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Perceptions of Female Veterans Regarding Mental Health Services in the Veterans Administration System

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Walden University
2022

Abstract

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by

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MA, Liberty University, 2008

BS, Liberty University, 2006

Dissertation Submitted in Partial Fulfillment

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Abstract

Over the past 2 decades, women's roles in the United States military have changed which has increased their risk of developing post-traumatic stress disorder. In 2016, all military occupational specialty were opened to women which allowed women to fight and be exposed to a combat environment. As more female veterans are returning home and reintegrating into their communities, they are seeking care for combat-related post-traumatic stress disorder and combat exposure. The purpose of this generic qualitative study was to understand the female veterans' perception of the utilization of the Veterans Health Administration when seeking care for combat-related post-traumatic stress disorder and combat exposure. This study was guided by feminist theory which asserts that women have the same rights has men, but inequality still exists as was the case when women veterans sought health care for mental health concerns within the Veterans Health Administration. The research question focused on the female veterans' perception on their use of the Veterans Health Administration. Utilizing in-depth semi structured interviews conducted using video conferencing, data were collected from 14 female veterans. Using thematic analysis, three themes emerged: (a) negative experiences, (b) emotional experiences, and (c) ambivalent attitude. These three themes combing to form the overall finding that female veterans were dissatisfied with care for the issues of PTSD and combat exposure. The findings could result in positive social change when used to advocate for enhanced attention to mental well-being and efficient and effective services within the Veterans Administration to address mental health.

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Dedication

This dissertation is dedicated to the loving memory of my mother, Bobbye Louis Payne Perry. You have supported, encouraged, and loved me and never missed any of my educational endeavors throughout my life. May you rest in peace in Heaven!

Acknowledgments

It was through His strength and love that I was able to remain steadfast in this journey to achieve my goal that I set for myself in my life. But it was His Grace and Mercy that guided me through the trials of completing this voyage by remembering the Serenity Prayer written by the American theologian Reinhold Niebuhr as my daily motto, *"**God grant me the Serenity to accept the things I cannot change, the Courage to change the things I can, and the Wisdom to know the difference**."* I would like to thank my committee chair Dr. Barbara Benoliel for all the encouragement, feedback, and guidance throughout this journey. To my methodology expert Dr. Curt Sobolewski for all his support, feedback, and knowledge he shared with me on this journey. To my University Research Reviewer Dr. Andrew Carpenter, thank you for all the edits and feedback you gave me to ensure my research study aligned, so that I could move forward in this journey. To female veterans who have served and who will serve in the future, thank you for serving your country and allowing me to be your voice. To Mr. Whitaker and Mr. Schwartz thank you for your support and consideration since I started this journey. To my family and friends for all their loyalty, support, and encouragement thank you for taking this journey with me.

Lastly to my greatest supporter my sister Karen who completed her on journey of earning her Doctorate, I am so proud of you. Thank you for never given up on me and for continuing to always mentor, encourage, and motivate me to continue moving forward toward my goal of completing my dissertation even when I wanted to give up. Thank you for always being there for me and encourage me to strive to be a better person!!

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Chapter 1: Introduction to the Study

Post-traumatic stress disorder (PTSD) is a mental health problem that affects people who have experienced or witnessed a traumatic life-threatening event, such as accidents, natural or man-made disasters, sexual violence, or combat exposure (American Psychological Association [APA], 2021). Although PTSD is a debilitating disorder, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), to be clinically diagnosed as having PTSD, individuals must have specific symptoms for 3 months or more that cause significant impairment of their daily living (Lewis, Roberts, Andrew, Starling & Bisson, 2020). The symptoms of PTSD that individuals may experience include paranoia, flashbacks, and difficulty engaging in interpersonal relationships and activities of daily living that change the cognition and mood of individuals (Lewis et al., 2020). In 2019, 8 million adults in the United States experienced PTSD (National Center for PTSD, 2019a).

As PTSD affects millions in the United States, our U.S. military service members are not exempt. In a 2019 study by Cameron et al. (2019), the researchers revealed that 300,000 service members who deployed suffer from PTSD. In a separation study conducted by Taylor et al, (2020), 102,632 veterans suffered from PTSD or other mental health disorders, a potential decrease from the previously noted study. Of those 102,632 veterans, 19% were female veterans, indicating they developed PTSD at a higher rate than men, where 7% of male veterans developed PTSD (Lehavot et al., 2018b; Taylor et al., 2020).

Women veterans face both personal and social challenges as they attempt to re-integrate into society upon retiring from military services. These challenges are compounded when female veterans suffer from and attempt to seek care for PTSD. The social and personal challenges that women veterans may face while suffering from combat-related PTSD include unemployment, relationship problems, divorce, suicide, homelessness, parenting problems, financial problems, and women's health issues, all of which can have an implication on female veterans' high rate of unemployment and their increased suicidal self-injurious behavior (Afari et al., 2015; Koblinsky et al., 2017; Meffert et al., 2019; Murphy et al., 2018).

As service members transition from military to civilian life, 40% of service members seek treatment for mental health illnesses (Taylor et al., 2020). Veterans who seek treatment from the Department of Veteran Affairs utilize three major treatment programs which are Eye Movement Desensitization and Reprocessing (EMDR), Prolonged Exposure Therapy (PE), and Cognitive Processing Therapy (CPT) for PTSD. Studies have shown that there are no specific treatment prevention programs designed specifically for PTSD in women veterans, but instead, are designed for all veterans (Huang & Ramoni, 2019; Spoont et al., 2017).

In this chapter, I review the topic of PTSD as it relates to combat exposure among women veterans and their perceptions of the utilization of the veterans' healthcare administration (VHA). In the background section, I focus on defining PTSD in women veterans who have combat exposure from the current Iraq and Afghanistan war era. Following the background section, I discuss the purpose of the study, and the research

question. In the nature of the study section, I will provide a brief overview of the phenomena being studied and the analytical methodology that I utilized in collecting the data for this study. The utilization of feminist theory as the conceptual framework and the foundation of this study provided a lens through which I sought to understand the beliefs, behaviors, and values that female veterans' have when seeking care for mental healthcare services. Finally, I provide the definitions, assumptions, scope and delimitations, limitations, and significance of my research. I conclude this chapter by summarizing the content and providing an introduction to the literature review in Chapter 2.

Background

Women have served in the Armed Forces from the beginning of the American Revolutionary War to the current wars in Iraq and Afghanistan (Huang & Ramoni, 2019). The role of women has shifted over the past 2 decades, which has put them at greater risk of developing PTSD. PTSD affects approximately 23% of veterans of the post 9/11 era (Mallonee et al., 2020). Women represent approximately 20% of the veteran population with PTSD symptoms (Lawrence et al., 2019). Research has shown that in 2016, 49% of women in the Iraq and Afghanistan wars sought mental health care services at the Department of Veteran Affairs (VA; Koblinsky et al., 2017). Koblinsky et al., (2017) revealed that female veterans have often confronted barriers such as a lack of gender sensitive care and access to quality care, when seeking quality mental health care at the VHA. In the male-dominated environment within the VHA, female veterans recognized the unequal healthcare services provided for them (Ryan et al., 2015).

After an extensive review of the literature, I found no research that specifically explored the female veteran's perceptions of the utilization of the mental healthcare services within the VHA regarding combat exposure and PTSD (Ryan et al., 2015). This study is important because provides insight into the personal and social challenges that female veterans face as they re-integrate into society (Mefferet et al., 2019).

Problem Statement

Women have served in the military for numerous reasons such as financial hardship, family tradition, and educational opportunities that may occur in life that may make joining the military a turning point in one's life (Huang & Ramoni, 2019; Taylor et al., 2020). Women's roles in combat have evolved significantly since the 9/11 terrorist attacks as more women deployed to Iraq and Afghanistan. Prior to that time, many women were excluded from serving in combat areas of interest. However, in 2016, the Secretary of Defense opened all combat positions to women, which allowed them to participate in direct combat (Yeung et al., 2017). Since the Global War on Terrorism began in 2001, approximately 150,000 women have served in a combat zone in Iraq and Afghanistan (Berg & Rousseau, 2018). Women have become the fastest-growing segment in the Armed Forces. Berg & Rousseau's (2018) study revealed that women deployed to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) have served in various capacities of combat support operations such as explosive ordnance disposal specialists, ammunition specialists, intelligence analysts, counterintelligence agents, human intelligence collectors, combat medical specialists, medical doctors, and attorneys (Berg & Rousseau, 2018) and many may also be exposed

to hostile actions in a combat zone (Koblinsky et al., 2017). Veterans exposed to more combat and the aftermath of deployment are at risk for mental and physical health issues such as PTSD (Henschel & McDevitt-Murphy, 2016).

The inclusion in these high-profile theaters of operation potentially increases a female veteran's risk for PTSD as it relates to combat exposure (Shura et al., 2017; Spivack, 2016). Combat exposure has also been linked to military sexual trauma (MST) among some military personnel. According to Gross et al. (2018), the association between MST and mental health outcome depends on the amount of combat exposure in the context of warzone deployment as "42% of women reported experiencing MST while deployed" (p.2). As service members return from multiple deployments, research has revealed that female veterans are at a higher risk of PTSD and other mental health disorders than their male counterparts (Adams et al., 2021). Female veterans' impression of themselves and their recollection of the trauma are cognitive traits that increase their risk of PTSD with regards to processing, recalling, and responding to their trauma from their military experiences with combat exposure or the aftermath of battle (Adams et al., 2021; Frank et al., 2018). According to Lehavot et al. (2018b), as of 2018, 21 % of female veterans had self-reported that they suffered from PTSD.

In 2017, 290,133 veterans separated from the military. Of that number, 49,585 were women (United States Department of Veterans Affairs, 2020a). In 2018, 1,078,739 female veterans utilized the VHA, but only 176,526 of them utilized the health care services for mental health issues, provided by the VA (United States Department of Veterans Affairs, 2020b; Womenshealth, 2018). There are several reasons why many

veterans do not utilize VA services. Some of these include excessive wait times, difficulties navigating services, lack of sensitivity to health issues, transportation hardship (getting to and from the VA), and financial hardship (Meffert et al., 2019).

Although the research discussed above regarding female veterans who have combat-related PTSD has illuminated important findings, I found no studies that explored the female veterans' perspectives on combat exposure, PTSD, and utilization of the healthcare in the VHA services. Given such, further research is warranted that could address the documented social problem of female veterans' utilization of healthcare services provided for PTSD specifically related to combat exposure.

Purpose of the study

The purpose of this generic qualitative study is to increase the understanding of female veterans' perceptions of the utilization of the VHA healthcare services as they transition from military to civilian life when seeking care for combat-related PTSD mental health services. This study is unique because it gives women veterans a voice regarding the utilization of the VHA healthcare system when seeking care for combat-related PTSD and mental healthcare services (Adams et al., 2021).

Research Question

Research Question: What are the perceptions of female veterans who have experienced combat exposure, regarding the utilization of the Veterans Health Administration for combat-related PTSD mental health services?

Conceptual Framework for the Study

The conceptual framework for this study is feminist theory (see Shapiro, 1992). Feminist theory first emerged in 1848 under the Woman Suffrage Movement (Stanton, 1897). It was known then as the first wave and became known as the feminist movement in the 1960s (Friedan, 1963; Laughlin et al., 2010). The second wave of the feminist movement occurred in the 1960s through the 1990s during the civil rights movement where equal rights were being fought for social equality regardless of their gender (Friedan, 1963; Cott, 1987). The feminist movement was solidified with feminist theory after the third wave in the 1990s (Chancer, 1991). The core principle of feminist theory is based on the belief that women should have the same rights as men. Feminist theory advocates for gender equality to bring about gender justice (Butler-Mokoro et al., 2018). Feminist theory is not only about gender inequality, but it also seeks to describe, explain, and predict social patterns, such as normative male versus female roles (Butler-Mokoro et al., 2018). Much of the focus of feminist theory is the analysis of gender equality and examines social roles that are considered stereotypical through the lens of a patriarchal society. Feminist theory also looks to describe and predict human behavior based on four underlying assumptions: (a) women's lives matter and are worthy of explanation; (b) inequality exists between genders; (c) inequality is not natural but produced and maintained by complex set of social, economic, political, and historical forces over time; and (d) inequalities should not be tolerated (Butler-Mokoro et al., 2018). The use of feminist theory in the current study provided a lens through which I examined female veterans' perspectives of their healthcare services provided, but not utilized, as they

suffer from combat-related PTSD and combat exposure. Feminist theory provided a theoretical foundation or platform for understanding the way female veterans perceive the utilization of services provided for treatment for those diagnosed with PTSD as it relates to combat exposure.

Nature of the Study

The nature of the study is a generic qualitative approach. The generic qualitative approach, also known as the basic qualitative approach, can blend one or more established methodologies (phenomenology, grounded theory, and ethnography) while maintaining the flexibility of not falling into a particular established methodology (Kahlke, 2014). Utilizing the generic qualitative approach, the researcher is not obligated to stay within the restricted confinement of each structured methodology listed but allows the flexibility of using one or more of those methodologies in this study (Aspers & Corte, 2019). The generic qualitative approach is the best approach for this study because it gave me the ability to capture and understand the perception that female veterans have of the VHA when seeking care for combat-related PTSD and mental health services. It provided me the ability to study the female veterans' perceptions of the utilization of healthcare services at VHA without the guidelines and restrictions that different qualitative approaches (phenomenology, grounded theory, and ethnography) place on a researcher when conducting a study on individuals' experiences. Using the generic qualitative, interpretive approach, I explored the participants' perceptions of their experiences of services provided from the VHA.

Definitions

The following definitions were utilized throughout this study as key terms of concepts.

Austere operational environment is defined as having been deployed to an environment whether it is on land or on sea by soldiers adapting to that environment in which conflicts are being fought faster, quicker, and fluid then previous wars of the Cold War Era of large Forward Operational Bases (FOB; United States Army, 2017).

Cognitive behavior therapy (CBT) is defined as a self- reporting therapy utilized by individuals to report their negative thoughts of the trauma (National Center for PTSD, 2020).

Combat has been defined has direct combat on the ground in which units engage in hostile bodily risk from an enemy threat or confrontation of any kind that may result in danger to service members or their units (Strong et al., 2015).

Combat exposure has been defined as being exposed to multiple traumatic events during life-threatening combat situations and stressors where one feels threatened or in danger (National Center for PTSD, 2019b; Strong et al., 2015). To be considered exposed to combat exposure one must have suffered at least three of the seven combat experiences referenced in the Combat Exposure Scale (CES) utilized by the National Center for PTSD (National Center for PTSD, 2019b).The scale includes:

> (1) did you ever go on combat patrol or have other dangerous duty (2) were you under enemy fire (3) were you ever surrounded by the enemy (4) what percentage of the soldiers in your unit were killed (KIA), wounded, or missing in action

> (MIA) (5) how often did you fire round at the enemy (6) how often did you see someone hit by incoming or outgoing rounds (7) how often were you in danger of being injured or killed (i.e. being pinned down, overrun, ambushed, near miss, etc.). (p. 3)

Department of Veterans Affairs (VA) is defined as a federal organization that helps veterans and their family's transition from military to civilian life with multiple resources from health, educations, and career benefits (VA, 2021a).

Deployment is defined has the movement of forces in and out of an operational area (United States Army, 2021).

Eye movement desensitization and reprocessing (EMDR) is defined as a therapy that is utilized to help individuals process and make sense of their trauma (National Center for PTSD, 2020).

Feminist theory is defined as a theory that "seeks to describe, explain, and predict social patterns of both gender differences as well as gender inequalities for the purpose if bringing about gender justice" (Butler-Mokoro & Grant, 2018.p.16).

Forward operational base (FOB) is defined as a secure military operational location that supports all tactical military operations that include but are not limited to hospitals, airfields, and maintenance shops in support of strategic goals in accordance with U.S. military missions (United States Army, 2021).

Military sexual trauma (MST) is being defined as sexual harassment or physical assault of a sexual nature of military personnel while serving in the military as defined by the Veterans Administration (VA; Gross et al., 2018).

Operation Enduring Freedom (OEF) refers to military personnel serving in Afghanistan (U.S. Department of Veterans Affairs, 2022c).

Operation Iraqi Freedom (OIF) refers to military personnel serving in Iraq (U.S. Department of Veterans Affairs, 2022c).

Post-traumatic stress disorder (PTSD) has been defined as a severe chronic anxiety, mental health disorder that can develop or occur after being exposed to one or more deep psychologically traumatic or life-threatening events (Brownlow et al., 2018 & Lehavot et al., 2018a). According to the Swan & Hamilton, 2017 "the Encyclopedia of Mental Disorders defined *post-traumatic stress disorder* as a complex disorder in which the affected person's memory, emotional responses, intellectual processes, and nervous system have been disrupted by one or more traumatic experiences" (p.1).

Prolonged exposure (PE) is defined as a therapy that helps individuals gain control facing their negative feeling regarding the trauma they have been avoiding (National Center for PTSD, 2020).

Veterans Health Administration (VHA) is the largest health care organization providing healthcare services from medical, surgical, mental health services, and the quality of life needs to veterans (VA, 2021a).

Veteran defined as a person who served in the active military, naval or air service and who was discharged or released under conditions other than dishonorable (Govinfo, 2014).

