of dealing with her trauma, she can start to separate the positives of her service from the MST, but still has difficulty even discussing what happened to her:

Military Structure and MST

“I did. I liked that accountability and the camaraderie. I just didn’t like some of the people that were in there and the men. I wanted to excel and I was great at my job. I ended up getting like airman of the year for two years in a row. I made staff my first time, but it was getting harder for me to excel in rank just because I had this supervisor who was a male, and yeah it’s hard to separate that incident…

Her sobriety has opened the door for further communication with her family:

Social Support

“Oh my family yeah. For the first time in my life, now that I’m clean and stuff, they’re really supportive.

Mary. Mary, the final participant in the group, is in her 40’s, single, and reports white/Caucasian background. Although she served in the Coast Guard, her
experiences echo that of the other study participants. She too experienced MST that led to encapsulation and subsequent development of an alcohol use disorder and maladaptive relationships. Her story is harrowing but stories like hers are crucial to understanding women Veterans and their trauma:

**MST and Consequences**

“And women don’t usually open up and speak their minds because they’re used to being ignored. Like with MST issues in the military, I know when I said something…it was I went to the clinic the next day and got checked out, the morning after pill, all that, and it was brushed under the rug. And if something bad had happened to a guy in there, it wouldn’t have been brushed under the rug most likely you know. I mean they would at least investigate… I was actually in school when it happened and he got to stay in his Radiomen School, and I was made to leave Electronic School. And then when I got on the ship there was another incident where I was surrounded by these guys that were threatening a rape when we got underway on the ship. And I had gotten off the ship by means other than honorable you might say. I jumped overboard. And so they sent me to a psych ward… And so I was like you know, in my opinion it was God doing for me what I couldn’t do for myself at that point was getting me off that ship so I didn’t get underway with them. Something bad was going to happen. So that probably would have been brushed under the rug too had it happened or who knows, somebody would have been really, really hurt. Because I knew I would have fought back.”

**MST and Mental Health**

“And I’m just now realizing that there’s a direct correlation between my drinking which got me in here and my PTSD, MST, all that. And it’s really affected me. I’ve always had an issue with even being able to hold relationships. And real trust issues. And they’re still following me. I’m 42 going on 43 pretty soon and they’re still following me. And I need to be able to work through this or I’m never going to have one that’s going to last you know and be worthwhile.”

She offers the following advice to women Veterans:

**Reclaiming Identity**

“. I would say it’s time to start loving you and taking care of you instead of always doing for others, but if you don’t take care of you first you’re no good to anyone else. And address your issues whether it’s physical or mental, emotional whatever, head on. And clear away your wreckage that you’ve had in your past...”
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