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Effects of Posttraumatic Stress Disorder for U.S. Women Veterans

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Walden University
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Abstract

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MSW, Florida State University, 2003

BSW, Florida State University, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The purpose of this qualitative phenomenological study was to explore the lived postdeployment experiences of U.S. women veterans with posttraumatic stress disorder (PTSD) and their perception of the impact their diagnosis had on their immediate families. The theoretical framework was Heider's causal attribution theory. The first two research questions directly addressed the purpose of the study, and the third research question addressed each participant's experience with accessing mental healthcare services. NVivo was used to transcribe, code, and analyze data derived from semistructured interviews with six U.S. women veterans who were diagnosed with PTSD by a licensed mental health professional postdeployment. Findings emerged PTSD diagnosis, U.S. women veterans experienced effects of PTSD on themselves and their immediate family members, access challenges to mental health care services. Eight subordinate themes (codes) also emerged history of traumatic events during active duty (i.e., sexual assault);communicative challenges, elevated verbal exchanges/angry outbursts with immediate family members; lengthy process of claims to begin Veterans Affairs mental health services, prescription medication to treat PTSD symptoms; denied mental health care services due to peacetime service; desire for improved U.S. women veterans' mental health care services; anxiety/panic attacks; and difficulty rescheduling therapy sessions and/or distractable teletherapy sessions due to Covid-19 pandemic. The positive social change implications include increasing awareness for the need of rapid response and access to mental health care services for U.S. women veterans living with PTSD.

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Dedication

I am extremely thankful to God for blessing me throughout my dissertation journey. I am in awe with all that I was able to accomplish as a doctoral candidate, while withstanding many challenges and a global pandemic. Thank you, Jesus! I dedicate this dissertation to my parents Lydia and Vincent Mount. My parents have been my constant prayer warriors and cheerleaders all of my life. Thank you, Mom and Pop for your unconditional love, prayers, encouragement, and unwavering faith in our Lord and Savior, Jesus Christ. Mom, thank you for the late-night edits and always encouraging me to manage my writing time responsibly. Pop, thank you for always listening and allowing me to vent whenever I was overwhelmed. You have a steady calmness about you that always helps me to see the silver lining during challenging and stressful times. I also dedicate this dissertation to my siblings, Mr. Darius Mount, Attorney Tiffany Mount, Dr. Beverly Mount, and Danielle Mount (deceased). Thank you all for your love, support, prayers, and encouragement. Beverly, we started our doctoral journeys together and how sweet it is to conclude our doctoral journeys side by side. I love you all so very much! I hope that my niece and nephews will be inspired by this dissertation to be future agents of positive social change. I also dedicate this dissertation to my maternal grandmother, Mrs. Vertia Gavin Rollins. Grandmother, thank you for your prayers, encouragement, love, and support over the years. You are such a blessing to our family! Lastly, I dedicate this dissertation to the many upstanding U.S. women. God bless and thank you for your service!

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Table of Contents

List of Tables

Chapter 1: Introduction to the Study

In this study I explored the lived experiences of U.S. women veterans living with posttraumatic stress disorder and how they perceived the impact of their diagnosis on their immediate families postdeployment. Daily life can often be stressful and challenging for U.S. women veterans living with posttraumatic stress disorder and their immediate families due to the severe effects of the illness (Street et al., 2009). The results of this study can contribute to social change by affirming these veterans' day-to-day challenges. In Chapter 1 of this study, I will provide a background, problem statement, purpose, research questions, theoretical framework, nature of this study, definitions, assumptions, scope and delimitations, limitations, significance of the study, and a summary.

Background of the Study

The enlistment and deployment of U.S. military servicewomen have significantly increased in recent years (Boyd et al., 2013). Women veterans as a population are rapidly expanding, and they are experiencing significantly more mental and physical health challenges than nonmilitary women (Smith et al., 2015). Despite military servicewomen constituting approximately14.5% of the 1.4 million reporting as active military, minimum resources have been directed toward the mental health needs of women in the military (Boyd et al., 2013). In the United States, the focus is on U.S. military men due to their being the more dominant group in the military (Boyd et al., 2013). However, there is a significant need for mental health services for women veterans post Operation Enduring

Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND; Boyd et al., 2013; Creech et al., 2016).

There is a gender bias of posttraumatic stress disorder and treatment between U.S. women and male veterans (Feczer & Bjorklund, 2009). For instance, despite U.S. women veterans demonstrating more posttraumatic stress disorder symptoms than U.S. male veterans, U.S. male veterans receive a posttraumatic stress disorder diagnosis 3.4 times more (Feczer & Bjorklund, 2009). But combat exposure for female service members in Afghanistan and Iraq led to distinct evaluations of gender differences regarding mental health postdeployment (Vogt et al., 2011), indicating that women would experience more combat-related stressors than men postdeployment. It is important for these veterans to receive psychotherapy, posttraumatic stress disorder symptom management, and a strong social support system, including both family and military (Feczer & Bjorklund, 2009). Further, couples-based mediations and resources, such as psychoeducation on emotional deadening symptoms of posttraumatic stress disorder, are imperative for female spouses who are veterans or civilian wives of their veteran spouses (Renshaw et al., 2014). In-depth knowledge and comprehension of military spouses' psychosocial indicators of susceptibility to posttraumatic stress disorder assists clinical professionals' efforts in classifying, evaluating, and providing support and resources to vulnerable spouses and their loved ones (Green et al., 2013).

More research is needed to increase knowledge on the mental health challenges that afflict U.S. military women (Boyd et al., 2013). Current literature regarding postdeployment family and relationship functioning involving members of the U.S.

military is largely based on the experiences of active-duty male members of the military and male veterans (Creech et al., 2016; Erbes et al., 2012; Gwyn, 2013; Ingelse & Messecar, 2017; Tan et al., 2013). Despite increasing awareness of the challenges those military women face during deployment, there is a gap in research on their roles and the stressors that they experience (Fox et al., 2016). This gap in the literature is significant, as there is a significant gender difference in postdeployment functioning (Creech et al., 2016, p. 44). For example, there is insufficient literature regarding how combat exposure affects a mother's parental identity, which can affect mental health professionals' approaches in treating this population (Gewirtz et al., 2014).