Assumptions

The first assumption I had in this study is that the participants were truthful in divulging information during the interview process. The justification for this assumption was that I wanted to ensure the accuracy of the data from the participants (see Birt et al., 2016). The second assumption as that, in this study, there may not be equal representation throughout the branch of services (Army, Air Force, Navy, Marines & Coast Guard). The justification for this assumption of inequality of representation among the branches was due to the demographic area in which the study was conducted (Blais et al., 2021). The third assumption in this study was that I obtained good quality data from the participants during the data collection process. The justification or obtaining good quality data in this study started with encouraging participants to be open with their experiences and perceptions during the interview (see Moser & Korstjens, 2018). The fourth assumption I had was that feminist theory would be an effective and supportive conceptual framework for my research study. The last assumption justification was that women still face inequality, and that feminist theory was effective and supported this study (see Rasheed, 2018).

Scope and Delimitations

The scope of this study focused on exploring the mental healthcare service provided at the VA from the perspectives of female veterans exposed to combat-related PTSD. A delimitation of this study was that it only focused on target gender, which are female veterans. Another delimitation of this study is that I only focused on combat-related PTSD and no other mental health disorders. Another delimitation of this study

was that I did not focus on any other services sought at the VHA and that I did not focus on participants who used the VHA for combat-related PTSD treatment. Finally, in using the generic qualitative approach, the findings from this study can be utilized in future research studies.

Limitations

There were some limitations concerning this study, such as self-reported data that can rarely be independently verified once collected (see Shields et al., 2020). The second limitation of this study was that I reviewed the utilization only within the VA and not at non-VA facilities that female veterans may use for their healthcare services (Finley et al., 2017). The third limitation of this study was the effectiveness of the recruiting method of obtaining participants to ensure that I reached adequate representation of the female veteran population from all the branches of services that included the Army, Air Force, Navy, Marines and Coast Guard (see Moser & Korstjens, 2018). Finally, a challenge in this study was to ensure that my personal bias of being a female veteran who has utilized the VHA in the past did not influence my analysis of the data and thus the findings of this study (Roller, 2018). I did, however, understand and empathize what other female veterans may have experienced when seeking treatment within the VHA system. To control for this bias, I kept accurate field notes, conducted member checking and peer reviews, journaled about my experiences, feelings, thoughts, and last, brought my concerns about potential bias to my dissertation chair (see Roller, 2018).

Significance

The results of this study provided insight into the female veterans' perceptions of the utilization of the healthcare services at the VA center, specifically as it relates to treatment addressing mental health services related to PTSD and combat exposure. The findings from the study may contribute to the existing body of literature about how female veterans seek care for combat-related PTSD and combat exposure. This study expands the literature on female veterans specifically as it relates to combat exposure, PTSD, and women's health care (see MacGregor et al., 2021). The results of this study may provide insight for healthcare professionals on the female veterans' perception concerning their needs of suffering from PTSD and combat exposure. A positive social change of this study would be improved health care treatment provided by healthcare provider to female veterans (see Kehle-Forbes et al., 2017). With improved healthcare services female veterans will have a better quality of life in meaningful relationship and in maintaining stable households (McKenzie, Anderson, Maydon, & Shivakumar, 2021). The significance of the current study is that it offers a view of the 'signature wounds' known as PTSD, previously understood relating to the predominately male veterans of the past decades, indicating female veterans are prone to the same symptomology when living through combat situations (see Lehavot et al., 2018a). The findings from my study may bring social awareness to the specific challenges that female veterans are suffering from combat-related PTSD face when seeking care.

Summary and Conclusion

In Chapter 1, I began with the introduction followed by the background and problem statement of the purpose of the topic of the research which is the perception of mental healthcare services provided at the VA for female veterans who are seeking care from combat related PTSD. I discussed how the conceptual framework of feminist theory was the foundation to supporting the research question in this generic qualitative study. Finally, I discussed my assumptions, delimitations, and limitations I had regarding my study as a novice researcher. In Chapter 2, I present the literature review.

Chapter 2: Literature Review

PTSD is a mental health disorder that affects approximately 3.6% of US adults in the United States in the course of a year (National Institutes of Mental Health [NIMH], 2017). It is estimated that, at some point, 70% of adults will have experienced some type of trauma such as combat, natural, or human-made disasters, violent personal assault, and accidents in their lifetime. Of these, 20% will develop PTSD (Sidran, 2018; NIMH, 2017). Since the terrorist attacks on September 11, 2001, the United States has been engaged in its most prolonged military conflict to date, where several thousand military personnel have served in Iraq and Afghanistan (Arraf, 2018).

Almost 280,000 women have served in Iraq and Afghanistan, some of whom have served in direct combat roles. Combat may expose women to the risk of developing PTSD (Koblinsky et al., 2017; Strong et al., 2015). Women veterans of OEF/OIF reported that one in four experienced MST (Koblinsky et al., 2017). The relationship between sexual harassment and poor mental health of female veterans suggest it is independently associated with detrimental health consequences such as PTSD (Peskin et al., 2018). Of the 14,900 military personnel who experience unwanted sexual contact, 42% of women reported those incidents during deployment (Gross et al., 2018). These developments have raised considerable debate over women's roles in combat and the increased risk of combat exposure as it relates to PTSD (Haun et al., 2016). Among the 1,965,534 military personnel who returned from Iraq and Afghanistan as of 2015, 422,167 reported health care problems of PTSD, and 96,228 (43%) reported using healthcare services (U.S. Department of Veterans Affairs 2017a; U.S. Department of

Veterans Affairs, 2017b). According to the National Center of PTSD (2019), 10% to 18% veterans of OIF and OEF will develop PTSD upon returning from deployment (PTSD, 2019). Being a female veteran is a strong predictor of PTSD as their population has grown the fastest and has shown a significant and positive association of being directly linked between combat exposure and PTSD symptoms (Creech et al., 2016). Regardless of the link between combat exposure and PTSD, 73% of female veterans serving in Iraq and Afghanistan were affected by combat exposure and showed lower utilization in the VHA healthcare system (Buttner et al., 2017).

The literature review revealed significant gaps in research regarding female veterans' perceptions of seeking care for PTSD and combat exposure as it relates to the Iraqi and Afghanistan conflict. These represent the biggest gaps in this era in which women are allowed to fight in combat and the ethnicity of some of the participants in the cited studies. This study was focused on understanding the female veterans' perceptions of the utilization of the VA healthcare services for treating PTSD and combat exposure. The literature review is focused on the female veterans' perceptions of the treatment provided upon returning from deployment.

This literature review focused on PTSD and combat exposure as I explored the social problems that female veterans may face upon reintegration into civilian life after separation from the military. I reviewed the issues that increase the risk of PTSD among female veterans. I also reviewed feminist theory as a conceptual framework for this study, including how it framed the study and focused the lens on the perceptions that

female veterans have when it comes to seeking care and the utilization for PTSD and combat exposure within the VA.

Literature Search Strategy

For this literature review, I gathered peer-review articles from several different databases. The academic search engine used for collecting journals and articles by topics was Walden University Library. I used a variety of multidisciplinary databases such as ProQuest Central, HHS Public Access, SAGE, EBSCOhost, Google Scholar, and US Department websites. When searching for scholarly research articles, I used Google Scholar, which resulted in 28,500 potential articles that I filtered to the last 5 years resulting in 19,300 for my review of female veterans with PTSD and combat exposure. My search's key terms were *female, women, veterans, post-traumatic stress disorder, PTSD, combat exposure, utilization, perception, healthcare, deployment, feminist theory,* and *generic qualitative approach*.

Conceptual Framework

In the 1970s, feminist theory was developed out of the first wave movement, which originated between the 1840s and 1920s under the women's suffrage movement (Stanton, 1897; Ware, 1970). The second wave of feminist theory occurred from 1960-1980 under Wollstonecraft's influence, a feminist (Cott, 1987). The feminist movement known as the third wave began in the 1990s, as women fought for equality within the workplace and against sexual abuse toward women and women's reproductive rights on a state, national, and global level (Drake, 1997; Butler-Mokoro et al., 2018). Feminist theory is defined as ideas and beliefs that women should have equal rights and receive

equal respect as men (Feminist Philosophy, 2018). Feminist theory seeks to describe, explain, and predict social patterns of inequality and gender differences in men and women's roles concerning standing or positions in society today (Butler-Mokoro et al., 2018; Feminist Philosophy, 2018).

Feminist theory shares four basic assumptions that help describe, explain, and predict the theory's human behavior. The first principle of feminist theory is that women's lives matter and are worthy of exportation and interpretation of their life stressors (Butler-Mokoro et al., 2018; McGraw, 2016). The second principle is that inequality still exists today between men and women, even though women should share the same benefits and rights as men (Butler-Mokoro et al., 2018; Duman, 2012). The third principle is that inequality is not natural but produced and maintained by a complex set of social, economic, political, and historical forces over time and places through reasonable principles based on education (Butler-Mokoro et al., 2018; Duman, 2012). The last principle of feminist theory is that it should not be tolerated (Butler-Mokoro et al., 2018).

I used feminist theory to frame this study around the perceptions of female veterans seeking care for PTSD within the historically male-oriented military culture of the VA medical centers (Butler-Mokoro et al., 2018; Strong et al., 2018). The feminist theory provided the foundation for understanding female veterans' negative perception of care utilization for combat exposure and PTSD at the VHA (Butler-Mokoro et al., 2018; DiLeone et al., 2015).

Literature Review Related to Key Variables and/or Concepts

Combat in Military

The last war fought in the 20th Century that comprised 7% of women deployed of the 700,000 military personnel serving in the Gulf War in 1991 were female veterans that were susceptible to intense levels of combat and toxicant exposures (Coughlin et al., 2017). Although some 41,000 women served, they served in combat support functions, driving trucks, flying planes and helicopters, directed artillery, port security, military police, intelligence, supply, and administrative jobs (Bellafaire, 2019). The US Armed Forces sent 41,000 military women in support of the Persian Gulf War, the single most massive deployment in US military history (Bellafaire, 2019).

In the 21st Century, the United States Armed Forces were challenged by enemy forces after the global terrorism attack on September 11, 2001, on the Twin Towers of the World Trade Center, the Pentagon, and Flight 93. Women were not allowed to fight in combat in previous conflicts, but, in 2013, the Secretary of Defense Leon Panetta decreed that women would be allowed in combat post within the next 3 years (Spivack, 2016). Since 9/11, 2.77 million military personnel have deployed to Afghanistan (OEF) and Iraq (OIF) with 590,000 military personnel with two deployments and 528,000 military personnel with three or more deployments (Taylor, Miller, Tallapragada, &Vogel, 2020). As the battlefields in Iraq and Afghanistan conflicts changed from previous wars, females exposed to more direct combat from insurgent attacks (Ferragamo, 2021). With this new way of fighting, women's roles in previous wars have shifted in recent years. Women

now fight in combat are more prevalent to a higher rate of PTSD (Frank, Zamorski, Lee, & Colman, 2018).

In 2016, the Defense Secretary opened all combat positions to women, which allowed them to participate in direct combat, as women are now the fastest-growing population in the US military (Koblinsky et al., 2017; Spivack, 2016). Although females were allowed in combat positions, they still faced scrutiny and pressure to succeed than their male counterparts both physically and mentally (Ferragamo, 2021). The Armed Forces sent almost 280,000 women to Iraq and Afghanistan, representing 12% of deployed forces, including military police, medics, truck drivers, helicopter pilots, security guards, and explosive ordnance technicians (Koblinsky et al., 2017). Female veterans who served in OEF and OIF also experienced hostile actions in a combat zone (Koblinsky et al., 2017). These developments have raised debate over women's roles in combat and the increased risk of developing PTSD (Haun, Duff, Lind, Kisala, & Luther, 2016).

Rate of PTSD and Women

As the United States has been in its longest conflict to date, in Iraq and Afghanistan, more than 2.4 million service members have separated (Vogt et al., 2016). Since the war began, 308,536 veterans were identified within the VHA care as having PTSD. Of that number, 265,566 veterans have received treatment for mental health care (Maguen et al., 2019). Twenty percent of female veterans surveyed reported suffering from PTSD, and 14% suffered from depression and other mental health issues (Koblinsky et al., 2017). According to Lehavot, Katon, Chen, Fortney, & Simpson, (2018b) "combat

exposure was not a significantly correlated for women veterans, likely as a result of limited power, but it was in a similar direction as for the men" (p.e6). Women's risk for PTSD is higher when men and women have similar combat experiences (Lehavot et al., 2018b). Lehavot et al. (2018a) found that women veterans are more at risk for combat-related PTSD than their male counterparts. Of the 36,101 individuals surveyed, 20,386 were women, of whom 1.8% were (*n*=379) women veterans suffered from a lifetime (13.2%) or past-year (11.4%) prevalence of PTSD (Lehavot et al., 2018b). Ryan, McGrath, Creech, and Borsari (2015) found that of the 133 women surveyed, who were exposed to combat exposure and PTSD, only 37% showed utilization of VHA services.

Findings That Increase the Risk of Getting PTSD

PTSD has become a major health concern among soldiers and veterans who served in the Armed Forces in the last 2 decades that fought in the constant wars in Iraq and Afghanistan (Nisiparu, Matei, & Sălceanu, 2020). Those who experience traumatic events may develop PTSD months or years following the trauma. In a recent study, Nichter, Haller, Norman and Pietrzak, (2020) revealed that female gender, ethnic minority status, and lower socioeconomic position were associated with PTSD. There are individual findings that may contribute to the development of PTSD, such as age, race, pre-existing trauma, and the number of deployments (Wang et al., 2019). I looked in-depth at each of those findings and the link they had with female veterans at risk of developing PTSD.

Age

According to Xue et al., (2015), there are mixed results on the finding of age as a predictor of being a risk of one developing PTSD, as one's age may impact an underlying traumatic event. An example of this would be in military personnel, especially the differences between young and older women. Younger women who are deployed are at a higher risk of experiencing PTSD compared to older women (Xue et al., 2015). The age of female veterans who experience lifetime and past-year PTSD is significantly higher than both their female civilians and male veterans (Lehavot et al., 2018a).

Race

The sociodemographic determined among the military personnel is under debate as to whether or not minorities are at a higher risk than non-white of experiencing PTSD (Xue et al., 2015). This could possibly be due to their combat role assignments (Xue et al., 2015). Racial and ethnic minority veterans who have been diagnosed with PTSD are less likely to seek treatment than white veterans (Spoont, Nelson, Ryn, & Alegria, 2017).

Pre-existing Trauma

Pre-existing trauma (e.g., child abuse, prior exposure to trauma, and pre-trauma psychological problems) may also contribute to the development of combat-related PTSD (Lehavot et al., 2018a; Xue et al., 2015). Female veterans with multiple pre-traumas are at a higher risk of experiencing combat-related PTSD (Xue et al., 2015). An example of female veterans' vulnerability to prior trauma (e.g., childhood abuse, family history of mental disorder, and personality traits) increases their risk of PTSD because previous traumas are unknown (Xue et al., 2015).

Number of Deployments

The number of combat-related deployments are directly tied to combat-related PTSD (Xue et al., 2015). The more times female veterans are deployed, the higher the risk of mental health issues (Carlson, Stromwall, & Lietz, 2013). Female veterans who are deployed are 1.6 to 3 times as likely to be diagnosed with mental health disorders (Carlson et al., 2013).

Female Veterans Perception

United States service women have served a long time in the Armed Forces with restrictions and without recognition of their duty (Ferragamo, 2021). In 2016, the "Risk Rule" that excluded women from the battlefield was rescinded that allowed women into all combat position (Ferragamo, 2021). As female veterans of the Iraqi and Afghanistan war reintegrate into their communities, they will face challenges concerning the utilization of medical and mental health services at the VHA as they sought care for treatment for combat exposure, military sexual trauma (MST) and PTSD (Ryan et al.,2016). Female veterans have self -reported traumatic stress exposure that contributes to PTSD as well as the 64% who report combat exposure and 78% who report exposure to aftermath to battle, but only 37% have used the VHA for MST and combat trauma (Mustillo & Kysar-Moon, 2017; Ryan et al., 2016).

Although female veterans have access to health and mental healthcare services within the VHA, in a study conducted by Kehle-Forbes et al. (2017) revealed that females have access, but they later discontinue utilizing those services. The female veterans' perception of their healthcare revealed that they were skeptical of the skills of the

providers within the VHA that are providing treatment for them (Kehle-Forbes et al., 2017). Female veterans found low satisfaction in the access of gaining treatment from the VHA as they see barriers for women in the lack of gender-specific mental health care services being provided (Kehle-Forbes et al., 2017). Previous literature focused on female veterans from the Vietnam era where women were not allowed to fight in combat. I focused on female veterans from the current conflicts in Iraq and Afghanistan where female veterans were exposed to combat trauma that increases their risk for PTSD. It is important to note that previous study's limitation focused on one ethnic race rather than multiple races, which gives an inaccurate representation of the veteran female population as a whole. I focused on representing the veteran female population as a whole instead of one ethnic group as I focused on their perception of the utilization of care they received for PTSD as it related directly to combat exposure.

Personal and Social Challenges of PTSD

Female veterans are transitioning from military to civilian life; they are likely to face a greater number of personal and social challenges than their male counterparts that contribute to PTSD. The personal challenges comprise of relationship problems, parenting problems, and financial problems linked to higher rates of unemployment and suicidal self-injurious behavior (Afari et al., 2016; Koblinsky et al., 2017; Meffert et al., 2019; & Murphy, Busuttil, & Turgoose, 2018).