This current qualitative study's findings will help close the literature gap on the lived experiences of U.S. women veterans living with posttraumatic stress disorder and how they perceive the impact of their diagnosis on their immediate families postdeployment. The findings of this study may also motivate additional investigation surrounding the daily experiences of U.S. women veterans living with posttraumatic stress disorder.

Problem Statement

Investigating the lived experiences of U.S. women veterans living with posttraumatic stress disorder and their perceptions of the impact their posttraumatic stress disorder diagnosis has on their immediate families postdeployment is current, relevant, and significant (Ingelse & Messecar, 2017; Tan et al., 2013). With the increase in the number of U.S. women veterans, there are several barriers that have prevented them from accessing mental healthcare services. Examples of barriers include living in rural

communities (e.g., affordability, work release, and lack of transportation) or feeling disrespected by health care providers and other military establishment personnel (Ingelse & Messecar, 2017; Washington et al., 2015).

In addition, U.S. women veterans generally have experienced less access to mental health care services in comparison to their male colleagues (Ingelse & Messecar, 2017). Despite posttraumatic stress disorder symptoms presented by U.S. women veterans, gender disparities such as U.S. women veterans not meeting the benchmark of combat experience conditions when assessed with unisex Veterans Administration (VA) measures often result in their receiving delayed posttraumatic stress disorder diagnoses, being assigned lower disability ratings, and receiving fewer treatment benefits, which results in increasing anxiety and depression diagnoses (Conard & Armstrong, 2016). Investigation is needed to determine the challenges faced by the U.S. women veteran's population in order to pinpoint their mental health risk factors that can be averted while providing sufficient clinical resources (River & Johnson, 2014).

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore the lived experiences of U.S. women veterans living with posttraumatic stress disorder and how U.S. women they perceived the impact of their diagnosis on their immediate families postdeployment. From 2002–2014 over half of the U.S. women veterans accessing Veteran Health Administration (VHA) services had received a mental health diagnosis (Sairsingh et al., 2018). U.S. women veterans using VHA services have accumulated

more health care appointments with and outside the VHA than their male counterparts (Kehle-Forbes et al., 2017).

Research Questions

RQ1: What are the lived experiences of U.S. women veterans diagnosed with posttraumatic stress disorder postdeployment?

RQ2: How do U.S. women veterans perceive the impact of their posttraumatic stress disorder on their immediate families postdeployment?

RQ3: What are the experiences of U.S. women veterans' access to mental health care services?

Theoretical Foundation

Heider's (1944) causal attribution theory (CAT) explains that an individual's needs and emotions are determined by attribution. Attribution is a process used for determining what information is assembled and how it is merged to form a causal judgment or perception (Fisk &Taylor, 1991). According to Heider, something short-term is associated to something lasting and invariant, a probability or ability. For instance, for different populations globally, variances in posttraumatic stress disorder pervasiveness can be attributed to geographically specific assessments of trauma type and severity or to other issues such as the loss of private or communal material assets (Yehuda et al., 2015). In addition, posttraumatic stress disorder development for veterans is related to multiple risks such as frequent deployments and brain injuries (Hoge et al., 2008; Pietrzak et al., 2010; Reger et al., 2009; Seal et al., 2009; Skelton et al., 2012). Heider (1958) asserted that individuals attempt to ascertain the dispositional entities that cause observed

behavior and do so by attributing behavior to external causes (e.g., situational) or internal causes (e.g., dispositional).

As a framework, CAT supported this phenomenological study and research questions investigating the perceptions of U.S. women veterans living with posttraumatic stress disorder and the impact of their diagnosis on their immediate families postdeployment. In addition, the findings of this study were considered in view of the CAT. There is a more detailed explanation on how CAT supports the concepts of this study in Chapter 2.

Nature of the Study

The nature of this study is qualitative using a phenomenological method. Phenomenology is a process "designed to carry out increasingly sophisticated descriptions of what is essential to our experiences in their multifarious variety and our experience as a whole" (Staiti, 2014, p. 3). Selecting the phenomenological method enabled me to study the lived experiences of U.S. women veterans living with posttraumatic stress disorder and their perceptions on the impact of their diagnosis on their immediate families postdeployment. I used semistructured interviews to collect data for this study (see DiCicco-Bloom & Crabtree,2006). Questions for semistructured interviews involve open-ended questions that offer researchers a wide-ranging account regarding research questions (Turner, 2010). The semistructured interviews were scheduled in advance for confirmed designated times and preapproved locations. Scheduled semistructured interviews for social distancing purposes were facilitated telephonically.

I used NVivo software to transcribe and analyze data derived from the semistructured interviews for this study. NVivo is a computer-assisted software developed by QSR International (CAQDAS) that analyses qualitative data (Wong, 2008). NVivo software enables coding, categorization, and recovery of data for analysis (Wong, 2008). According to QSR International (2021), NVivo software also transcribes uploaded audio files, which I used to transcribe all interview audio files for this study.

Definitions

Immediate family members: Includes spouse and children.

Posttraumatic stress disorder: Behavioral symptoms consistent with reliving a negative event or trauma, negative thoughts, negative mood, or stimulation (American Psychiatric Association [APA], 2013).

Assumptions

I assumed that during the semistructured interviews, each study participant would respond openly and truthfully to questions regarding their postdeployment experiences and access to mental health care. I also assumed that each study participant would have already received a clinical diagnosis of posttraumatic stress disorder postdeployment prior to the interviewing process. My third assumption was that each study participant believed that their participation in this study was beneficial and an overall contribution to the betterment of mental health services provided to U.S. women veterans postdeployment. These assumptions were necessary for this study because they each sustain the likelihood of this study's success based on the overall commitment of voluntary participants.

Scope and Delimitations

The scope of this study was to examine the lived experiences of U.S. U.S. women veterans living with posttraumatic stress disorder. The specific focus of this study is the U.S. women veteran's population, because I wanted to provide readers with a narrative that utilizes their voice as a group on their perception of living with posttraumatic stress disorder postdeployment. Regarding delimitations or boundaries, with this study's population being gender specific, with military background, and residents of Florida U.S. women, the findings may not be transferrable to other populations such as U.S. male veterans and nonmilitary men and women living with posttraumatic stress disorder or U.S. women veterans living in other states.

An excluded theory related to the concepts of this phenomenological study but beyond the scope of this study is cognitive dissonance theory (Festinger, 1957). Similar to CAT, cognitive dissonance theory explains that cognitions can consist of an individual's beliefs pertaining to a myriad of personal and societal interests. However, the theory is different than CAT in that it examines an individual's change in their ideas and when specific phenomena occur in their lives and predicts human behavior patterns that involve inconsistent cognitions.

Limitations

Though phenomenological designs can yield significant research data, there are also limitations (Creswell, 2014). For instance, a qualitative phenomenological method does not produce empirical data (van Manen, 2018). Empirical data involves collecting and analyzing data and is viewed as the proper way to evaluate phenomenological

research (Given, 2008). Another limitation is the bias associated with a purposeful sample method, because bias in purposive sampling cannot be determined or regulated (Acharya et al., 2013). For example, with purposive sampling, a researcher is able to select participants for their study, as opposed to using a random selection of participants (van Manen, 2016). Another limitation involves potential lack of integrity or truthfulness regarding the study participants' responses during the semistructured interviews.

Regarding transferability, where a study's findings can be applied to other populations or contexts (Lincoln & Guba, 1985), this study's findings will not be transferable to generalized population-based studies due to participants being U.S. women veterans diagnosed with posttraumatic stress disorder only. Regarding dependability, where a study's results are reliable and can be recreated (Lincoln & Guba, 1985), it is my assumption that the findings of future phenomenological studies on the perceptions of U.S. women veterans living with a posttraumatic stress disorder diagnosis will be similar to the findings of this study if researchers use the same or a similar framework such as CAT.

Lastly, research with veterans living with posttraumatic stress disorder often triggers anxiety and abrupt changes in their moods and behaviors (Beks, 2016). Such occurrences may affect the population of this study by decreasing the total number of participants that could be recruited without the potential need for replacements. Possible options for recruiting potential study participants included the local VHA hospital and community-based veterans' organizations. Reasonable measures to address limitations

included encouraging study participants to respond honestly during the semistructured interviews and to recruit alternate participants for the study.

Significance of the Study

U.S. women veterans are a growing group of VHA users (Lehavot et al., 2018, p.2). With the ever-increasing number of women in the U.S. military, there is a need to understand their experiences with posttraumatic stress disorder (Creech & Misca, 2017, p. 7). Despite U.S. Navy women and men demonstrating comparable combat experiences, posttraumatic stress disorder has been significantly higher among women (MacGregor et al., 2017). The study contributes to filling the gap in literature on the lived experiences of U.S. U.S. women veterans clinically diagnosed with posttraumatic stress disorder and their immediate families post deployment. There is little knowledge regarding the adjustment of military mothers and their families postdeployment to Iraq and Afghanistan (Gewirtz et al., 2014). Social support provided to military women requires current examination on the immediate and extended family experiences in order to ascertain the impact of military experiences (Thomas et al., 2017).

This qualitative study will impact social change by demonstrating the need for readily accessible mental health care services for U.S. women veterans living with posttraumatic stress disorder. For example, the findings can be used to urge VA and non-VA mental health providers to utilize, improve, and or increase their use of modern communications systems such as electronic-screenings (or e-screenings) for posttraumatic stress disorder and other mental health illnesses. E-screenings and systems alike should not only be consistently available for U.S. women veterans to access, but

they should also disseminate mental health resources on a national scale. The limited E-screening which is available via six sites and by request, has generated over 1,000 assessments or interventions for high-risk VA patients (Elnahal et. al., 2017).

Summary

In summary, Chapter 1 provided the background, problem, research questions, and the purpose of this phenomenological qualitative study. As I set out to explore the lived experiences of U.S. women veterans living with posttraumatic stress disorder and how U.S. women they perceive the impact of their diagnosis on their immediate families postdeployment, my goal was to demonstrate the significance of making mental health resources and communications more accessible to this population U.S. women veterans. This process will involve distribution of this study's findings to mental health care policy administrators while advocating for access or improved mental health care services to U.S. women veterans who are under-resourced. This is especially important considering that more than 12% of U.S. women veterans who screened positively for posttraumatic stress disorder reported they had not received mental health services (Washington et al., 2013). Additionally, most U.S. women veterans utilize non-VA health care providers and are uninformed of posttraumatic stress disorder risks postdeployment (Washington et al., 2013). Chapter 1 also identified CAT as the theoretical framework and described the nature of this phenomenological qualitative study, definitions, assumptions, scope and delimitations, limitations, and significance. In Chapter 2, I provide the literature search strategy, theoretical framework, literature review related to key concepts of this study, and a summary with conclusions.