Parenting behavior can negatively affect the children of veterans who have PTSD with consequences of psychological, social, and emotional difficulties in their children (Christie, Hamilton-Giachritsis, Alves-Costa, Tomlinson, & Halligan, 2019; Collins,

2018). Children of veterans of multiple or extended deployments are at an increased risk for depression as they experience a sense of loss for their military parent (Collins, 2018). Veterans with PTSD will also struggle with emotional connections with their families that can bring about a sense of loss for the child, interfere with the veterans' ability to care for the child's emotional needs that can provoke an emotional turmoil that puts the child at risk (Collins, 2018).

Murphy et al. (2018) stated that veterans who have PTSD also reported experiencing relationship difficulties. Female veterans are 5 times likely to be married to another soldier in a dual-service marriage (Segal & Lane, 2016). Every month men and women are separated due to deployment; there is a greater risk of divorce. For women, the divorce rate is 1.4 % higher than the 0.3 % for men (Segal & Lane, 2016; Southwell & MacDermid-Wadsworth, 2016). Veterans with PTSD experience greater difficulty in intimate relationships with their partners (Vogt et al., 2016). Female veterans who have PTSD reported a 22.2 % dissatisfaction rate with their significant others (Vogt et al., 2016). Veterans with PTSD felt that family and friends could not understand the daily struggles or conditions that they face with PTSD (Huan et al., 2016).

Two social challenges related to PTSD that female veterans face are unemployment and suicide. The overall rate of unemployment among female veterans was 6.3 % compared to the overall female veteran population, which was 4.7 % (Vogt et al., 2016). That high unemployment rate brings about financial issues among veterans, such as loss of home, bankruptcies, and their inability to provide for themselves and their families (Haun et al., 2016).

When veterans lose the ability to care for their loved ones, it affects their psychological health and may lead to suicidal behavior (Hester, 2017). Suicidal death is extremely high among the veteran population; an example of this is the female veteran suicide rate is 35 per 100,000 compared to the rate of their civilian counterparts (Hester, 2017). As veterans re-integrate into society, there is a link between veterans' unemployment rate of 5 % and the high suicide rate with the low utilization of the veterans' mental healthcare system (Hester, 2017; Johnson et al., 2016).

Treatment Intervention Programs For PTSD

Women represent 10 % of the veteran population and are the fastest-growing population among all veterans (Huang & Ramoni, 2019). Female veterans serving in Iraq and Afghanistan have historically experienced different military exposure than their male counterparts (Huang & Ramoni, 2019). Female veterans combat-related trauma has been associated with a greater risk of developing PTSD (Ryan et al., 2015).

Upon returning from deployment, female veterans had expressed low satisfaction with their care and were less trusting when it came to their combat-related mental health needs being met by the Veteran Health Administration (VHA; Kehle-Forbes et al., 2017; Ryan et al., 2015). According to Johnson & Possemato (2019), a National study showed a low utilization of mental healthcare among veterans diagnosed with PTSD. Those returning from Afghanistan (OEF)/ Iraqi (OIF) had a 9.5 % adequate mental health care. However, 20 % did not receive mental healthcare services within the first year of returning from deployment (Johnson &Possemato, 2019).

At some point in their lifetime, 93 % of female veterans will experience a traumatic event (Williams, Pavlish, & Washington, 2018). The generic qualitative approach focused on their perception of seeking care for PTSD as it relates to combat exposure (Williams et al., 2018). According to McGuire, Lee, & Drummond (2019), "early understanding of PTSD processes was driven by behavioral theories that were based on conditioning and learning principles" (p.277). As female veterans sought care within the VHA for PTSD as it relates to combat exposure, there are three conventional treatments (prolonged exposure therapy, cognitive behavioral therapy, and eye movement desensitization and reprocessing therapy) utilized to treat PTSD that I would address in detail (Boucher, 2014).

Prolonged Exposure Therapy (PE)

Prolonged exposure therapy (PE) is one of the most common interventions used at the VHA for female veterans with PTSD (see Boucher, 2014). Prolonged exposure therapy is the most effective therapy in that the patient is exposed consistently to an activity, situation, or objects that remind them of the trauma that they experienced. The patient does not avoid the symptoms cluster of PTSD (Boucher, 2014). Prolonged exposure therapy consists of psychoeducation, imaginal retelling of the traumatic event, and in vivo exposure exercise treatment for PTSD (C'de Baca, Castillo, DeBeer & Qualls, 2020). The strength of prolonged exposure therapy and cognitive-behavioral therapy identified has been a direct treatment that works on reducing PTSD symptoms overall as they are the top two therapies used by the VHA for female veterans of the Iraq and Afghanistan war (Boucher, 2014; Doran, Shea, & Harpaz-Rotem, 2019). The

weakness of prolonged exposure therapy and cognitive-behavioral therapy was that the patient sessions were too short and structured in nature (Doran et al., 2019). There was a lack of flexibility and inadequate time to work with the patients to achieve resolution in those sessions (Doran et al., 2019). Another weakness of prolonged exposure therapy is the patient's readiness for trauma-focused psychotherapy (Ruzek et al., 2017). Another weakness of prolonged exposure therapy and cognitive-behavioral therapy is that it fits and works well for some veterans but not for all veterans in general in which that is the general consensus (Doran et al., 2019).

Cognitive Behavioral Therapy (CBT)

In cognitive-behavioral therapy, veterans take their negative memories and dysfunctional thoughts and thoughts of the trauma and translate those thoughts into realistic thinking (Boucher, 2014). Cognitive-behavioral therapy is a self-report therapy were veterans report their thoughts and behaviors to the therapist in a structured counseling session (McTighe, 2017). At the end of the session, patients' take-home assignments that were co-created with their therapist (McTighe, 2017). What was interesting about cognitive-behavioral therapy is that 61-82.4 % of patients lose their PTSD diagnosis (Watkins, Sprang, & Rothbaum, 2018).

Eye Movement Desensitization and Reprocessing Therapy (EMDR)

The Veteran Health Administration utilizes eye movement desensitization and reprocessing therapy, an evidence-based therapy of eight phases of psychotherapy (Boucher, 2014). Eye movement desensitization and reprocessing therapy works differently from prolonged exposure therapy by stimulating the brain through eye

movement as it tries to reprocess the veteran trauma by labeling it into a new memory (McTighe, 2017).

The strength of eye movement desensitization and reprocessing therapy is that it reduces symptoms of post-traumatic stress disorder. It also requires fewer treatment sessions resulting in the same outcome, which results in fewer program dropouts (Doran et al., 2019; McGuire et al., 2019). EMDR is more efficient and better tolerated and does not require homework like the exposure-based treatment models (McGuire et al., 2019). EMDR therapy's weakness is determining the treatment's efficiency based on the number of sessions it takes to reduce the patient's symptoms for PTSD (McGuire et al., 2019). Another weakness of EMDR is that it requires the patient to open up emotionally about their memories necessary for this therapy to be successful (Minnen, Voorendonk, Rozendaal, & Jongh, 2020).

Although the Department of Veterans Affairs has utilized the conventional treatment methods of prolonged exposure therapy, cognitive behavioral therapy, and eye movement desensitization and reprocessing therapy for PTSD, they are now seeing promising results with resiliency-based therapeutic intervention (McKenzie, Anderson, Maydon, & Shivakumar, 2021). Resilience is an individual’s ability to adapt to adversity, trauma, threat, or stress when faced (McKenzie et al., 2021). In McKenzie et al., (2021) study revealed that resiliency therapeutic intervention showed promising results toward female veterans in a pilot study treatment for maintenance for PTSD while social connection to other female veterans who have experienced the same trauma.

Summary and Conclusion

Posttraumatic stress disorder has been studied for more than 30 years among veterans. Since the conflict in Iraq and Afghanistan, it has become a public health concern (see Reisman, 2016; Xue et al., 2015). Since the United States has become involved in wars from the War of Independence to the current wars in Iraq and Afghanistan, Operation Enduring Freedom (OEF)/ Operation Iraqi Freedom (OIF)/Operation New Dawn (OND), women have engaged in every major conflict to date without being recognized until 1977. As women have become more active in Iraq and Afghanistan, their potential risk for PTSD related to combat exposure increases significantly (Kintzle, Barr, Corlette, & Castro, 2018; Reisman, 2016). Female veterans of OEF/OIF return home from deployment; noted that 21 % of the 96 women surveyed screened positive for PTSD (Afari et al., 2016). Of those female veterans seeking care for combat-related PTSD at the Veterans Health Administration, many started care but later discontinue their care because of their perception of being unwelcome by the VHA provider (Kehle-Forbes et al., 2017).

In this literature review, I discussed the female veterans' perception of the healthcare they sought through the Veterans Health Administration system. I also discussed females' roles in the current military conflicts. Then I talked about the influences of PTSD, personal and social challenges, and treatment intervention programs that pertain to PTSD. This generic qualitative approach captured the overall perception of female veterans' experience regarding care when it comes to combat exposure and PTSD (Kahlke, 2014). In Chapter 3, I discussed in depth the research methodology.

Chapter 3: Research Method

The purpose of this generic qualitative study was to identify the beliefs, attitudes, and perceptions of female veterans regarding the utilization of the healthcare system at the VHA when seeking treatment for combat exposure (Kennedy, 2016). This chapter included the research design and rationale, the role of the researcher, methodology, ethical considerations and trustworthiness issues. This chapter concludes with a summary of the main points discussed in this section.

Research Design and Rationale

The Research Question guiding this study was:

What are the perceptions of female veterans who have experienced combat exposure, regarding the utilization of the veterans' health administration (VHA) for mental health services?

Danan et al. (2017) found that 38% of female veterans of the Iraq and Afghanistan era who have access to and utilize mental health services still face barriers when seeking care (Danan et al., 2017). While determining the appropriate research design for this study to answer the research question, I recognized four viable qualitative strategies that I could use. A grounded theory approach allowed the researcher to focus on a single phenomenon using a systematic method of coding and categorizing data with the flexibility of uncovering the phenomena that are grounded in data based on the theory (Tie et al., 2019; Williams & Moser, 2019). Although grounded theory may seem like it was similar to generic qualitative approach, it was different because of the structured procedures in which a researcher looks at the data to either expand the theory or develop

a new theory that would support the phenomena of the study. In a society where researchers look at real world issues, case study research was unique in that it can be applied in multiple areas of study such as education, social science, and psychology when those issues affect human behavior (Harrison et al., 2017). The difference with case study was that it pertains to a specific timeframe that an event had occur as the boundaries were not clear between the phenomena and context, therefore multiple sources of data must be used as evidence. In understanding a case study approach, I the relied on my ability to self-learn the complexity of the participant behavioral pattern when dealing with a specific event or situation using multiple data sources (see Harrison et al., 2017). In phenomenological research, I explored the experiences from the participants' perspective that answered *what* and *how* they experienced the phenomenon (Neubauer et al., 2019). The phenomenological approach was unique in that it allowed me to understand the participants perceptions as they are not bounded by a specific time when doing a study. In using ethnographic research, I sought to understand a specific group or culture through multiple methods of triangulation (Hamilton & Finley, 2020). Last, the generic qualitative method gave me the ability to interpret the participants' attitudes, beliefs, subjective opinions, and reflections of their experience of the phenomenon (Percy et al., 2015). For this study, I chose to utilize the generic descriptive qualitative approach because it allowed me to interpret the participants' experiences through their interpretation (Kahlke, 2014).

Role of the Researcher

There are multiple roles within a qualitative study that a researcher must take on. The primary function of a researcher was to be the instrument of the study in which they gather the data (i.e., take notes, talk to participants, and conduct interviews), analyze the data and interpret the results. Another role of the researcher was to build trust between the researcher and the participants, so they were comfortable enough that they would speak freely and openly during the interview to ensure accuracy and reliability of the information that was collected (Sutton & Austin, 2015). The other function of the researcher was to ensure that the data collected was safeguarded during the data collection process (Sutton &Austin, 2015). Another role of the researcher was to ensure that biases were not introduced into the study by the researchers' beliefs and personal interest to ensure the study's validity and reliability (Birt et al., 2016). While I self-reflected for this study, my connection to the potential participants began with learning the traditions of military culture in basic training by drill sergeants as they instilled core values of selfless service, loyalty, honor, duty, personal courage, integrity, and respect which are the military cultural norms that bond individuals in the military together. It was this same military culture that potentially created biases in this study. As a female veteran having served over 20 years on active duty, I recognized that understanding of the military culture may represent bias in terms of military jargon, language, and norms in this study. In studying the female veterans' perception of their mental healthcare, I realized that I may have had some biases due to the fact I served in the Armed Forces although I had never sought care for mental healthcare services through the VHA. After

much self-reflection, to ensure the accuracy, reliability, and trustworthiness of the participant and their data, I utilized member checking to validate the data and identified my biases toward this study by journaling to ensure I captured all thoughts and experiences (Ravitch & Carl, 2016). When characterizing the accuracy of information in this study, understanding the norms of the military culture in terms of language, organization structure, military installation, and respect for those who served in uniform helped in preventing the introduction of biases into the study (Blaisure et al., 2016). The utilization of charts and tables assisted me in verifying the accuracy and reliability of the information collected for a comprehensive comparison of the data collected (see Leung, 2015). In using member checking, I allowed the participants to review their report for accuracy and reproof as well as keeping me from misinterpreting their report that could in essence be researcher bias (see Candela, 2019). Member checking not only gave voice to the participants, but it also allowed me the option to strengthen the study by applying the participants feedback to the study (see Candela, 2019). This study's trustworthiness was established through the utilization of member checking, self-reflection, and journaling about the data collection process such that I attempted to prevent bringing preconceived biases into my research (see Birt et al., 2016).

Methodology

Participant Selection Logic

The target population for this study was female veterans who have separated from the military in the last 20 years. These female veterans must have been deployed in an Austere Operational Environment which was defined as serving in an environment

whether it was on land or on sea that troops adapt to the environment in which a conflict was being fought faster, quicker, and fluid instead of the old Cold War ways of big tents and large Forward Operational Bases (FOB) tactics of fighting in conflicts of Wars. To ensure each participant is eligible for this study, I would qualify each participant based on the recruitment criteria found on the recruitment flyer. The sampling strategy that best suits this study that provided vital and valuable information was criterion and purposive sampling. The utilization of a flyer as a recruitment tool on social media platforms and with local organizations would expand the sample population of the target audience of female veterans. The recruitment of female veterans across all branches of services would be the unpaid advertisement on social media platforms and groups (Facebook and LinkedIn) dedicated to female veteran organizations as well as through local organizations. Upon Walden Institutional Review Board (IRB) approval, number 04-14-22-0596269. I obtained a letter of agreement from the local female veteran organizations to post recruitment flyer for this study on their website. Unlike quantitative research, where the number of participants was calculated using the tool G*Power, participant numbers in qualitative research was determined when saturation has been met in a study (Malterud, Sierma, & Guassora, 2016). In determining the sampling size for this qualitative study, I relied on previous researchers who have determined that 8-10 participants should be considered for data collection (Moser & Korstjens, 2018). Although previous literature suggests 8-10 participants for a study, it truly is not a reliable study until saturation has been achieved. Saturation was reached once no more vital or redundant information was obtained by me (see Moser & Korstjens, 2018).

Instrumentation

In understanding the participant's interpretations in the real world and their experiences I utilized the generic qualitative approach (Kahlke, 2014). In this qualitative study, I utilized an interview protocol, interview guide, and interviews to gain insight into the participant's perspectives and experiences related to the research topic.

Procedures for Recruitment, Participation, and Data Collection

For this research study I focused on female veterans' perceptions of their health care utilization of the Veterans Health Administration. The recruitment of participants consisted of utilizing social media and recruitment flyers. I would recruit female veterans of all branches of the Armed Forces (Army, Air Force, Navy, Marines, and Coast Guard) that have served at least one day in uniform which technically by the Armed Forces standards makes them a veteran. In using social media sites such as Facebook and LinkedIn, I placed the recruitment flyer in groups geared toward female veteran organizations in order to reach maximum target population. The recruitment flyer provided the invitation to join this research study by contacting the researcher through email. The recruitment process continued until I reach the number of participants needed for this study. In order to reach the 8 to 10 participants needed for this study, I sent each participate a short demographic survey for qualification. I email the electronic Informed Consent to those participants to "I consent" and return and then I set up the initial interviews for the research study.

Interview Protocol

The strategy I chose to use in preparation of the participant's interview was the interview protocol refinement framework (IPR). To ensure I was able to gain the valuable information during the interview phrase, I had craft intellectual interview questions that line up with the research question using IPR. To obtain detail responses from participants, the used the four steps of IPR when developing a plan of action of gathering the information in a natural conversation with participants who would speak freely about their experiences (Castillo-Montoya, 2016).

- Aligning interview questions to the research questions
- Ensuring the conversation was truthfully
- Receiving feedback
- Execution of interview protocol

To ensure I understand the participants feedback concerning the interview questions and my intent, the utilization of IPR would enhance the reliability and trustworthiness during the data collection process (Castillo-Montoya, 2016).

Interview Guide

The purpose of the interview guide was to ensure that I asked specific things as they pertain to the topic of study regarding the research study. As a novice researcher, the utilization of the interview guide allowed me to organize and identify key topics that I want to ask from the participants during the data collection phase. The interview guide help me to brainstorm on knowing how and when to ask questions, how to probe for

information, and cross check the information for accuracy during the interview (Taylor, Bogdan, & DeVault, 2016).

Interview

For this study, I concentrated on gathering the participant experiences through open-ended semi-structured interview questions pertaining to their perspectives on the healthcare service provided at the VHA but not utilized. According to Daykin et al., (2018), "an in-depth interview on a semi-structured schedule gives interviewees time to expand on their responses and raise other important issues from their perspective and experience" (p.3). The utilization of the interview protocol allowed me the flexibility to be more effective in gaining valuable information from participants in the various setting during the data collection phase (Hitchings & Latham, 2020). Due to the recent health conditions in the world regarding COVID-19, I conducted all in-depth interviews through video conference using Zoom or Skype Apps upon Walden Institutional Review Board (IRB) approval. To gain the most valuable information from participants, I conducted a semi-structured interviews utilizing open-ended questions. In an attempt to prevent receiving redundant information, I conducted a 45-60- minute interview with 8-10 participants to explore the female veterans' perspective on the utilization of healthcare services at the VHA (Adams, 2015). For confidentiality, each participant was assigned a pseudonym for the duration of this study.

Video Recording

With written permission from the participants, I audio record and videotape each interview. This ensured that I was able to capture the participants every word. In utilizing

these platforms to conduct the interviews, I also understood that I had to safeguard the participants identity and confidentiality to ensure that there were no ethical issues with regard to the validity of my study. Therefore, by videotaping the interviews I was able to give mine full attention to the participant so that I could capture their verbal and non-verbal expressions that would warrant me into asking further questions to the original question.

Informed Consent

All participants who voluntary for this research study had a right to understand the risks and benefits of participating in a video conference interviews which was explained in the electronic Informed Consent form. The Informed Consent being utilized in this study consists of the following elements to ensure that the participants understood what they are undertaking by participating in this study. I ensured that I begin with a statement regarding the purpose of the study and provide the participants an opportunity to make a clear concise, and conscious decision about participation in the study. The second element of the Informed Consent was a summary of the research which provided an understanding of the purpose, the expected duration the interviews, and member checking protocol, in order to ensure the accuracy of the information for this study. The third element of the informed consent was to ensure that the participants understood any risk that may be involved in participating in my study. Although there were no physical risk, some participants may experience some discomfort or anxiety due to the nature of the conversation. Therefore, a counseling resources referral list was available to all participants upon request. A participant had the right to withdraw from this study at any

time without fear of retaliation or penalties. The fourth element of the informed consent was to discuss the benefits of participating in my research study, such as how their knowledge and experience may contribute to social change and studies in the future. The final element of the informed consent was to ensure that the participants understood that they consented to be video record and that they may withdraw from this research study at any time for any reason. To ensure the interviews' reliability and accuracy, I video record and took notes of all responses during the interviews (Adams, 2015). As a way of thanking the participants, a $15 e-gift certificate was given after the completion of each interview.

Transcription of Interview

In transcribing the interview, I was able to capture the participants every thought, whether it is verbal or non-verbal expression, no matter how intelligible the transcript is read back once it is transcribed (Sutton & Austin, 2015). In transcribing, it is importance to know that every verbal and non-verbal gesture made by the interviewee is significant and must not be overlooked during the interview. Upon completion of each interview, I transcribed the data to identify any similarities and differences that may exist between the interviewee's experiences.

I chose thematic analysis for this generic qualitative study as it is an analytic approach that allowed me to identify patterns of interest in the data collected from the participants interviews (Lester, Cho, & Lochmiller, 2020). Once interviews were transcribed, I began the coding process to find patterns and themes (Lester et al., 2020). The coding process sets the foundation of the analysis as it described as a word or phrase

that relates to the study's interest based on the participant experience and reflection. Using the thematic analysis allowed me to present the different themes recognized from the data that I collected in an organized fashion based on the evidence collected from the participants interviews. By going further in depth with the inductive thematic analysis gave me the flexibility to analyze the data by following six phases: phase 1) familiarizing yourself with the data; phase 2) generate initial codes; phase 3) search for themes; phase 4) review themes; phase 5) define and name themes: and phase 6) write the report (Nowell, Norris, White, Moules, 2017). The coding being utilized was causation because it allowed me to focus on the participants beliefs, experiences and effects on the phenomena (Miles, Huberman, & Saldaña, 2020). I utilized ATLAS.ti Scientific Software in the data analysis that was developed by GmbH in fully complies with GDPR regulations. If I was to understand the phenomena in question, I could not be afraid to draw assumptions from the participants experience (see Sutton & Austin, 2015).

Issues of Trustworthiness

Credibility/Transferability

To establish my study's trustworthiness, I had to establish credibility, dependability, transferability, and confirmability from all assumptions and biases. The respect I gave the participants during the interview process lends credibility to the study in understanding the valuable information from the participant viewpoint (Nowell et al., 2017). For my study to be truthful, my interpretation of the participants' information must be correct so that it was plausible (Korstjens & Moser, 2017b). When I can interpret the participants information correctly then the study's credibility was more truthful and

believable. Conducting member checking was a critical component to ensure credibility of this study as it is the feedback of the participants on their experiences that I had interpreted. Transferability is my ability to be transparent in the telling of the participants experience that make their story unforgettable for the reader (Connelly, 2016). The transferability of rich descriptive detail, such as the data context, gave the reader a vivid picture of accuracy (Amankwaa, 2016).

Dependability/Confirmability

To ensure I was accurate with the findings and conclusions an audit trail with support the interpretation of the data's dependability in this qualitative study (Amankwaa, 2016). During the duration of my study, the perseverance of the data within this study shows the dependability of the findings regardless of the situation or conditions of the study (Connelly, 2016). The confirmability in a qualitative study was the ability that other researchers can confirm the results of my study. The use of audit trail in qualitative research to validity the confirmability of the researcher study by giving detail account for the data collection process, data analysis to the data interpretation from the participants perspective rather than that of the researcher's biases (Connelly, 2016).

Ethical Procedures

As I began this research project, the ethical consideration that I had to face was to do no harm when dealing with human subjects in qualitative research study (Dooly, Moore, & Vallejo, 2017). As stated earlier, the participants risk may be an emotional risk from speaking about their experiences in the military from their deployments. To ensure no harm to the participants, the Informed Consent outlines in details that the participants

can ask questions regarding the research before they began and they can quit the study at any time without any risk of penalty (Barrow, Brannan, & Khandhar, 2020). There are counseling resources available for the participants upon request. When working with human subjects, I obtained approval from Walden Institutional Review Board (IRB) sole purpose is to protect the rights of the participants (Sobacan, Bertotti, & Strom-Gottfried, 2019). Another ethical issue was the privacy and confidentiality of the participants once I obtained the Informed Consent of the participate in this research study (Arifin, 2018). The ethical considerations I had to address with this study when dealing with human subjects were to ensure the participants understood that their participation was freely given with Informed Consent form. The participants were given a brief summary of the study as well as the risks and benefits in order that they could make a conscious decision to participate in this study (Arifin, 2018). Another ethical consideration I addressed was to ensure that I keep the participants names and identities safe and secure throughout the study (Arifin, 2018). Finally, I need to ensure that all data that was collect and disseminate is properly protected in a safe environment that was required when doing research (Arifin, 2018).

Summary and Conclusion

In summarizing the conclusion of Chapter 3, I began by stating the purpose, followed by the research design and rationale to explain the researcher's role. I discussed the methodology I chose as a generic descriptive qualitative approach in finding the female veterans' beliefs, attitudes, and interpretations of their perception of care for PTSD and combat exposure when seeking care at the VHA. I further examined the sampling

strategy through which my recruitment of participants from female veteran organizations is vetted to meet the interview criteria. Finally, I analyzed the data using the thematic analysis to ensure the data collected is reliable, accurate, and trustworthy. Upon defending my proposal successfully, I submitted my IRB application to conduct my research study upon immediate approval was; in Chapter 4, I would discuss the result of this study.

Chapter 4: Results

The research problem addressed in this study was related to women veterans retiring and reintegrating into civilian life and then seeking care for their mental health concerns for combat-related PTSD and combat exposure. Although women were not allowed to fight openly previously, women have fought in every war since the Revolutionary War to the previous wars in Iraq and Afghanistan from 2001-2021. The purpose of this generic qualitative study was to explore the beliefs, attitudes, and the perceptions of combat exposed female veterans concerning accessing the mental healthcare services through the VHA. Through data analysis, I identified emerging themes from the female veterans' lived experience that helped answer the research question about perceptions of female veterans who have experienced combat exposure regarding the utilization of the veterans' health administration for combat-related PTSD mental health services. Chapter 4 describes in detail the research setting, the demographics, the data collection process and the analysis process, the evidence of trustworthiness, the results of the data from this study, and concludes with a chapter summary.

Setting

The primary setting for each interview was my private home office, where I recorded and transcribed each interview verbatim from April 22, 2022, to June 3, 2022. Each participant gave a specific date and time they wished to conduct the interviews using video conferencing tool Zoom in a location of their choosing for their privacy and

confidentiality. Each participant was sent a Zoom invite with a specific link that consisted of a member number and a passcode to connect to their in-depth interviews.

Demographics

There were 14 participants who participated in this research study from across the United States. I assigned each participant with an alpha numeric code for the branch of service they served in: (AR-Army, AF-Air Force, NA-Navy, MA-Marines, and CG-Coast Guard) and a three-digit numerical number (001-014) for each military service to correspond with the participants interview that occurred. Table 2 gives a brief synopsis of the participants' demographics and a narrative description. The female veterans ranged from 30-60 years of age and their service to their country encompassed 286 years total. During their time in service, each participant was exposed to a combat environment. Their ranks/grades were as follows: seven were E-5/Sergeant, two were E-6/Staff Sergeant, three were E-7/Sergeant First Class, one was E-9/Command Sergeant Major, and one was O-4/Lieutenant Commander (see Table 1). Of the female veterans interviewed, 13 served on active duty in the United States Army and 1 served in the reserve in the United States Navy. The participants were all educated from one having some college, one having an Associate degree, eight having a bachelor's degree, three having a master's degree, one having a professional degree and one having a doctoral degree. The race/ethnicity among the female veterans were 13 were Black/African American and one was White not-Hispanic. The participants' employment status showed that two were employed, six were unemployed and six were self-employed (see Table 2).

Table 1

Military Ranks

Military Ranks	*n*
E-5/Sergeant	7
E-6/Staff Sergeant	2
E-7/Sergeant First Class	3
E-9/Command Sergeant	1
O-4/Lieutenant Commanc	1

Table 2

Demographic Synopsis of the Participants

Characteristic	*N*	Characteristic	*n*
Age Range		**Rank**	
30-40	1	E4-E6	8
40-50	8	E7-E9	4
50-60	5	O1-O9	1
Ethnicity		**Years Served**	
African	13	10-20 Years	7
American	1	20-30 Years	7
Caucasian			
Branch of Service		**Component**	
Army	13	Active Duty	13
Navy	1	Reserve	1
Education		**Employment Status**	
Some College	1	Employed	2
Associate	1	Self-	6
Bachelor's	8	employed	6
Master's	3	Unemployed	
Professional	1		
Doctoral	1		
Combat Exposure			
Yes	14		

Note. One participant had dual degree (Master and Professional)

Data Collection

Recruitment

The recruiting of participants came through a variety of resources. Once I had Walden's Institutional Review Board (IRB) approval, I placed my recruitment flyer on various outlets such as the Walden participant pool portal, social media platform sites Facebook and LinkedIn, and a female veteran organization website. Permission was sought and granted to post the flyer on the local female veterans' organizations website. In addition, I sent my recruitment flyer to family and friends to generate prospective interest in this study. In a recent study by Gelinas et al. (2017), the authors concluded the utilization of social media is reaching a wider segment of potential participants for future research studies. With all the exposure, I was able to recruit 14 participants interest in this study.

Protection of Participant/Data

Before each of the 14 participants agreed to this study, I sent them the Informed Consent. I asked each participant to read the Informed Consent thoroughly and ask any questions before making their decision to participate. If they chose to participate, once I received their written consent by email, I scheduled their in-depth interviews. Upon receiving their "I consent" which constituted as their Informed Consent, each email was given the same unique identifier that corresponded to each of the participants interviews, held in its own protective folder. All electronic documents are stored on a secure password computer owned by me. All printed data will be locked and maintained and destroyed in accordance with Walden University policies. The in-depth interviews were

scheduled on the availability of the participants for taking time out of their schedule. The only unusual circumstance that I did encounter was I had two participants agree to the study but did not schedule an interview. Additionally, I had two participants conduct the study but not validate the interview through member checking and I assumed that the lack of response was agreement with the accuracy of the transcript.

Conduction of Interview

For the generic qualitative research, I used an in-depth semi-structure interview for the 14 participants that scheduled the interviews. The in-depth semi-structured interviews were completed by using the video conference platform Zoom and lasted between 30 to 45 minutes. Upon completion of the initial interview utilizing the interview guide I refined the interview questions to be more relevant to the research question. At the beginning of each interview, I informed the participants that they were being recorded and that I would like to get to know them better before our conversation by asking some demographic questions to build rapport and to make each participant feel more comfortable. At the end of our conversation, I would thank them for participating in this study and serving our country and ask if they had any final thoughts or words, they would like me to know on this important subject. Then the oral narrative data from the Zoom conference platform was transcribed into written text utilizing Microsoft Word online transcribe program. Then I validate the accuracy of the written text by listen to the audio transcription and made the necessary correction. Then I did a 10–15-minute follow-up with each participant for member checking of the transcribed written text transcription of their interview to check for accuracy to ensure that it reflected the participants'

perceptions and not the researcher's. Although previously stated, I believed I had reached saturation after 10 interviews, I conducted an additional four interviews to ensure that saturation had been achieved and no new information was obtained by the additional interviews. Each participant was given a $15 e-gift certificate as a thank you for their participation.

Data Analysis

Coding Strategy

The data analysis began with copying the audio file to the transcript verbatim of the 14 interviews from the participants. Step 2 of the data analysis is where I organized the data from the 14 participants. In Step 3 of the strategic plan, I became familiarize with the data. Step 4 of the plan is where I manually coded each of the 14 transcripts using a two-column table in Microsoft 365 Word during the first cycling coding known as the *in vivo coding* (Saldaña, 2015). In vivo coding was utilizing the participants owns words or phrase as codes according to Saldaña, (2015). During that step, I had three pre-codes in mind of perceptions, attitudes, and beliefs that would be used to start the codebook. Step 6, during the second cycling coding known as *Axial coding*, the I reanalyzed and reorganized the data, looking for patterns that emerged from the coding in the first cycling coding that were redefined, color coded, and clustered together to form the categories (Williams &Moser, 2019). Step 7 of the strategic plan was the final coding to form the themes from the categories that emerged from the second cycling coding that brought meaning and identity to the story. Upon the completion of the manual coding, I imported the 14 copied verbatim interviews into ATLAS.ti 22 qualitative software and

coded them again utilizing the same coding strategic plan and initial codes to verify my findings.

Coding Process

Using thematic analysis, I had the ability to organize, transcribe, and familiarize myself with the data to start the coding process (Nowell et al., 2017). The coding process began with the first cycle coding known as open coding in ATLAS.ti 22 coding verifying the manual finding that resulted in 224 quotations with 253 codes utilizing *in vivo coding, emotion coding,* and *values coding* which is the "critical link between the data collected and their meaning" (Miles, Huberman, & Saldaña, 2020). During the second cycle coding known as *Axial coding* I searched for patterns in the data to link bit of codes together that female veterans' perceptions to the mental healthcare services provided through the VA. Through the final coding known as *selective coding*, I refined the codes into the higher level of ideas that emerge the data categories. Through that refinement, I coded 17 codes with 64 participants' quotations that merged into 5 categories that gave me my three themes.

Codes

Through data analysis, I familiarized myself with the data in the coding cycle that produced 253 codes that consisted of words and phrases from the participants which once refined led to the 17 codes (see Figure 1) that emerged in this qualitative study. The codes now reflect the conceptual ideas of the study as it relates to female veterans focus on their perception regarding the utilization of healthcare system within the VA system. The 17 descriptive codes listed in Figure 1 mirrored the participants' perceptions,

certainties, and demeanors with respect to the healthcare system in the Veterans' Administration (see Figure 1).