Chapter 2: Literature Review

The purpose of this qualitative phenomenology was to explore the lived experiences of U.S. women veterans living with posttraumatic stress disorder and how U.S. women they perceive the impact of their diagnosis on their immediate families postdeployment. In 2014, U.S. women veterans totaled over 2 million, which is approximately 10% of the total veteran population (Strong et al., 2018). Furthermore, there is an increased number of U.S. women veterans experiencing barriers to accessing mental healthcare services (Ingelse & Messecar, 2017). But many U.S. women veterans must cope with mental health and physical conditions experienced postdeployment (Strong et al., 2018). Military service affects all aspects of their lives such as marital relationships, social support, health outcomes, education and career opportunities, and personal growth (Borah & Fina, 2017). With the anticipated rise in the number of U.S. women veterans, it is necessary to determine this population's unique needs related to mental health (Strong et al., 2018).

Improving access to mental health care services for veterans has remained a priority for Veteran Affairs (Sripada et al., 2019). U.S. women healthcare specialists have a duty to endorse social justice while empowering disadvantage d populations that include U.S.U.S. women veterans, whose needs may require specialized skills and knowledge that is different from or dissimilar to the needs of male veterans (Strong et al., 2018). In addition, health care workers need to acknowledge the varied age, economic, and minority statuses of women veterans (see Strong et al., 2018).

Chapter 2 contains a comprehensive literature review of the theoretical foundation for this study, the key concepts, and the methodology for this study. Regarding the theoretical framework for this study, Heider's (1944) CAT, it is important to study the perceptions individuals have regarding the behavior attributions of others (Leifker & Marshall, 2019). For example, an individual's intentions contribute to their behavior attributions of others regarding the cause, intentions, and defining behaviors (Leifker & Marshall, 2019). The key concepts for this study are U.S. women veterans living with a posttraumatic stress disorder diagnosis and their immediate families. Chapter 2 also includes the literature search strategy for this study and a summary and conclusion.

Literature Search Strategy

I obtained the literature U.S. women from peer-reviewed journal articles. The literature review for this study involved comprehensive searches of Walden University's and Florida State University's online library resources. I searched databases that include ProQuest, PsycARTICLES, Research Gate, The National Center for Biotechnology Information (NCBI), Women veterans Health care (United States Department of Veterans Affairs), and Google Scholar. To identify germane scholarship, I searched for recent literature pertaining to U.S. women veterans living with posttraumatic stress disorder. Due to little current research on this topic U.S. women, I widened the search to peer-reviewed journal articles published from 2009 to 2020. The following are keywords I used to conduct literature searches for this study: *female veterans*, *women veterans*, *United States*, *United Stateswomen veterans*, *posttraumatic stress disorder*, *posttraumatic*

stress disorder, *family*, *families*, *spouse*, *children*, *mental health*, *community*, *outreach*, *assistance*, *access*, *help*, *Veterans Affairs*, *data*, *OIF*, *OEF*, *living*, and *experiences*.

Theoretical Foundation

The theory that served as a foundation for this phenomenological study is Heider's (1944) CAT, which was developed to explain events occurring in the lives of others. Heider (1958) maintained that individuals are inclined to comprehend and manage their various environments. For instance, apprehending is adaptive and leads to behaviors while being curious (Heider, 1958). Comprehensions and management of various environments involve knowledge surrounding the causes of events (Heider, 1958). Individuals are often vigorous observers who make cognizant assumptions regarding why they behave the way that they do or make the decisions that they make.

Researchers have applied CAT to understand health care behaviors. Gollust et al. (2018) grounded their study using CAT to understand health providers' insights of reasons of racial health care inequalities. Gollust et al. unveiled variances in the meaning that individuals attributed to causal factors. For instance, individuals who believed providers contribute to disparities discussed racial inequalities more willingly, pinpointed the processes through which inequalities emerge, and circumstantial patient-involved instances, more than individuals who contended health care providers contributed less towards inequalities. Likewise, variances in health care providers' perception of the inherent causal attributions proposed a multifaceted method to involve health care providers in treatment equality.

Kimber et al. (2020) also used CAT as their framework in order to observe distinctions based on specific characteristics of veterans. Veterans with posttraumatic stress disorder symptoms and physical complaints mostly attributed these to their stress/mental health and or a medically unexplained syndrome. On the contrary, veterans who reported low or no physical, mental, and or posttraumatic stress disorder symptoms, mostly attributed the cause of physical symptoms to daily lifestyle choices (e.g., eating habits and exercise).

CAT has also been applied specifically to posttraumatic stress disorder. With CAT, individuals who develop external attributions often believe that events are triggered by external factors, such as environmental events (Ginzburg et al., 2003). Individuals who develop internal attributions distinguish events as based on their personal behaviors or characteristics (e.g., exhaustion and or carelessness; Ginzburg et al., 2003). According to Ginzburg (2003), the only dimension of CAT for which findings have been constant is controllability. For instance, existing studies demonstrate that posttraumatic stress disorder sufferers often attribute positive and negative events to uncontrollable factors (Ginzburg et al., 2003).

CAT provided a framework for examining the postdeployment lived experiences of U.S. women veterans. CAT comprises of associations among self-perceptions and social perceptions of individuals (Kelley, 1973). For instance, CAT as a framework asserts that individuals are observers who develop unique assumptions and perceptions on the reasons for choices people make (Heider, 1958). CAT supported the examination of the social perceptions, self-perceptions, and psychological epistemologies of each

participant U.S. woman veteran participants. The research questions for this study also related to CAT, because they sought to ascertain attributions that each U.S. women regarding their perceptions that posttraumatic stress disorder has on their lives and the lives of their immediate family members postdeployment.

Literature Review Related to Key Concepts

In this section I review literature on the concepts being studied. These include U.S. women veterans living with a posttraumatic stress disorder diagnosis, the effects of posttraumatic stress disorder on U.S. women veterans and their immediate family members, and access to mental health care services for U.S. women veterans. This literature review presentation combines literature and methodology.