Figure 1

Codes

Codes	
Adversary	Honest
Appointment	Judgmental
Attitude	Longtime
Available	Performance
Communication	Private Care
Difficulty	Respect
Disjointed	Right Care
Embarrassment	
Enhance	
Expert	

Categories

In utilizing the 17 descriptive codes, I began to see patterns emerge that I group together to form the first category as negative responses. Negative responses was defined as something one avoids or withdrawals from any unpleasantness due to a stimulus in one's life. In the first category of negative response, as one participant AR012 stated "the healthcare system at the VA during that time and even current to this day I would classify it as rather difficult," and AR002 stated "I felt that was my first-time accessing healthcare, and it wasn't all that successful". The second category that merged was a systematic weakness. Systematic weakness was defined as problems within an organization that prevent it from being affective and efficient in terms of services provided. The systematic weakness in the VA as female veteran AR001 stated, "I just had

a negative connotation that I always associated with the VA in terms of lack of care, the services were timely," and female veteran AR008 stated "I feel like there's at that point there was no psychiatrist, there was no psychological counselor like it was one or two, which wasn't really available." The third category was the emotional responses. Emotional responses was defined as how one reacts to their environment, are they happy, sad, confused, embarrassed, afraid, shocked, worried, basically how you feel. The emotional response like participant AR010 said," I didn't even want to disclose like I was having issues with my mental health," and one felt like female veteran AR008 "I feel like they judge me, and I feel like I was judge." The emotional response also carried the weight of the respect. Respect was defines as treating people kindly. As female veteran AR005 stated "so that it makes people feel like they are also human, no matter where you are" and participant AR008 said, "like these people are human, treat them like humans." The final section of the third category was honest. Honest was defined as being truthful and genuine. Which female veteran AR007 stated "let it be a fair system." The fourth category avoidance. Avoidance defined as staying clear of something. As female veteran AR002 stated, "at times you'll even feel like you don't want to access the help, they don't go to hospital, just be fine by your own, "or as participant AR001 said "didn't feel right to me the VA service, none of it did and I felt like I just did not want to be a part of that service." The fifth category was the alternative. Alternative was defined as having another choice or option of care. The alternative of private care as female veteran AR011 stated, "that's why I even opted for private health care because even though it's

expensive" and female veteran AR005 stated, "they also had to seek private help elsewhere."

Themes

The five categories discussed in detail emerged into the three themes seen in tables 3 through 5. Theme 1 negative experiences discussed the categories of negative responses and systematic weakness that female veterans face when dealing with the challenges in accessing, locating services, navigating the system, lack of organization in the VA (see Table 3). As one female veteran stated AR001, "it was crowded, it was very hard to find your way around and there weren't a lot of people willing to help you either" or as female veteran AR006 said, "feel like it was quite disorganized at that point."

Table 3

Theme 1-Negative Experiences

Category	Codes
Negative response	Adversary-1 quotation Difficulty-2 quotation Respect-1 quotation Right Care-1 quotation
Systemic weakness	Adversary-1 quotation Available-2 quotation Difficulty-3 quotation Disjointed- 2 quotation Longtime- 1 quotation

The negative experiences that female veterans had led them to the second theme that emerged from the codes that was emotional experiences that female veterans face the challenges when dealing with the VA. Those challenges were under the category of emotional responses, as female veteran AR001 said, "it wasn't beneficial to them, they

actually felt stigma" or as female veteran AR008 stated "it was something that I don't won't like experience ever in my life." That also lead to the respect that one participant stated that they "wish to see we like people treated fairly (AR005)" as did one said that the way "proper way of handling clients (AR006)" should be of upmost importance to the Veterans Administration as female veteran AR007 stated, "because it's not fair" (see Table 4).

Table 4

Theme 2-Emotional Experiences

Category	Codes
Emotional response	Attitudes-1 quotation Embarrassment- 2 quotation Honest- 2 quotation Judgmental-3 quotation Respect- 4 quotation

This led to the final theme of ambivalent attitude toward the VA services that female veterans had which is the category of avoidance the servicing as female veteran AR008 stated "one should not be in that judgmental environment," and that "basically, I felt like someone who live in, tell me this is something you can deal with at home." Which explored the category of these participants having an alternative to VA service, using private or other insurance providers as female veteran AR008 stated, "that's why now later on I had to like to seek private healthcare" and "I had to like connect to a private counselor," stated female veteran AR010. (see Table 5).

Table 5

Theme 3-Ambivalent

Category	Codes
Avoidance	Adversary- 1 quotation Attitude- 2 quotation Judgmental- 1 quotation Right Care- 1 quotation Category
Alternative	Private Care- 6 quotation

Of the data analyzed, there was no major discrepancies among the participants in their lived experiences, some had fair, good and bad experiences which was reflected in their comments during their interviews.

Evidence of Trustworthiness

Credibility

To establish the trustworthiness of this study, I first needed to establish the credibility by giving the respect to the participants for the valuable information that they each gave the researcher during the interviews (Nowell et al., 2017). In utilizing the member check, I ensured the accuracy of that information represented the participants own meaning and perceptions and not that of the researchers' agenda. In conducting the member check on each interview for accuracy of information to ensure that it was plausible so that it was more truthful and believable (Korstjens & Moser, 2018). The utilization of triangulation to establish credibility by using manual coding, interview transcripts, and ATLAS.ti 22 coding resulted in the generated codes, categories and themes from the participants' perception and not the researchers' biases of the data.

Transferability

I achieved transferability in this study by recruiting a small group of female veterans from the military branch of services that had been exposed to a combat environment. Their lived experiences had the rich descriptive detail they had described in their interviews gave an accurate picture of their perception regarding the utilization of the Veterans healthcare system (Korstjens & Moser, 2018). I utilized the participants' own words and phrases to give voice to those who do not have a voice.

Dependability

To ensure the dependability of this study, I used the interview guide to preserve the process and organization of the data to ensure the accuracy of the information gained from the participants. The utilization of the audit trail with the researchers' journaling notes described the data collection process journey from the beginning to the end of the research study achieved dependability. To achieve dependability, there had to be consistency throughout the data collection, data analysis, results, and the whole qualitative research process (see Kyngäs, Kääriäinen, & Elo, 2020). Finally, regardless of the situation, the findings of the data within the study show the dependability of this study.

Confirmability

Before this research study commenced, I used the interview protocol to provide details of the activities related to confirmability of this research study. The use of the researchers' journaling notes gave detail accounts on the data collection process, analysis and interpretation as well as the express thoughts and ideas that related to the research

study (Korstjens & Moser, 2018). Confirmability was achieved using with triangulation using journal notes, transcribed interviews, manual coding, and ATLAS.ti 22 software coding that shaped the research study from the participants' viewpoint without the researchers' bias or interest (Kyngäs et al., 2020).

Results

This study explored the female veterans' perception of the utilization of healthcare system within the Veterans Administration for those who sought care for combat-related PTSD and combat exposure. During the analysis, I identified frequent words that were utilized by the participants in this study that described their experience, what they felt, and what they saw when dealing with the Veterans Healthcare system (see Figure 2).

Figure *2*

Words Frequently Used by Participants

The analysis of the data resulted in the three themes of negative experiences, emotional experiences, and ambivalent attitude that female veterans perceived which led to the final overall summary of the theme as overall dissatisfied. Of the 14 female veterans 8 were dissatisfied. The satisfaction level affects female veterans' utilization of care at the VA varied as female veteran AR011 stated, "I'm not very satisfied" and female veteran AR002 said "I'm not so much satisfied with it, not very satisfied" or "it's probably at 50%, it's definitely not at a 75%" from female veteran AR012. Although the overall satisfaction level was dissatisfied, there was one female veteran NA001 who stated, "then there was nothing I could do, so I had no opinion about satisfaction or not." The participants in this study indicator, that there was a decisive lack of care within the VA system of health for women. The areas of partially interest where: communication, appointment, treatment plan, availability, and resources. Although 4 of the female

veterans stated they were satisfied, all the participants' felt there was still room for improvement as female veteran AR003 said, "honestly, for me I'm at 80%. I feel like there's a 20% improvement needed, so I'm at 80%." And one participant did not answer. The study also showed that 13 participants did not utilize the VA and 1 participant did utilize the VA. This study also revealed as an outlier that several female veterans had a positive experience with the professional that attended them as female veteran AR003 said "I think I found it very professional, the person that I was attending to me, the Doctor was very friendly, very warm," as female veteran AR007 revealed "they were amazing actually because there was a very friendly doctor," and female veteran AR001 found "they were professional. I believe that they were certainly qualified." Although this study revealed a positive experience, the overall dissatisfaction that the female veterans perceived came some recommendation for improvements for the Veterans Administration to consider implementing in the future.

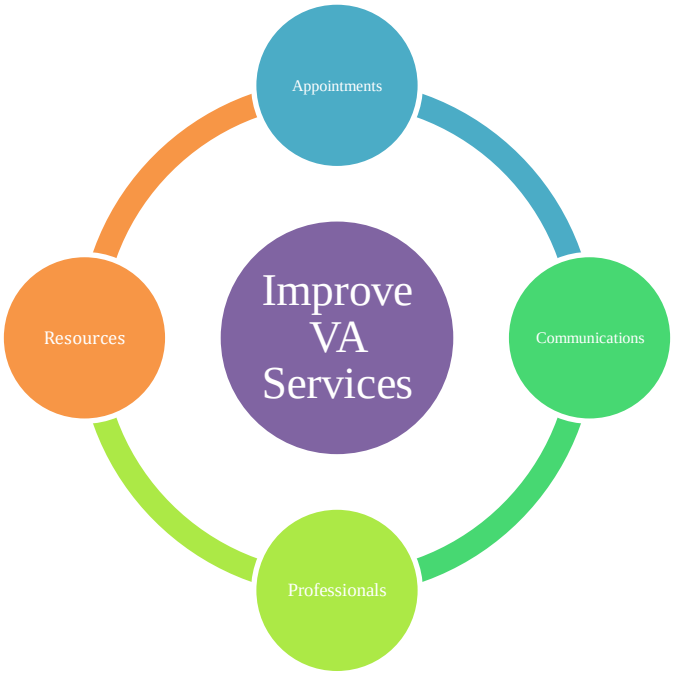
Recommendations

Based on the recommendation of the study participants on how to improve the VA that would help streamline the effective processes of enhancing the scheduling and communication for their female veterans' healthcare overall. The female veteran's recommended improvement in four areas they felt that would help streamline the whole processes in the VA began with appointments. As female veteran AR013 said, "don't overbook appointments for certain professionals" and had "better scheduling" as having "more appointments" stated female veteran AR007 would be more effective. As appointment were the first stage of getting care. The second area of concerned was the

lack of communication. Communication was vital when dealing with people as female veteran AR006 put it “at least communication should be good,” or they should learn how to “communicate better” as female veteran AR006 stated when an error occurs with scheduling or cancellation of appointments and “they should at least communicate that to you in a proper communication is not yet done to you” as female veteran AR011 stated to give patients the courtesy due them from the patient rights one receive when they go to the doctor’s office. Another recommendation was for personnel or specialist as female veteran AR010 said, “more advocacy and being people coming out to like talk about mental well-being” and with them seeing “all want to see their specialist being available,” said female veteran AR005 then “having adequate number of staff and personnel” stated female veteran AR009 would help with the availability of female veterans being seen when they need it. This recommendation was vital in that without the right personnel in place, then female veterans could not receive the right care. The final recommendation was to have more resources as female veteran AR008 said, “a lot of services are needed for female veterans” as well as “mental well-being should be something that is to be addressed fully like don’t overlook,” another female veteran AR010 stated that “mental well-being resources are also made available” and female veteran AR005 said “make it more accessible” since mental health issues are now in the fore front in bring awareness of the impact it has on lives and female veterans are not excluded as well as other veterans (See Figure 3).

Figure 3

Recommendations



Summary and Conclusion

In summarizing the conclusion of Chapter 4, I began by stating the purpose of this qualitative study and the driving force of the research question what are the perceptions of female veterans who have experienced combat exposure regarding the utilization of the Veterans Health Administration for combat-related PTSD mental health services. Then I discussed the setting in which the study took place as well as the demographics of the participants that led to the data collection process. Following the data collection process, I analyzed the data for evidence of trustworthiness of the study to the results from the raw data collected and interpreted that will be discussed in Chapter 5 of the findings of this study.

Chapter 5: Findings

Health issues have become a major concern in our society today and military veterans have not been exempted from the health consequences that manifest from traumatic events in their lives (Waitzkin et al., 2018). The purpose of this study was to explore the female veterans' perceptions, beliefs, and attitudes regarding their utilization of the VHA. The goal of this generic qualitative study was to understand the lived experiences of female veterans and their perceptions of their utilization of the mental healthcare system at VHA when seeking care for combat-related PTSD and combat exposure. In the previous chapter, some key findings from the female veterans illustrated negative experiences that consisted of their receiving negative responses which showed systematic weakness with the VA. The female veterans spoke of dealing with emotional challenges they faced with the VA, which ultimately led to their ambivalent attitudes toward the VA system and an overall dissatisfaction with the healthcare system. Although, most of the female veterans were dissatisfied with using the VA, there was an outlier of a positive experiences within the VA, but they also did see room for improvement that was discussed in Chapter 4. In Chapter 5, I will discuss the interpretation of the findings of the themes as well as the limitations of this study, the recommendations, implications, and the conclusions to this study.

Interpretation of the Findings

Theme 1-Negative Experiences

In the study findings, I revealed the emerging theme of negative experiences of female veterans when seeking care for mental health at the VA. Negative experiences, as

I defined it, is a hindrance or failing in an event or situation that occurs in one's life that is the result of denial of failure to accept what the experience is either physical, visible, or emotional trying to show the individual. Negativity is a residual by-product of an occurrence or experience not favorably received by the individual. The negative experiences that female veterans in this study revealed were the inability to received proper health care services within a timely manner. As one participant, AR009, said, "it was a bit hard in our way to like get these services". Consistent with previous literature conducted by Meffert et al. (2019), this study confirmed that female veterans faced challenges as they sought care for mental health issues, including being able to gain access to VA, locating services, navigating the system, and experiencing a lack of organization within the VA. In that study conducted by Meffert et al. (2019), they found several reasons why veterans did not utilize the VA including difficulty navigating services, lack of sensitivity to health issues, and excessive waiting times. The difference with my study was that I focused on the female veterans' perception of the mental health care services where the study conducted by Meffert et al. (2019) focused on the veterans' perception. The participants also mentioned how difficult it was to get assistance with specialty appointments due to a shortage of staff and the disorganization of the VA with regards to the health care services that female veterans were seeking from combat exposure as it relates to PTSD. Some participants revealed that they felt unwelcomed and that there was a lack of care being given to them. Female veterans do not only have to put up with the negative experiences but also the emotional ones of some questioning their rights to use the VA for care and their identity as veterans (Klap et al., 2019). Although

my study confirmed what has been found in previous literature, it does extend knowledge in areas of systematic weakness within the VA healthcare system. The systematic weakness of the VA in terms of disorganization, services not being timely, and cyber navigation difficulties of services within the VHA system were not effective and efficient when providing services to female veterans who sought care for combat exposure and combat-related PTSD.

Theme 2- Emotional Experiences

When speaking of emotional experiences, I defined emotional experiences as experiences that bring about a reaction from the individual based on the individuals' feelings regarding the circumstance of the event or situation at the time in their lives (see Figure 4). The participants in this study revealed how hectic, chaotic, uncaring, unconcerned, and frustrated it was when dealing with the VA when they sought care for their mental health care services. This confirmed the emotional experiences that female veterans perceived when they sought specialty care at the VA, they felt they were ignored, discounted, and dismissed as they were being labeled as "hysterical female" by providers as it related to their experiences with mental health concerns that arise from combat exposure (Mattocks et al., 2020). The findings from the study revealed the emerging second theme of emotional experiences that female veterans faced when they sought care for mental health in the VA that is a male-dominated environment (Strong et al., 2018). The emotional experiences of participants when dealing with the VA as they sought care ranged from expressed embarrassment, shame, feeling they were being judged or stigmatized because they were asking for assistance with a mental health issue.

Kotzias et al., (2019), revealed that veterans did not engage in mental health services for fear of being labeled or stigmatized. Throughout a soldiers' military career, it is verbalized that asking for help is a sign of weakness for mental health care issues in the past as military culture represent strength, discipline, and mental toughness as a fear of stigmatism that is associated with the perception of military culture (McCormick et al., 2019).

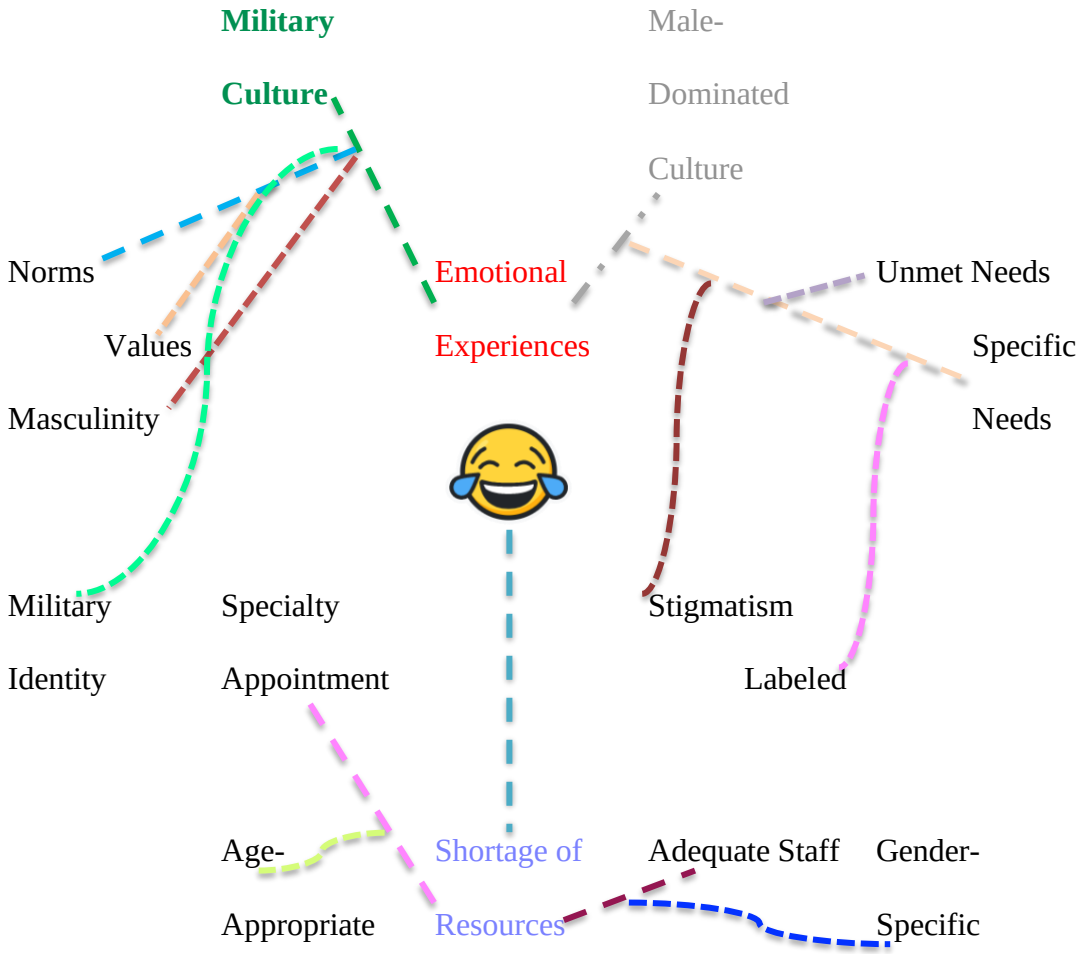
As a veteran who served her country for over 20 years, the military culture plays a vital role in a soldier's life from the day they join the United States military. The military culture is a structured multidimensional norm that unites individuals around values of strength, resilience, courage, and personal sacrifice that identify them as a "warrior culture" (Neilson, Singh, Harper, & Teng, 2020). That warrior culture in the military culture has been exposed to the traditional masculinity ideology which separates it from the civilian culture (Neilson et al., 2020).

Upon retiring from military service, female veterans transition into the civilian workforce with a guided structure of values that were instilled in them from military culture. As female veterans sought care for their mental healthcare needs at the VA, they had to navigate into a world that was predominately a male environment that was constructed from a hypermasculine military culture (Strong et al., 2018). That traditional masculinity was one of toughness, antifeminism, show no emotions, and power to succeed at any cost, in a recent study has revealed a negative health outcome on veterans' who sought care for mental health care issues (Ramon et al., 2019).

This study revealed a shortage of resources to meet the need of female veterans who sought mental health care needs within the Veteran health care system. As women and female veterans are becoming the fastest population that has served in the U.S. military, it is critical that their healthcare and mental health care needs are being met (Koblinsky et al., 2017; Williams et al., 2018). The female veterans revealed that the resources afforded them was lacking in the areas of appointments, communications, professionals, and resources. Although the Veterans Administration has established a women health center within the VA, the female veterans felt more improvements where needed to meet their needs when dealing with mental health issues. In a study conducted in 2019, Brunner et al revealed that the VHA established policies for women's care to acknowledge the disparities of care that female veterans received. The female veterans in this study advocated that more resources for mental well-being needs to be available and accessible. This study reveal that resources should be accessible to address female veterans' specific needs as far as counselors, available appointments, and adequate staff and personnel to assistance female veterans with their healthcare needs these includes gender specific and age-appropriate accommodations. This confirms with previous literature that female veterans' healthcare needs should been tailored to them and their needs (Strong et al., 2018).

Figure 4

Conceptual Model of Emotional Experiences



Theme 3- Ambivalent

The ambivalence feeling that female veterans had shown once they reintegrate into civilian life as they sought care for mental health care concerns has been identified as being associated with losing their military identity which was developed in military culture (see Markowitz, Kintzle, & Castro, 2022). As revealed in this study, as female veteran AR001 stated, “it wasn’t a managed care team type of concept. It wasn’t like I

had a team of people coming from the active-duty side where I had a team of providers." The study revealed that it wasn't that cohesive feeling that female veterans got from the military culture while they served on active duty. In conducting this study, the final theme that emerged was that participants had an ambivalent attitude toward the VA services. These ambivalent attitudes stem from the participants' perception that they were not receiving the best health care services when they were seeking care for mental health care services from combat exposure related to PTSD. This study confirmed the previous literature review of the study conducted by Kehle et al., 2017, that women felt unwelcome, VHA providers were unskilled at treating women, and relatively insensitive to female veterans' concerns. This study revealed that female veterans seek alternative health care to the VA services through private doctors and counselors. This confirmed previous research study that veterans have options to various healthcare facilities other than seeking services at VA facilities (Adams et al., 2017). The participant in this study revealed that they were not given the right care, being overlooked, and not being listen to by the provider. It was also confirmed that female veterans felt they were being disrespected as if they were being rushed through their appointments and not getting the care they needed through the VA (Kotzias et al., 2019).

Summary of the Findings

As previous literature had stated, regardless of the link between combat exposure and PTSD, 73% of female veterans serving in Iraq and Afghanistan were affected by combat exposure and showed lower utilization in the Veterans Health Administration (VHA) healthcare system (Buttner et al., 2017). The finding from this study conducted,

59% of the female veterans showed dissatisfaction with the utilization of the Veterans Health Administration (VHA) healthcare system as one female veteran AR001 stated, "didn't feel right to me the VA service. None of it did and I felt like I just didn't want to be a part of that service." This confirms that the female veterans' that participated in this study found the services in the Veterans Administration to be difficulty, unfriendly and challenging to where that preferred to find their healthcare services through an alternative private healthcare provider confirmed the skepticism that was found in a study conducted by Kehle-Fobes et al., 2017. The literature discussed findings that were linked with female veterans at risk of developing PTSD, as one study discussed age as having mix result since the finding of this study found that the participants ranged 30-60 years in age, could not confirm or disconfirm that finding. Another finding tied to combat-related PTSD was the number of deployments that female veterans had experienced, the participants in this study all experienced a combat environment were female veteran NA001 stated, "I didn't realize that I was affected by the war." The literature review revealed personal and social challenges that female veterans face when seeking care for PTSD. The personal challenge of having a higher rate of unemployment was found in the literature review, in this study I found that the employment status was a mix as 2 were employed, 6 were self-employed and 6 were unemployed. The circumstance of the unemployed were varied from taking care of children to attending school, so the participants chose their status as female veteran NA001 said, "I resigned that because I want to focus on my PhD." So, this study could not confirm that unemployment was a significant representation as previous literature had revealed. Finally, the literature

discussed the treatment intervention plans that were provided for those seeking care, but in this study, female veteran AR008 stated, “I didn’t feel like I was comfortable with it, so that’s why now later on I had to like to seek private health care.”

The foundation of this study was the feminist theory as I previously discussed there were four underlying assumptions based on predicting human behavior that I showed that: 1) female veterans lives matter and are worthy of explanation, 2) inequality exist between genders, 3) inequality is not natural but produced and maintained by complex set of social, economic, political, and historical forces over time; and 4) inequalities should not be tolerated (Butler-Mokoro et al., 2018). Although female veterans were not recognized as veterans for a long time, these 14 participants that I interviewed served their country an encompassing 286 years combined and all in a combat exposed environment at some point in their military service. All 14 participants are educated, but when it comes to seeking care, they had difficulty as one study showed that the VA is a historically male-dominate culture, as one female veteran participant AR007 had this to say “I think there needs to be maybe a little bit more care for women” and female veteran AR008 had this to say “a lot of services are needed for the female veterans,” this shows how inequality within services that are provided within the VA from the perceptive of the participants in this study. Although women’s roles have changed in our military, their healthcare service provide through the Veterans Administration still need improvement.

Limitations of this Study

There were several limitations in this study. The self-reporting data collected could not be independently verified once collected since I did not go into the participants' mental health history. The second limitation of this study was that 13 of the female veterans utilized non-VA facilities as their primary healthcare and the VA as a secondary care provider. The third limitation of this study was the effectiveness of recruiting from all branches of the military services for adequate representation of the female veteran population which based on the study being conducted near an army base, the majority of the participants were army (13) and (1) Navy. The fourth limitation of this study was the ethnicity of the majority of the participants were Black/African American (13) and (1) White not-Hispanic which did not represent the diversity within the United States Armed Forces. The final challenge was maintaining control of the researchers' personal bias was accomplished through journaling my experiences, feeling and thoughts and brought any concerns to my chair and then I conducted member checking for accuracy.

Recommendations

The results of this generic qualitative study highlighted that female veterans' perceptions of the utilization of the Veterans Health Administration as low satisfaction. The findings revealed that future research is needed to continue to explore the gap of utilization of VA mental health services on a larger diverse female veteran population utilizing a quantitative methodology. More studies should be explored into the use of non-VA providers versus VA providers for mental health services and well as other health care services. The literature review had revealed that little research has been

achieved on this subject of female veterans' exposure to combat exposure and PTSD. Finally, studies need to look at future research study on the streamlining processes as a whole of the VA as the participants in this study had made recommendation for improvement on their health care systems.

Implications

Positive Social Change

Female veterans face a great number of challenges when they leave the military. The personal challenges were two-fold as some will return home to their families and work while dealing with trying to seek care for combat-related PTSD and combat exposure. Although the participants interviewed had an overall dissatisfied level with the utilization of care, they received at the VHA, they did bring to light that a team management concept of care would make their overall lives better when they are trying to access services for care. The participants saw these as a way to save time, money, and emotional frustrations when they were dealing with the VA if it went to a team management concept as female veteran AR005 stated, "Well, that would be amazing. At least you will not have to go to different people, will not have to struggle. You do not have to spend a lot of time and money going from place to place from one doctor to another if they are all at one place." For the female veterans themselves it would alleviate the emotional stress they affects other areas of their lives, so they can be productive in taking care of their families and themselves that could possibly reduce issues that cause financial hardship that may lead to suicidal behaviors. For the families, if their loved one could get the care and attention need then that could possibly reduce the

consequence of the psychological, social, and emotional difficulties that may face. For the VA to improve it services for female veterans, would not only improve their reputation in the health care services they provide, but it would also be a huge financial savings for the healthcare industry as well as be more efficient and effective in taking care of patients who have served their country.

Theoretical Implications

The theoretical framework for this study was the feminist theory based on the assumption that women should have the same rights as men in a society where inequality still exist. The complexity of the feminist theory of social patterns in describing and predicting human behavior when it comes to the complex sets of social and historical forces over time has significantly affected the female veterans' perceptions of the health care services provided through the Veterans Health Administration (O'Nell, 1969). The Veterans Health Administration has served veterans for more than 100 years since the Civil War. The Veterans Health Administration once known as the Veteran Homes were established to provide direct medical and hospital care to all veterans that were injured, disabled, and who had diseases (VA, 2021b). Although the Veterans Health Administration still provides care for all veterans, one must remember that female veterans were not recognized as military members or veterans until 1948, which means the VA was a male-dominated environment led by men, from 1989 until present day, all of the Secretaries of Department of Veterans Affairs have been males (VA, 2021b). Therefore, the healthcare services were tailored to male veterans, but as time has evolved, female veterans now have access to care in the VHA and the healthcare services needs to

adapt to all veterans no matter their gender. In a recent study conducted by Silvestrini et al., 2020, found that female veterans had to have access to an array of VA and non-VA providers to have the same basic care as male veterans get care from 1 primary care visit.

Practical Implications

There are several practical recommendations that came from this study. As female veterans continuing to be the fastest growing segment that eligible to utilize the Veterans Affairs (VA), female veterans continue to seek care elsewhere (Silvestrini et al., 2020). The 14 female veterans that participated in this study gave insight into some recommendations they felt would improve the VA overall system so that it was more efficient and effective for all those who may utilize it. The participants felt that appointments were being mishandled to point that they were overbooking and not scheduling correctly, so the patients did not have sufficient time with the provider for care that they needed. Another recommendation from the participants was better communications, since is does cost time and money going back and forth to the VA when one does not need to when simple communication could solve that issue. The participants recommended having more advocacies and personnel staff for mental well-being issues. Finally, the participant found that more resources needed to be made available that address mental health issues for female veterans and made them more accessible.

Conclusion

In conclusion, the purpose of this generic qualitative research study was to understand the female veterans' perception of the utilization of Veterans Health Administration (VHA) healthcare services when female veterans sought care for combat-

related PTSD and combat exposure. The data analysis revealed that female veterans' attitudes, beliefs, and perceptions concerning the utilization of the Veterans Health Administration services was a stronger indicator of their overall dissatisfied level of care they received. The data revealed an outlier that female veterans had a positive experience when dealing with the Veterans Health Administration. The theoretical foundation of this study was the conceptual framework of the feminist theory that women should been treated fairly just as men regardless of the social, economic, political, and historical forces when seeking care for mental health problems. This study had a unique opportunity to focus on specifically on female veterans lived experiences when seeking care for mental health care services regarding the utilization of care provided by the Veterans Health Administration. The rich descriptive detail provided by these 14 female veterans during the data collection process not only confirmed previous literature but also extended the literature that recommends further research is needed to understand the gap within the Veterans Health Administration when dealing with female veterans seeking care for combat-related PTSD and combat exposure. The findings from this study provided insight into the world of the female veterans' perception of their lived experiences when dealing with the Veterans Health Administration as they sought care from having negative experiences to emotional experiences that led to their ambivalent attitude which resulted in their overall dissatisfaction of using the VA as a whole for their mental health care services. Therefore, this study recommended changes that would enhance the Veterans Health Administration overall process that would help streamline the services to be more efficient and effective in taking care of female veterans in the

present and future for mental health care services as they relate to combat exposure and PTSD.

References

Adams, R. E., Hu, Y., Figley, C. R., Urosevich, T. G., Hoffman, S. N., Kirchner, H.L., Dugan, R. J., Boscarino, J. J., Withey, C. A., & Boscarino, J. A. (2021). Risk and protective factors associated with mental health among female military veterans: Results from the veterans' health study. *BMC Women's Health, 21*. 55-65. https://doi.org/10.1186/s12905-021-01181-z

Adams, R. E., Urosevich, T. G., Hoffman, S. N., Kirchner, H. L., Hyacinthe, J. C., Figley, C. R., Boscarino, J. J., & Boscarino, J.A. (2017). Social support, help-seeking, and mental health outcomes among veterans in non-VA facilities: Results from the veterans' health study. *Military Behavior Health, 5*(4), 393-405. https://doi.org/10.1080/21635781.2017.1333067

Adams, W. C. (2015). Conducting semi-structured interviews. In K. E. Newcomer., H.P. Hatry & J.S. Wholey (Eds.), *Handbook of practical program evaluation*. (4th ed, pp. 492-505). Jossey-Bass. https://doi.org/10.1002/9781119171386.ch19

Afari, N., Pittman, J., Floto, E., Owen, L., Buttner, M., Hossain, N., Baker, D. G., Lindamer, L., & Lohr, J.B. (2016). Differential impact of combat on post-deployment symptoms in female and male veterans of Iraq and Afghanistan. *Military Medicine, 180*(3), 296-303. https://doi.org/10.7205/MILMED-D-14-00255

Amankwaa, L. (2016). Creating protocols for trustworthiness in qualitative research. *Journal of Cultural Diversity, 23*(3), 121-127. https://pubmed.ncbi.nlm.nih.gov/29694754 /

American Psychological Association. (2021). Post-traumatic stress disorder. https://apa.org/topics/ptsd

Arifin, S. R. M. (2018). Ethical considerations in qualitative study. *International Journal of Care Scholars*, *1*(2), 30-33. https://doi.org/10.31436/ijcs.vli2.28

Arraf, J. (2018). US end major ground combat in Iraq. NPR. http://www.npr.org

Aspers, P., & Corte. U. (2019). What is qualitative in qualitative research. *Qualitative Sociology, 42*. 139-160. https://10.1007/s11133-019-9413-7

Atuel, H. R., & Castro, C. A. (2018). Military cultural competence. *Clinical Social Work Journal, 46.* 74-82. https://doi.org/10.1007/s10615-018-0651-z

Barrow, J. M., Brannan, G. D., & Khandhar, P. B. (2020). Research ethics. *StatPearls.* 1-8. https://www.Ncbi.nihi.gov/books/NBK459281/

Bellafaire, J. (2019). America's military women-the journey continues. https://www.womensmemorial.org/americas-military-women

Berg, P. E., & Rousseau, J. (2018). The effects of combat stress on women in a military academic environment. *Journal of Military Learning*, *2*(1), 29-43. https://www.armyupress.army.mil

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation. *Qualitative Health Research*, *26*(13), 1802-1811. https://doi.org/10.1177/1049732316654870

Blais, R. K., Tirone, V., Orlowska, D., Lofgreen, A., Klassen, B., Held, P., Stevens, N., & Zalta, A. K. (2021). Self-reported PTSD symptoms and social support in U.S. military service members and veterans: A meta-analysis. *European Journal of*

Psychotraumatology, *12*(1), 1-17. https://doi.org/10.1080/20008198.2020.1851078

Blaisure, K.R., Saathoff-Wells, T., Pereira, A., MacDermid-Wadsworth, S., & Dombro, A. L. (2016). *Serving military families: Theories, research, and application*. Routledge.