U.S. Women Veterans Living with a PTSD Diagnosis

Between psychiatric disorders and medical illnesses in general, posttraumatic stress disorder, depression, and hypertension are the top three diagnoses among U.S. women veterans (Dursa et al., 2019). Posttraumatic stress disorder occurs for some individuals that have experienced or witnessed a traumatic event (e.g., experiencing terrorism in combat, sexual assault, or being threatened with death) and can lead to intense, disturbing thoughts and feelings related to their experience (APA, 2020). Such experiences may involve flashbacks and or nightmares of traumatic experiences accompanied with feelings of detachment from others, melancholia, terror, and rage (APA, 2020).

It is likely that the onset of health circumstances (e.g., posttraumatic stress disorder, anxiety, depression, comorbid mental health, substance use disorder, and

chronic health challenges) began post entrance into the military (Gaska & Kimerling, 2018). Military trauma has a greater likelihood of leading to depression, anxiety, and posttraumatic stress disorder (Albright et al., 2019). Further, U.S. women veterans experience greater exposure to traumatic events (Lehavot et al., 2018). The transition for U.S. women veterans from military life to the unpredictable and sometimes fast paced civilian life is already challenging (Makowski et al., 2015). For instance, many U.S. women veterans are adjusting to physical and mental injuries and or wounds that require significant time and energy (Mankowski et al., 2015). Similarly, posttraumatic stress disorder symptoms and depression require significant time for adjusting to civilian life (Mankowski et al., 2015). Symptoms of posttraumatic stress disorder and depression for U.S. women veterans included trouble with focusing, sense of physical diffidence and hyper-vigilance, social isolation, noise irascibility, panic attacks, feeling of despondency, anger management and moodiness, and sleep disorders (Mankowski et al., 2015).

Effects of PTSD on U.S. Women Veterans and Their Immediate Family Members

Ray and Vanstone (2009), examined the "impact of posttraumatic stress disorder on veterans' family relationships and the impact of these relationships on healing from trauma" (p. 838). According to Ray and Vanstone (2009), the impact of posttraumatic stress disorder on family relationships and the impact of these relationships on healing from trauma, presented two major themes. Ray and Vanstone (2009) conducted a phenomenological study and analyzed descriptions of lived experience offered by their participants. For instance, "as the themes evolved for the secondary analysis, the primary researcher returned to the transcripts several times for verification of meaning and to find

exemplary quotes" (p. 838). This first theme demonstrated how emotional deadening or numbing can damagingly impact States Women causing additional emotional withdrawal (Ray & Vanstone, 2009). Additionally, this theme was only one half of the emotional pain. The second part of the theme cycle was emotional withdrawal from support of family members, and the related challenges for healing from trauma (Ray & Vanstone, 2009).

According to Ray and Vanstone (2009), the impact of posttraumatic stress disorder on veterans and their family members, more specifically symptoms of emotional deadening or numbing and rage, should be closely monitored. Furthermore, Ray and Vanstone (2009) recommended that posttraumatic stress disorder treatment involve family support and relational or interactive skills training for military employees agonizing while recovering from trauma. Future studies can further investigate the impact of posttraumatic stress disorder on veterans' family relations on provisions of improved treatment methods (Ray and Vanstone, 2009).

Yambo et al. (2016), examined the experiences of spouses living with veterans with combat-related posttraumatic stress disorder. Yambo et al. (2016) applied Husserlian phenomenology as the theoretical framework, as it allowed a more profound understanding of the military spouses' daily experiences. Yambo et al. (2016) used a purposive sample that consisted of fourteen spouses of veterans with symptoms of posttraumatic stress disorder. Each spouse completed an unstructured interview (Yambo et al., 2016). Application of a modified Colaizzi phenomenological method was used to analyze data (Yambo et al., 2016). Spouses distinguished that their veteran spouse had

changed or the person they used to know, was no longer present (Yambo et al., 2016). In addition, the spouses shared that their lives evolved to living with the changeableness of posttraumatic stress disorder (Yambo et al., 2016). Likewise, the military spouses demonstrated how they bear the hardships of attempts to maintain normalcy in their families (Yambo et al., 2016). Military spouses endured psychological stress and strain while living with a veteran with posttraumatic stress disorder. According to Yambo et al. (2016), there is a great need for additional programs that will support the resiliency of military spouses.

The challenges of adjusting to civilian life for U.S. women veterans also involved the constraints of several responsibilities accompanied by their post-traumatic/postwar experiences according to Mankowski et al. (2015). Constraints of several responsibilities accompanied by post-traumatic/postwar experiences, often resulted in deficient communication between U.S. women veterans, their partners, and or other family members and friends. According to Mankowski et al. (2015), the U.S. women veterans that participated in their qualitative study responded in their own words regarding challenges in their personal relationships. However, emotional and purposeful support assisted in counterbalancing the hopelessness and isolation some U.S. women veterans experienced (Mankowski et al., 2015).

With rapidly expanding roles in the United States military, female service members were noted to endure substantial stressors during their deployment experiences (Yan et al., 2013). As for post deployment stressors, Yan et al. (2013) reported that U.S. women veterans conveyed difficulties in their romantic and familial relations. For

example, a United States woman veteran shared that the she had to break up with her significant other and how it depressed her (Yan et al., 2013). Another United States woman veteran shared that her sister was incarcerated, resulting in her becoming the legal guardian of her sister's three children in addition to her own three children (Yan et al., 2013). According to Yan et al. (2013), there are limited studies that research interpersonal stressors that U.S. women veterans experience prior and post deployment (Yan et al., 2013).

McGaw et al. (2019) maintained that qualitative research is the basis for understanding and exploring phenomena via social settings and interactions, behaviors, and experiences. By exploring phenomena, we increase our understanding of various human experiences (McGaw et al., 2019). Provided the challenges of quantifying the concepts of an individuals' experiences, qualitative research involving military persons living with a posttraumatic stress disorder diagnosis along with their family members associated experiences and perceptions, makes exploring phenomena more achievable (McGaw et al., 2019). Qualitative research is vital and should include simultaneous synthesized data from intimate partner relations, parenting perspectives, and children's voices (McGaw et al., 2019)

Strengths and Weaknesses of Reviewed Literature

Ray and Vanstone's (2009) research study used a phenomenological approach that sought to determine the meanings of their study's participants' experiences via an analysis of descriptions. As a strength regarding their phenomenological approach, Ray and Vanstone (2009) conducted a successful secondary analysis that involved a second

researcher validating the first researcher's data analysis. A secondary analysis is the process of re-analyzing data previously collected for a study, by one or more researchers addressing a newfound research question (Payne & Payne, 2004). I agree with researchers Ray and Vanstone (2009) on identifying a secondary analysis as a strength for their study. The secondary analysis for Ray's and Vanstone's (2000) study, resulted in the primary researcher revisiting transcripts multiple times for substantiation of meaning and quotes. Regarding limitations and weaknesses of Ray's and Vanstone's (2009) study, I agree with their observation regarding the incapability for meticulously following the guiding principles of their chosen method for a secondary analysis. Their use of the Van Manen method would indicate a third step of analysis inclusive of participants (Ray & Vanstone, 2009). This was not feasible for them conduct and thus adherence to the method was incomplete (Ray & Vanstone, 2009).

For their phenomenological approach, Yambo et al. (2016) used a multi-method qualitative design, grounded in post-positivism for their study. This included qualitative descriptive and hermeneutic approaches that steered the data collection and analysis process (Yambo et al. (2016). In addition, semistructured interviews were conducted that comprised of a "thematic analysis of self-recorded thoughts, activities, and accounts were categorized, coded, and described, and in-depth textual analysis of storied interviews were interpreted for meaning" (Yambo et al., 2016, p. 534-536). In addition, categorical data were attained via a real time ecological momentary assessment (EMA) approach that offered a way for apprehending each participant's perceptions and experiences via the time of each event (Yambo et al., 2016). I am in agreement with the researchers that a

strength for their study was the magnitude of copious data that materialized via their patients' perspectives in real time. I also agree with the researchers that a weakness identified in their study involved a decline in related memories or recollections of earlier experiences shared by their patients, thus lessening the probability of their data.

I am in agreement with Yan et al. (2013), regarding an identified strength being accessibility to data via several time points from a sample of non-treatment seeking military employees enrolled pre-deployment in their longitudinal observational cohort study. Accessibility to data is extremely helpful in research, especially during time-sensitive occurrences in research where resources may be limited. As a weakness for their study, Yan et al. (2013) reported that their study comprised of a fairly small sample size and that they lacked resources and time for facilitating comprehensive in-person qualitative interviews with study participants. I agree with researchers Yan et al. (2013), as a saturated sample size is necessary and a lack in resources and time to facilitate a study can oppress potential success of research in general.

Access to Mental Health Care Services for U.S. Women Veterans

According to Farmer et al. (2020), very little is known regarding the barriers to care and aspects associated with United Stateswomen veteran's posttraumatic stress disorder utilization of psychotherapy services and retention. What is known, is that posttraumatic stress disorder is a predominant and debilitating illness that significantly lessens the quality of one's life (Farmer et al., 2020). It is estimated that 14% to 23% of Veterans Health Administration (VHA) consumers suffer from posttraumatic stress disorder (Famer et al., 2020). In 2017, the Department of Veterans Affairs (VA) paired

with the Department of Defense (DOD) updated clinical practice guidelines and revised recommendations for posttraumatic stress disorder treatment, with trauma-focused psychotherapy alone as the gold standard treatment (Farmer et al., 2020). Psychotherapy is more efficacious in reducing posttraumatic stress disorder symptoms and a more cost-effective treatment option compared with pharmacotherapy (Farmer et al., 2020). In recent years, utilization of VA health care services has increased amongst women veterans as well as male veterans. Nevertheless, underutilization of VA health care services has persisted in U.S. women veterans compared to U.S male veterans at22% vs. 28% in 2015 (Evans et al., 2019).

The VHA is one of three parts of the VA. The other two parts include the Veterans National Cemetery Administration and the Veterans Benefits Administration (VBA) (Ritchie, 2019). The administrating policy for accessing VHA health care services are quite complex (Ritchie, 2019). For instance, two years of active duty is required for VA eligibility (Ritchie, 2019). In addition, service-related health concerns receive prioritized benefits and health care services (Ritchie, 2019). If an individual is discharged from services due to medical reasons, their health needs are often addressed by the VHA (Ritchie, 2019).

Generally, United States military dishonorable discharges in the past have been precluded from eligibility for VA services (Ritchie, 2019). Today, emergency mental health care services are available to U.S. women veterans and male veterans that were dishonorably discharged (Ritchie, 2019). In addition, a diagnosis of military sexual trauma enables United States veterans' access to health care services, even if an

individual served less than two years (Ritchie, 2019). It does not matter if they received an honorable discharge or not. Likewise, without qualifying diagnosis such as military sexual trauma, dishonorably discharged United States veterans may not be eligible for care through the VHA (Ritchie, 2019). Many United States Veterans are also seen by non-VA practitioners that are sometimes not referred for VA health care services. For instance, many United States veterans have insurance through their employer or educational provider (Ritchie, 2019). Consequently, it is imperative for all providers to general and current awareness of what the VA health care services offer to United States veterans (Ritchie, 2019).

Evans et al. (2019) maintained that U.S. women veterans seek mental health care services external the United States Department of Veterans Affairs (VA) for several reasons. Reasons listed by Evans et al. (2019) include insufficient knowledge regarding their eligibility for VA services, no accessibility to VA mental health care services or facilities, and adverse experiences and perceptions involving poor quality of gender-sensitive care. For instance, Mattocks et al. (2018) qualitative study on U.S. women veterans utilizing the Veterans Choice Program (VCP) care, found the eligibility criteria perplexing and access to care was extremely challenging. The VCP commenced in 2014 in order to manage the mounting concerns regarding the quality and timeliness of the Veterans Health Administration (VHA) care (Mattocks et al., 2018). According to Mattocks et al. (2018), multiple U.S. women veterans communicated their frustration with the inadequate communication of care amongst the VHA and non-VHA providers.