Boucher, J. (2014). Treatment of women veterans with PTSD. *Undergraduate Review*, *10*. 31-36. https://vc.bridgew.edu/undergrad_rev/vol

Brownlow, J. A., Zitnik, G. A., McLean, C. P., & Gehrman, P. R. (2018). The influence of deployment stress and life stress on post-traumatic stress disorder (PTSD) diagnosis among military personnel. *Journal of Psychiatric Research*, *103*. 26-32. https://doi.org/10.1016/j.psychires.2018.05.005

Brunner, J., Cain, C. L., Yano, E. M., & Hamilton, A. B. (2019). Local leaders' perspectives on women veterans' health care: What would ideal look like. *Women's Health Issues*, *29*(1), 64-71. https://doi.org/10.1016/j.whi.2018.10.005

Butler-Mokoro, S., Grant, L., & Foster, J. (2018). *Feminist perspective on social work practice*. Oxford University Press

Buttner, M. M., Godfrey, K. M., Floto, E., Pittman, Lindamer, L., & Afari, N. (2017). Combat exposure and pain in male and female Afghanistan and Iraq veterans: The role of mediators and moderators. *Psychiatry Research*, *257*. 7-13. https://dx.doi.org/10.1016/j.psychres.2017.07.001

Calhoun, P. S., Schry, A. R., Dennis, P. A., Wagner, R., Kimbrel, N. A., Bastian, L. A., Beckham, J. C., Kudler, H., & Straits-Troster, K. (2018). The association between

military sexual trauma and use of VA and non-VA healthcare services among female veterans with military service in Iraq or Afghanistan. *Journal of Interpersonal Violence*, *33*(15), 2439-2464. https://doi.org/10.1177/0886260515625909

Cameron, K. L., Sturdivant, R. X., & Baker, S. P. (2019). Trends in the incidence of physician-diagnosed posttraumatic stress disorder among active-duty U.S. military personnel between 1999 and 2008. *Military Medica Research*, *6*(1), 8-21. https://doi.org/10.1186/s40779-019-0198-5

Candela, A. G. (2019). Exploring the function of member checking. *The Qualitative Report, 24*(3), 619-628. https://nsuworks.nova.edu/tqr/vol24/iss3/14

Carlson, B. E., Stromwall, L. K., & Lietz, C. A. (2013). Mental health issues in recently returning women veterans: Implications for practice. *National Association of Social Workers, 58*(2), 105-114. https://doi.org/10.1093/sw/swt001

Carney, C. P., Sampson, T, R.,Voelker, M., Woolson, R., Thorne, P., & Doebbeling, B. N. (2003). Women in the Gulf War: combat experience, exposures, and subsequent health care use. *Military Medicine, 168*(8), 654-661. https://pubmed.ncbi.nim.nih.gov/12943043/

Castillo-Montoya, M. (2016). Preparing for interview research: The interview protocol refinement framework. *The Qualitative Report*, *21*(5), 811-831. https://nsuworks.nova.edu/tqr/vol21/iss5/2

C'de Baca, J., Castillo, D., DeBeer, B., & Qualls, C. (2020). Rationale and design of an efficacy study of group prolonged exposure for PTSD. *Contemporary Clinical*

Trials Communications, *17*. 1-7. https://doi.org/10.1016/j.conctc.2019.100509

Chancer, L. S. (1991, May 21). Third wave feminism. *Village Voice*, 28

Christie, H., Hamilton-Giachritsis, C., Alves-Costa, F., Tomlinson, M., & Halligan, S. L. (2019). The impact of parental posttraumatic stress disorder on parenting: a systematic review. *European Journal of Psychotraumatology*, *10*(1), 1-13. https://doi.org/10.1080/20008198.2018.1550345

Collins, T. (2018). Military parent's PTSD and children's mental health: A scoping review. *The Qualitative Report*, *23*(5), 1237-1255 https://www.nsuworks.nova.edu/tqr/vol23/iss5/15

Connelly, L.M. (2016). Trustworthiness in qualitative research. *MedSurg Nursing*, *25*(6), 435-436.

Cott, N. (1987). *The grounding of modern feminism*. Yale University Press

Coughlin, S. S., Krengel, M., Sullivan, K., Pierce, P. F., Heboyan, V., & Wilson, C. (2017). A review of epidemiologic studies of the health of Gulf War women veterans. *Journal of Environment Health Science*, *3*(2), 1-16. https://doi.org.10.15436/2378-6841.17.1551

Creech, S, K., Swift, R., Zlotnick, C., & Taft, C. (2016). Combat exposure, mental health, and relationship functioning among women veterans of the Afghanistan and Iraq wars. *Journal of Family Psychology*, *30*(1), 43-51. https://www.dx.doi.org/10.1037/fam0000145

Danan, E, R., Krebs, E, E., Ensrud, K., Koeller, E., MacDonald, R., Velasquez, T., Greer, N., & Wilt, T. J. (2017). An evidence map of the women veterans' health research

literature (2008-2015). *Journal of General Intern Medicine, 32*(12), 1359-1376. https://doi.org/10.1007/s11606-017-4152-5

Daykin, A., Clement, C., Gamble, C., Kearney, A., Blazeby, J., Clarke, M., Lane, J. A., & Shaw, A. (2018). 'Recruitment, recruitment, recruitment'-the need for more focus on retention: A qualitative study of five trials. *Trials, 19*(1), 76-86 https://doi.org/10.1186/s13063-018-2467-0

Difede, J., Rothbaum, B. O., Rizzo, A. A., Wyka, K., Spielman, L., Jovanovic, T., Reist, C., Roy, M. J., Norrholm, S. D., Glatt, C., & Lee, F. (2019). Enhanced exposure therapy for combat-related posttraumatic stress disorder (PTSD): Study protocol for a randomized controlled trial. *Contemporary Clinical Trials, 87*. 1-11. https://doi.org/10.1016/j.cct.2019.105857

DiLeone, B, A. L., Wang, J. M., Kressin, N., & Vogt, D. (2015). Women's veteran identity and utilization of VA health services. *Psychological Services*, 1-9. https://dx.doi.org/10.1037/ser0000021

Dooly, M., Moore, E., & Vallejo, C. (2017). Research ethics. In E. Moore & M Dooly (Eds), *Qualitative approaches to research on plurilingual education* (pp. 351-362). Research-publishing.net. https://doi.org/10.14705/rpnet.2017.emmd2016.634

Doran, J, M., O'Shea, M., & Harpaz-Rotem, I. (2019). In their own words: Clinician experiences and challenges in administering evidence-based treatments for PTSD in the veterans health administration. *Psychiatric Quarterly*, *90*. 11-27. https://doi:org/10.1007/s11126-018-9604-5

Drake, J. (1997). Third wave feminism. *Feminist Studies*, *23*(1), 97-108. https://doi.org/10.207/3178299

Duman, F. (2012). The roots of modern feminism: Mary Wollstonecraft and the French Revolution. *International Journal of Humanities and Social Science*, *2*(9),75-89

Feminist philosophy. (2018). https://plato.stanford.edu/entries/feminist-philosophy/

Ferragamo, S. (2021). It's my country too: Women's military stories from the American Revolution to Afghanistan. *Journal of Advanced Military Studies*, *12*(1), 222-234. https://muse.jhu.edu/article/795896

Finley, E. P., Mader, M., Bollinger, M.J., Haro, E. K., Garcia, H. A., Huynh, A.K. Pugh, J. A., & Pugh, M. J. (2017). Characteristics associated with utilization of VA and non-VA care among Iraq and Afghanistan veterans with post-traumatic stress disorder. *Military Medicine*, *182*(11/12), E1892-E1903. https://doi.org/10.7205/MILMED-D-17-00074

Frank, C., Zamorski, M. A., Lee, J, E, C., & Colman, I. (2018). Deployment-related trauma and post-traumatic stress disorder: does gender matter? *European Journal of Psychotraumatology*, *9*(1), 1-10. https://doi.org/10.1080/20008198.2018.1486123

Friedan, B. (1963). *The feminine mystique*. W.W. Norton & Company, Inc.

Gelinas, L., Pierce, R., Winkler, S., Cohen, I, G., Lynch, H, F., & Bierer, B. E. (2017). Using social media as a research recruitment tool: Ethical issues and recommendations. *America Journal of Bioeth*, 17(3), 3-14. http://doi.org/10.1080/15265161.2016.1276644

Govinfo. (2014). Department of Veteran Affairs. 38 CFR § 3.1. https://govinfo.gov/content/pkg/CFR-2014.title38-voll

Gross, G. M., Cunningham, K. C., Moore, D, A., Naylor, J. C., Birancu, M., Wagner, H. R., Elbogen, E. B., Calhoun, P. S., VA Mid-Atlantic MIRECC Workgroup., & Kimbrel, N.A. (2018). Does deployment-related military sexual assault interact with combat exposure to predict posttraumatic stress disorder in female veterans? *Traumatology*, 1-11. https://ncbi.nim.nih.gov/pmc/articles/pmc6128291

Hamilton, A. B., & Finley, E. P. (2020). Reprint of: Qualitative methods in implementation research: An introduction. *Psychiatry Research, 283*. 1-8. https://doi.org/10.1016/j.psychres.2019.112516

Harrison, H., Birks, M., Franklin, R., & Mills, J. (2017). Case study research: Foundations and methodological orientation. *Forum Qualitative Social Research, 18*(1), 1-13. https://nbn-resolving.de/urn:nbn:de:0114-fgs1701195

Haun, J. N., Duff, A., Lind, J. D., Kisala, P., & Luther, S. L. (2016). Qualitative inquiry explores health-related quality of life of female veterans with post-traumatic stress disorder. *Military Medicine, 181*. 1470-1475. https://doi.org/10.7205/MILMED-D-16-00064

Henschel, A. V., & McDevitt-Murphy, M.E. (2016). How do aftermath of battle experiences affect returning OEF/OIF veterans? *Military Behavioral Health, 4*(4), 345-350. https://doi.org/10.1080/21635781.2016.1181583

Hester, R, D. (2017). Lack of access to mental health services contributing to the high suicide rates among veterans. *International Journal of Mental Health Systems*,

11(47), 1-4. https://doi.org/10.1186/s13033-017-0154-2

Hitchings, R., & Latham, A. (2019). Qualitative method I: On current conventions in interview research. *Progress in Human Geography*, *44*(2), 389-398. https://doi.org/10.1177/0309132519856412

Huang, G. D., & Ramoni, R. B. (2019). Evidence-based care for women veterans: A burgeoning effort in the department of veterans affairs healthcare system. *Women's Health Issues*, *29*(S1), S6-S8. https://doi.org/10.1016/j.whi.2019.05.003

Johnson, E. M., Barrie, K. A., Possemato, K., Wade, M., Eaker, A., & Ouimette, P. C. (2016). Predictors of mental health care utilization in veterans with post-traumatic stress disorder symptoms and hazardous drinking. *Military Medicine*, *181*(10), 1200-1206. https://doi.org/10.7205/MILMED-D-15-00495

Johnson, E. M., & Possemato, K. (2019). Correlates and predictors of mental health care utilization for veterans with PTSD: A systematic review. *Psychological Trauma: Theory, Research, Practice, and Policy*, 1-10. https://dx.doi.org/10.1037/tra0000461

Kahlke, R.M. (2014). Generic qualitative approaches: Pitfalls and benefits of methodological mixology. *International Journal of Qualitative Methods, 13*. 37-52. https://doi.org/10.1177/160940691401300119

Kehle-Forbes, S. M., Harwood, E. M., Spoont, M. R., Sayer, N. A., Gerould, H., & Murdoch, M. (2017). Experiences with VHA care: a qualitative study of U.S. Women veterans with self-reported trauma histories. *BMC Women's Health*, *17*(1), 38-45. https://doi.10.1186/s12905-017-0395-x

Kennedy, D. M. (2016). Is it any clearer? Generic qualitative inquiry and the VSAIEEDC model of data analysis. *The Qualitative Report*, *21*(8), 1369-1379. https://nsuworks.nova.edu/tqr/vol21/iss8/1

Kintzle, S., Barr, N., Corletto, G., & Castro, C. A. (2018). PTSD in US veterans: The role of social connectedness, combat experience and discharge. *Healthcare*, *6*(102), 1-7. https://doi.org/10.3390/healthcare6030102

Klap, R., Darling, J. E., Hamilton, A. B., Rose, D. E., Dyer, K., Canelo, I., Haskell, S., & Yano, E. M. (2019). Prevalence of stranger harassment of women veterans at Veterans Affairs medical centers and impacts on delayed and missed care. *Women Health Issues*, *29*(2), 107-115. https://doi.org/10.1016/j.whi.2018.12.002

Koblinsky, S. A., Schroeder, A. L., & Leslie, L. A. (2017). “Give us respect, support and understanding": Women veterans of Iraq and Afghanistan recommend strategies for improving their mental health care. *Social Work in Mental Health*, *15*(2), 121-142. https://doi.org/10.1080/15332985.2016.1186134

Korstjens, I., & Moser, A. (2017b). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120-124. https://doi.org/10.1080/13814788.2017.1375092

Kotzias, V., Engel, C. C., Ramchand, R., Ayer, L., Predmore, Z., Ebener, P., Haas, G. L., Kemp, J. E., & Karras, E. (2019). Mental health service preferences and utilization among women veterans in crisis: Perspectives of veterans crisis line responders. *Journal of Behavioral Health Services & Research*, 29-42. https://doi.org/10.1007/s11414-018-9635-6

Kyngäs, H., Kääriäinen, M., & Elo. S. (2020). The trustworthiness of content analysis. *The Application of Content Analysis in Nursing Science Research,* 41-48. https://doi.org/10.1007/978-3-030-30199-6_5

Laughlin, K. A., Gallagher, J., Cobble, D. S., Boris, E., Nadasen, P., Gilmore, S., & Zarnow, L. (2010). Is it time to jump ship? Historians rethink the wave metaphor. *Feminist Formations*, *22*(1), 76-135. https://doi.org/10.1353/nwsa.0.0118

Lawrence, K. A., Matthieu, M. M., & Robertson-Blackmore, E. (2019). Civic service as an intervention to promote psychosocial health and implications for mental health in post-9/11/01 era women veterans. *Journal of Women's Health, 28*(8), 1133-1142. https://doi.org/10.1089/jwh.2018.7338

Lehavot, K., Goldberg, S. B., Chen, J. A., Katon, J. G., Glass, J. E., Fortney, J. C., Simpson, T. L., & Schnurr, P. P. (2018a). Do trauma type, stressful life events, and social support explain women veterans' high prevalence of PTSD. *Social Psychiatric and Psychiatric Epidemiology*, *53*. 943-953. https://doi.org/10.1007/s00127-018-1550-x

Lehavot, K., Katon, J. G., Chen, J. A., Fortney, J. C., & Simpson, T. L. (2018b). Post-traumatic stress disorder by gender and veteran status. *American Journal of Preventive Medicine*, *54*(1), e1-e9. https://doi.org/10.1016/j.amepre.2017.09.008

Lester, J. N., Cho, Y., & Lochmiller, C. R. (2020). Learning to do qualitative data analysis : A starting point. *Human Resource Development Review*, *19*(1), 94-106. https://doi.org/10.1177/1534484320903890

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research.

Journal of Family Medicine and Primary Care, *4*(3), 324-327. https://doi.org/10.413/2249-4863.161306

Lewis, C., Roberts, N. P., Andrew, M., Starling, E., & Bisson, J. I. (2020). Psychological Therapies for post-traumatic stress disorder in adults: systematic review and meta-analysis. *European Journal of Psychotraumatology, 11*(1), 1729633. https://doi.org/10.1080/20008198.2020.1729633

MacGregor, A. J., Zouris, J. M., Dougherty, A. L., & Dye, J. L. (2021). Health profiles of military women and the impact of combat-related injury. *Women's Health Issues*, *31*(4), 392-398. https://doi.org/10.1016/j.whi.2021.03.009

Maguen, S., Li, Y., Madden, E., Seal, K. H., Neylan, T. C., Patterson, O. V., DuVall, S. L., Lujan, C., & Shiner, B. (2019). Factors associated with completing evidence-based psychotherapy for PTSD among veterans in a national healthcare system. *Psychiatry Research, 274*.112-128. https://doi.org/10.1016/j/psychres.2019.02.027

Mallonee, S., Tate, L., DeOliveira, F., & Ruiz, A. (2020). Development and trial implementation of a 30-day outpatient program for subthreshold PTSD. *Military Medicine, 185*(1/2), E38-E42. https://doi.org/10.1093/milmed/usz165

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research, 26*(13), 1753-1760. https://doi.org/10.1177/1049732315617444

Markowitz, F. E., Kintzle, S., & Castro, C. A. (2022). Military-to-civilian transition strains and risky behavior among post-9/11 veterans. *Military Psychology*, 1-12.

https://doi.org/10.1080/08995605.2022.2065177

Mattocks, K., Casares, J., Brown, A., Bean-Mayberry, B., Goldstein, K. M., Driscoll, M., Haskell, S., Bastian, L., & Brandt, C. (2020). Women veterans' experiences with perceived gender bias in U.S. Department of Veterans Affairs specialty care. *Women's Health Issues*, *30*(2), 113-119. https://doi.org/10.1016/j.whi.2019.10.003

McCormick, W. H., Currier, J. M., Isaak, S. L., Sims, B. M., Slagel, B. A., Carroll, T. D., Hamner, K., & Albright, D. L. (2019). Military culture and post-military transitioning among veterans: A qualitative analysis. *Journal of Veterans Studies*, *4*(2), 287-298. https://doi.org/10.21061.jvs.v4i2.121

McGraw, K. (2016). Gender differences among military combatants: Does social support, ostracism, and pain perception influence psychological health. *Military Medicine*, *181*(1), 80-85. https://doi.org/10.7205/MILMED-D-15-00254

McGuire, T. M., Lee, C. W., & Drummond, P.D. (2019). Potential of eye movement desensitization and reprocessing therapy in the treatment of post-traumatic stress disorder. *Psychology Research and Behavior Management*, *4*(7), 273-283. https://doi.org/10.2147/PRBM.552268

McKenzie, V., Anderson, E. H., Maydon, A., & Shivakumar, G. (2021). Resiliency and posttraumatic growth following sexual trauma in women veterans of Iraq and Afghan wars. *Journal of Veterans Studies*, *7*(2), 34-43. https://doi.org/10.21061/jvs.v7i2.269

McTighe, A. J. (2017). Evidence-based practices, ethical considerations, and advocacy

efforts to reduce mental health stigma in veterans with post-traumatic stress disorder. *Journal of Trauma & Treatment*, *6*(5), 1-5. https://doi.org/10.4172/2167-1222.1000398

Meffert, B. N., Morabito, A. M., Sawicki, D. A., Hausman, C., Southwick, S. M., Pietrzak, R. H., & Heinz, A. J. (2019). U.S. veterans who do and do not utilize VA healthcare services: Demographic, military, medical, and psychosocial characteristics. *Primary Care Companion*, *21*(1), 1-18. https://doi.org/10.4088/PCC.18m02350

Miles, M. B., Huberman, A. M., & Saldaña, J. (2020). *Qualitative data analysis: A method sourcebook*. (4th ed). Sage Publication Inc.