Kotzias et al. (2019) used a qualitative method for their research to analytically assess call responders' perceptions involving barriers to mental health care services for women veterans. Kotzias et al. (2019) also identified potential ways for improving the use of mental health care services and suicidal prevention. Data for this qualitative study was collected via 54 Veterans Crisis Line (VCL) responder interviews in order to establish the experiences of women veterans in crisis. According to Kotzias et al. (2019), the VCL responders specified that women veterans conveyed various experiences with Veterans Administration (VA) and non-VA care, despite similar responses of satisfaction or dissatisfaction. Generally, Kotzias et al. (2019) reported that between 10 and 25% of VCL callers are women veterans. Whereas, 45 of the 54 responders that completed interviews for this study, reported that at least half to nearly all women veteran callers expressed receiving mental health care with the VA or a private mental health care provider (Kotzias et al., 2019). Kotzias et al. (2019) maintained that additional research may investigate models for modifying VA culture to be more receptive of women veteran needs. For instance, with the increase of women entering the military while use of online communications grows exponentially post-service socialization, there are multiple opportunities for the VA to explore culture changes that intersect mental health care awareness and social media platforms (Kotzias et al., 2019).

Hundt et al. (2018) maintained that posttraumatic stress disorder psychotherapy is a communal dilemma in the United States Department of Veteran Affairs (VA). For instance, half of veterans referred for evidence-based psychotherapy, failed to participate in treatment (Hundt et al., 2018). According to Hundt et al. (2018), previous studies have

focused on determining general obstacles to mental health care treatment for United States veterans opposed to evidence-based treatments for posttraumatic stress disorder. For their study, Hundt et al. (2018) aimed to determine obstacles for United States veterans who were specifically referred for evidence-based psychotherapy treatment but did not participate in treatment. An example of psychotherapy treatment is cognitive processing therapy such as prolonged exposure (Hundt et al., 2018). Hundt et al. (2018) conducted twenty-four qualitative interviews in order to ascertain a more in-depth understanding regarding the attitudes and experiences these United States veterans. According to Hundt et al. (2018), majority of the United States veterans study participants', shared that several obstacles prevented their access to treatment. The most significant obstacles that were reported include adverse experiences with VA staff and providers, uneasiness with the VA atmosphere, and complications circumnavigating the VA system. Overall, Hundt et al. (2018) concluded that the VA should develop a more patient-centered model for the care of United States veterans.

Eliacin et al. (2019) conducted a mixed methods study at three VA medical facilities. The overall basis of their study was Enhancing Motivation of Providers on Work to Eliminate Racial disparities (EMPOWER). The foremost objective of EMPOWER was to determine how to efficiently communicate with professional health care practitioners regarding disparities in health care (Eliacin et al., 2019). Eliacin et al. (2019) determined that despite their mixed-methods study's findings being at a descriptive phase, they accomplished the initials steps on developing a hypothesis on understanding health providers' causal attributions regarding health care inequalities

amongst the United States veteran population. For example, Eliacin et al. (2019), mapped progress of health equality efforts via adjustments in health providers' viewpoints and convictions, which led to acknowledgment by participating health providers that ineffectual patient–provider communication attributes to health care disparity. According to Eliacin et al. (2019), future steps in refining health care equality should concentrate on expanding providers and patients' participations joint efforts in decision-making processes. Noting limitations of their study, Eliacin et al. (2019) maintained that their constructed survey was solely based on literature that evaluated providers' perceptions on disparities in health care. For instance, although their study's results are not founded on validated measures, they offered a preface assessment on VA providers' perception on health care disparities (Eliacin et al., 2019). In addition, Eliacin et al. (2019) contracted the survey from a seven-point to a three-point Likert scale. This change in the Likert scale likely affected the reliability of data interpretation and measuring (Eliacin et al., 2019). Eliacin et al. (2019) argued that despite their study's results being descriptive at the present stage, they were the initial phases in constructing a hypothesis for apprehending providers' causal attributions disparities in health care, charting progressive health care equity exertions relating to variations in providers' beliefs and attitudes, while also constructing valid measures for impending studies (Eliacin et al., 2019).

According to Pyne et al. (2019), accessibility to high-quality health care that includes mental health services, is highly prioritized by the Department of Veterans Affairs (VA). The VA is increasing purchasing mental health services via community

mental health care providers (Pyne, 2019). In an attempt to ensure evocative monitoring of progress, patient-centered evaluations of access are required (Pyne et al., 2019). Correspondingly, Pyne et al. (2019) constructed the Perceived Access Inventory (PAI-VA), which focuses on access to VA mental health services. Utilizing a mixed qualitative and quantitative design, twenty-five interviews with veterans who previously experienced community mental health care services via the Veterans Choice Program (VCP) were conducted (Pyne et al., 2019). In addition, the PAI-VA was adapted to concentrate on access to mental health care in the participants' communities and the Hoge's 13-item evaluation (Pyne et al., 2019). Pyne et al. (2019) used invitational correspondences with opting-out options in order to recruit veteran participants. The qualitative interview results indicated that the four following topics were not addressed via the PAI-VA: "veterans being billed directly by a VCP mental health provider, lack of care coordination and communication between VCP and VA mental health providers, veterans needing to travel to a VA facility to have VCP provider prescriptions filled, and delays in VCP re-authorization" (Pyne et al., 2019, p. e301). As the VA grows its coverage of mental health care services, ability to evaluate the achievements of initiative via program users 'perspectives, becomes progressively imperative (Pyne et al., 2019).