Minnen, A. V., Voorendonk, E. M., Rozendaal, L., & De Jongh, A. (2020). Sequence matters: Combing prolonged exposure and EMDR therapy for PTSD. *Psychiatry Research*, *290*. 1-6. https://doi.org/10.1016/j.psychres.2020.113032

Moser, A., & Korstjens, I.(2018). Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. *European Journal of General Practice*, *24*(1), 9-18. https://doi.org/10.1080/13814788.2017.1375091

Murphy, D. M., Busuttil, W., & Turgoose, D. (2018). Understanding the needs of veterans with PTSD. *Journal of Healthcare*, *6*(100). 1-3. https://doi.org/10.3390/healthcare6030100

Mustillo, S. A., & Kysar-Moon, A. (2017). Race, gender, and post-traumatic stress disorder in the U.S. military: Differential vulnerability? *Armed Forces & Society*, *43*(2), 322-345. https://doi.org/10.1177/0095327X16652610

National Center for PTSD. (2019a). How common is PTSD in adults. https://ptsd.va.gov/understand/common/common_women.asp

National Center for PTSD. (2019b). War and combat. https://ptsd.va.gov/understand/types_war_combat.asp

National Center for PTSD. (2020). PTSD treatment basics. https://ptsd.va.gov/understand_tx/tx_basic.aps

National Institutes of Mental Health. (2017). Post-traumatic stress disorder (PTSD). https://nimh.nih.gov/health/statistics/post-traumatic-stress-disorder-ptsd

Neilson, E. C., Singh, R. S., Harper, K. L., & Teng, E. J. (2020). Traditional Masculinity ideology, posttraumatic stress disorder (PTSD) symptom severity, and treatment in service members and veterans: A systematic review. *Psychology of Men & Masculinities*, 1-13. https://dx.doi.org/10.1037/men0000257

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us Learn from the experiences of others. *Perspectives on Medical Education*, 90-97. https://doi.org/10.1007/s40037-019-0509-2

Nichter, B., Haller, M., Norman, S., & Pietrzak, R. H. (2020). Risk and protective factors associated with comorbid PTSD and depression in U.S. military veterans: Results from the national health and resilience in veterans study. *Journal of Psychiatric Research*, *121*. 56-61. https://doi.org/10.1016/j.jpsychires.2019.11.008

Nisiparu, E., Matei, R., & Sălceanu, C. (2020). The influence of posttraumatic stress disorder on military life. *Black Sea Journal of Psychology*, *11*(2), 28-36. https://www.hspsychology.ro

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Method, 16*. 1-13. https://doi.org/10.1177/1609406917733847

O'Neill, W. L. (1969). Everyone was brave: The rise and fall of Feminism in America. *The Canadian Historical Review, 52*(1), 109-111. https://muse.jhu.edu/article/569377/summary

Percy, W. H., Kostere, K., & Kostere, S. (2015). Generic qualitative research in psychology. *The Qualitative Report, 20*(2), 76-85. https://nsuworks.nova.edu/tqr/vol20/iss2/7

Peskin, M., Markowitz, J. C., & Difede, J. (2018). Interpersonal psychotherapy for posttraumatic stress disorder due to military sexual trauma: A case study. *Journal of Psychotherapy Integration, 28*(4), 556-566. https://doi.org/10.1037/int0000112

Ramon, A. E., Guthrie, L., & Rochester, N. K. (2020). Roles of masculinity in relationships between mindfulness, self-compassion, and well-being in military veterans. *Psychology of Men & Masculinities*, *21*(3), 357-368. https://dx.doi.org/10.1037/men0000240

Rasheed, L. (2018). *Feminist Perspectives on social work practices: The intersecting lives of women in the twenty-first century*.(S. Butler-Mokoro & S. Grant, Ed). Oxford University Press

Ravitch S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Sage Publication, Inc.

Reisman, M. (2016). PTSD treatment for veterans: What's working, what's new, and

what's next. *Pharmacy and Therapeutics*, *41*(10), 623-634. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047000/

Ruzek, J. L., Efekhari, A., Crowley, J., Kuhn, E., Karlin, B. E., & Rosen, C. S. (2017). Post-training beliefs, intentions, and use of prolonged exposure therapy by clinicians in the veterans health administration. *Adm Policy Mental Health*, *44*(1), 123-132. https://doi.org/10.1007/s10488-015-0689-y

Ryan, E. T., McGrath, A, C., Creech, S, K., & Borsari, B. (2015). Predicting utilization of healthcare services in the veterans health administration by returning women veterans: The role of trauma exposure and symptoms of post-traumatic stress. *Psychological Services*, *12*(4), 412-419. https://doi.org/10.1037/ser0000057

Saldaña, J. (2015). *The coding manual for qualitative researchers*. 3rd Editions. https://Vbk://9781473943582

Segal, M. W., & Lane, M. D. (2016). Conceptual model of military women's life events and well-being. *Military Medicine*, *181*(1), 12-19. https://doi.org/10.7205/MILMED-D-15-00345

Shapiro, A, L.(1992). Introduction: History and feminist theory or talking back to the beadle. *History and Theory*, *31*(4), 1-14. https://doi.org/10.2307/2505412

Shields, M., Thomas, K. H., Bernard, C., & Lumsden, D. (2020). The correlation between female veteran mental health and branch of military service. *Journal of Health Education Teaching*, *11*(1), 14-23. https://www.jhetonline.com

Shura, R. D., Rutherford, B. J., Fugett, A., & Lindberg, M. A. (2017). An exploratory study of attachments and post-traumatic stress in combat veterans. *Current*

Psychology, *36*. 110-118. https://doi.org/10.1007/s12144-015-9390-2

Sidran (2018). Traumatic stress disorder fact sheet. https://sidran.org

Silvestrini, M., Nicosia, F., Spar, M. J., Gibson, C. J., & Brown, R. T. (2020). We have a long way to go: A case study examination of older women veterans' experiences in VA primary care. *Inquiry: Journal of Health Care Organization, Provision, & Financing*, *57*. 1-7. https://doi.org/10.1177/0046958020931311

Sobocan, A, M., Bertotti, T., & Strom-Gottfried, K. (2019). Ethical considerations in social work research. *European Journal of Social Work*, *22*(5), 805-818. https://doi.org/10.1080/13691457.2018.1544117

Southwell, K. H., & MacDermid-Wadsworth, S. M. (2016). The many faces of military families: Unique features of the lives of female service members. *Military Medicine*, *181*(1), 70-79. https://doi:10.7205/MILMED-D-15-00193

Spivack, M. A. (2016). Women in combat. *CQ Researcher*, *26*(19), 433-456. https://library.cqpress.com/cqresearcher/document.php?id=cqresrre2016051300

Spoont, M., Nelson, D., Ryn, M. V., & Alegria, M. (2017). Racial and ethnic variation in Perceptions of VA mental health providers are associated with treatment retention Among veterans with PTSD. *Medical Care*, *55*(9), S33-S42. https://www.lww-medicalcare.com

Stanton, E. C. (1897). *Eighty years and more: Reminiscences 1815-1897*.T Fisher UnWin 1898. https://digital.library.upenn.edu/women/stanton/years/years.html

Strong, J. D., Crowe, B. M., & Lawson, S. (2018). Female veterans: Navigating two identities. *Clinical Social Work Journal*, *46*(2), 92-99.

https://doi.org/10.1007/s10615-017-0636-3

Strong, J. D., Findley, P., McMahon, S., & Angell, B. (2015). What is war? Female veterans' experiences of combat in Iraq and Afghanistan. *Journal of Women and Social Work*, 1-15. https://doi.org/10.1177/0886109915585383

Sutton, J., & Austin, Z., (2015). Qualitative research: Data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy*, *68*(3), 226-231. https://doi.org/10.4212/cjhp.v6813.1456

Swan, J., & Hamilton, P. M. (2017). Posttraumatic stress disorder (PTSD). *Wild Iris Medicine Education*, https://wildirismedicaleducation.com

Taylor, S. J., Bogdan, R., & DeVault, M. L. (2016). *Introduction to qualitative research methods: A guidebook and resource.* John Wiley & Son, Inc.

Taylor, S., Miller, B. L., Tallapragada, M., & Vogel, M. (2020). Veterans' transition out of the military and knowledge of mental health disorders. *Journal of Veterans Studies*, *6*(1), 85-95. https://doi.org/10.21061/jvsv6i1.131

Tie, T. C., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *Journal of Sage Open Medicine*, *7*. 1-8 https://doi.org/10.1177/2050312118822927

United States Army. (2017). Army field manual 3.0 https://armypubs.army.mil

United States Army. (2021). Army field manual 1-02.1 https://armypubs.army.mil

United States Department of Veterans Affairs. (2017a). Analysis of VA health care utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) veterans.

https://www.publichealth.va.gov/epidemiology/reports/oefoifond/index.asp

United States Department of Veterans Affairs. (2017b). Report on VA facility specific Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) veterans diagnosed with potential or provisional PTSD. https://www.publichealth.va.gov/epidemiology/reports/oefoifond/index.asp

United States Department of Veterans Affairs. (2022a). Demographic characteristic of veterans who separated in 2011 and 2017. https://data.va.gov/dataset/

United States Department of Veterans Affairs. (2022b). Veterans utilization profile FY18- table 1, participation trend by gender FY 2008-2019. https://data.va.gov/dataset/Veterans-Utilization-Profile-FY18-table-1-particip/pygk-j4gc

United States Department of Veterans Affairs. (2022c). Wars & operations. https://publichealth.va.gov/exposures/index.asp

VA. (2021a). National Center for veterans analysis and statistics: Glossary. https://va.gov/vetdata/glossary.asp

VA.(2021b). VA history-Department of Veterans Affairs (VA). Retrieved May 27, 2021, https://va.gov/history

Vogt, D., Smith, B, N., Fox, A. B., Amoroso, T., Taverna, E., & Schnurr, P. P. (2016). Consequences of PTSD for the work and family quality of life of female and male US Afghanistan and Iraq war veterans. *Social Psychiatry Psychiatr Epidemiol, 52*. 341-352. https://doi.org/10.1007/s00127-016-1321-5

Waitzkin, H., Cruz, M., Shuey, B., Smithers, D., Muncy, L., & Noble, M. (2018). Military personnel who seek health and mental health services outside the military. *Military Medicine*, *183*(5), e232-e240. https://doi.org/10.1093/milmed/usx051

Wang, Y., Karstoft, K. I., Nievergelt, C. M., Maihofer, A. X., Stein, M. B., Ursano, R. J., Byberg-Grauholm, J., Bækvad-Hansen, M., Hougaard, D. M., Andreassen, O.A., Werge, T., Thompson, W. K., & Anderson, S. B. (2019). Post-traumatic stress following military deployment: Genetic associations and cross-disorder genetic correlations *Journal of Affective Disorders*, *252*(1), 350-357. https://doi.org/10.1016/j.jad.2019.04.070

Ware, C. (1970). *Woman power: The movement for women's liberation*, Tower Publications

Watkins, L. E., Sprang, K. R., & Rothbaum, B.O. (2018). Treating PTSD: A review of Evidence-based psychotherapy interventions. *Frontiers in Behavioral Neuroscience*, *12*(258), 1-9. https://doi.org/10.3389/fnbeh.2018.00258

Williams, L., Pavlish, C., Maliski, S., & Washington, D. (2018). Clear away past wreckage: A constructivist grounded theory of identity and mental health access by female veterans. *Advances in Nursing Science, 41*(4), 327-339. https://doi.org/10.1097/ANS0000000000000219

Williams, M., & Moser, T. (2019). The art of coding and thematic exploration in qualitative research. *International Management Review*, *15*(1), 45-55. https://www.semanticscholar.org

Womenhealth. (2018). Sourcebook: Women veterans in the Veterans Health Administration. https://womenhealth.va.gov/womenhealth/docs/whs_sourcebook_vol-IV_508c.pd

Xue, C., Ge, Y., Tang, B., Liu, Y., Kang, P., Wang, M., & Zhang, L. (2015). A meta-analysis of risk factors for combat-related PTSD among military personnel and veterans. *Public Library of Science*, 1-21. https://doi.org/10.1371/journal.pone.0120270

Yeung, D., Steiner, C. E., Hardison, C. M., Hanser, L. M., & Kamarck, K. N. (2017). *Recruiting policies and practice for women in the military: Views from the field.* Rand Corporation. https://www.rand.org

Appendix A: Demographic & Interview Questions

Hello,
I would like to thank you for consenting on volunteering for this study on your perception regarding the healthcare services within the Veterans Administration. Before we begin the interviews I would like to get to know your better by asking a few demographic questions to help me to get to know you better.

Demographic Questions

1. Your age is between?

    - 20-30
    - 30-40
    - 40-50
    - 50-60
    - 60-70

2. What is your race and /or ethnicity (check all that apply)?
    - American Indian or Alaska Native
    - Asian
    - Black or African American
    - Hispanic or Latino
    - Native Hawaiian or Other Pacific Islander
    - White
    - Other

3. What is the highest level of education that you have completed (choose one)?
    - High school graduate or GED
    - Some college (1-4 years, no degree)
    - Associate degree
    - Bachelor's degree (BA, BS, AB, etc.)
    - Master's degree (MA, MS, MSW, MPH, etc.)
    - Professional degree (MD, JD, DDS, etc.)
    - Doctorate degree (PhD, EdD, etc.)

4. What branch of service did you serve?
    - Army
    - Air Force
    - Navy
    - Marines
    - Coast Guard

5. What component did you serve in?
    - Active Duty
    - Reserves

- National Guard

6. How long did you serve in the military?
    - 1 to 5 years
    - 5 to 10 years
    - 10 to 20 years
    - 20 or more years

7. What was your grade or rank?
    - E-1 to E-4 (Enlisted Personnel)
    - E-4 to E-6 ((Non-Commissioned Officer)
    - E-7 to E-9 (Senior Non-Commissioned Officer)
    - W-1 to W-5 (Warrant Officer)
    - O-1 to O-9 (Officer)

8. Where you every exposed to enemy fire?
    - Yes
    - No

9. What is your employment status?
    - Employed
    - Self-employed
    - Retired
    - Unemployed

Interview Questions

I am interested in understanding your perception regarding the utilization of the Veterans Administrative mental Healthcare services for those who have experience combat exposure.

1. When did you try to access the healthcare services through the VA?

2. Do you have access to private healthcare services?

3. What was your initial perception of the healthcare services at the Veterans Affairs Center (VA)?
4. What was your experience in getting an appointment at the VA?
5. How did you find the services with the VA healthcare professionals during your appointment?
6. How did you feel about the treatment plan provide by the VHA for you?
7. How would you describe your experience with the VHA with getting referrals for specialty appointment?
8. What would you like to see differently at the VA?
9. What is your level of satisfaction with the VA?
10. Where do you go for your healthcare services?
11. How often do you visit your healthcare provider?

Appendix B: Interview Protocol

- Interview prepares for the interview
    - Review interview script and research questions prior to each interview
    - Audio/video record each interview
    - Interview lasted between 45 to 60 minutes
- Interview Methodology
    - Interviewer customized in-depth semi-structure questions
    - The semi-structure questions consist of 11 questions
    - From the responses, follow-up questions will be asked to explore and expand on the interviewee experiences
    - Each participants will answer the same pre-determine questions
- How to document interview
    - Each participants is identified by their research ID
    - All interviews are teleconference
    - Each interview will begin with the date, start time and finish time
    - Any anomalies will be noted that may affect the outcome of the study