Strengths and Weaknesses of Reviewed Literature

In agreement with the researchers, as a strength Farmer et al. (2020) capitalized on the ability to incorporate survey data from a large representative sample. The outcome resulted in Farmer et al. (2020) obtaining women's individual evaluations of their care experiences. Also, in agreement with Farmer et al. (2020), a weakness derived from their

study entailed not being able to completely apprehend full calculation of psychotherapy used by study participants, as the reported psychotherapy actualized a year prior to their study's survey. As a strength for their study, Ritchie (2019) provided significant information on issues that affect U.S. women veterans with children. For example, Ritchie (2019) noted the lack of available contraception for active service women and veterans, especially when deployed. Regarding weakness, Ritchie's (2019) study lacked statistical data that could possibly address the gap in literature regarding the obstacles that U.S. women veterans diagnosed with posttraumatic stress disorder experience when attaining or utilizing health care services.

In agreement with Evans et al. (2019), their study's location being the state of California is a strength because there is a significant population of U.S. women veterans. As a weakness, I also agree with Evans et al. (2019) that several shared experiences of the U.S. women veterans who participated in their study occurred several years prior to their study, which is subject to retrospective or retroactive biases. Regarding Kotzias et al.'s (2019) study, a strength involves the study's overall contribution to bridging the gap in literature on the experiences of U.S. women veterans living with mental illnesses in general. For example, Kotzias et al. (2019) conveyed that the Veterans Crisis Line (VCL) call responders involved in their study, reported that a minor but vital segment of U.S. women veterans are not presently in receipt of mental health care. VCL call responders are VA personnel with former experience in social services, mental health, and or call lines (Kotzias et al., 2019). As a noted weakness in Kotzias et al.'s (2019) study, I agree that the researchers should have spoken to U.S. women veterans about their impressions

of the U.S. women veteran's population opposed to Veterans Crisis Line (VCL) call responders.

For Hundt et al.'s (2018) qualitative and grounded theory designed study, as a strength they were able to attain twenty-four consistent participants out of forty-five patients that were eligible and completed interviews. Grounded theory designed studies often involve two primary characteristics that are constant comparisons of emerging data via theoretical sampling and categories of indifferent groups, which maximizes the differences and similarities of data (Creswell, 2007). Hence the significance of a study attaining and maintaining consistent data from its participants throughout its entirety (Creswell, 2007). As a weakness for Hundt et al.'s (2018) qualitative study, I agree that that their research was not able to determine the prevalence or relative importance of various barriers to prolonged exposure (PE) and cognitive processing therapy (CPT) treatments. As future quantitative research, can study the related impact involving various identified barriers (e.g., delays in posttraumatic stress disorder treatment for United States veterans) via multiple VA health care facilities (Hund et al., 2018).

As a strength in the Eliacin et al. (2019) study, I agree with the researchers conjecture that their descriptive findings are a significant contribution in research regarding apprehension of providers' causal attributions in health care (e.g., fostering valid measures useable for future research). Regarding weakness in the Eliacin et al. (2019) study, I also agree with the researchers that the sample size possibly contributed to the deficiency in recognized relationships between site, study participants' views on racial health care inequalities and providers' attributes, and expertise. Regarding the Pyne

et al. (2009) study, I agree with the researchers that a strength in their study involves their apprehending access barriers from their participants' veteran experiences. Also, in agreement with Pyne et al. (2019), a presented weakness in their study was mainly administrative opposed to concerns involving unique clinical experiences. It is imperative that researchers clearly define their roles and professional expectations to avoid confusion and any other issues that can delay their research. Another identified weakness for Pyne et al.'s (2019) study, is the small number of veteran participants. Unfortunately, a small number in research participants for many studies can result in insignificant data.

What is Known, Not Known, and What Remains to be Studied

Based on the literature reviewed in this chapter, emotional numbing and anger negatively impacts the familial relationships of U.S. women veterans diagnosed with posttraumatic stress disorder (Ray & Vanstone, 2009). We also know that for U.S. women veterans diagnosed with posttraumatic stress disorder, emotional detachment from family support develops challenges for healing from traumatic experiences (Ray & Vanstone, 2009). In general, U.S. women veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are most likely to experience prior traumatic histories (e.g., childhood abuse) that seemingly increase their vulnerability, which often adds to the challenges of healing from traumatic experiences (Mankowski et al., 2015).

What is unknown, is how to improve supporting services that address mental health concerns (Ray & Vanstone, 2009). Continued research on the effects of posttraumatic stress disorder involving veterans' family relationships will provide more insight on how to improve supporting services that address mental health concerns (Ray

& Vanstone, 2009). While there are many studies on women veterans in general, literature on women veterans' post deployment lives is limited (Yan et al, 2013). What remains to be known, is whether or not U.S. women veterans are more vulnerable to stressful life occurrences than United States service men, United States male veterans, and women civilians, placing them in a significantly increased range for developing posttraumatic stress disorder (Lehavot, 2018). Likewise, this current study aimed to fill the gap of literature on the perceptions that U.S. women veterans have pertaining the impact their posttraumatic stress disorder diagnosis has on their immediate families.

Summary

In summary, Chapter 2 provided a literature review that substantiates the major themes of this study, by focusing on the perceptions that U.S. women veterans have pertaining to the impact their posttraumatic stress disorder diagnosis has on their immediate families. What is known in psychology regarding the perceptions that U.S. women veterans have pertaining to the impact their posttraumatic stress disorder diagnosis has on their immediate families, is how women suggest remedies to barriers that can both improve and redesign access to health care systems (Koblinsky et al., 2017). What is not known in psychology is the perceptions that U.S. women veterans have pertaining to the impact their posttraumatic stress disorder diagnosis has on their immediate families, and the effects of deployment stressors that U.S. women veterans are subject to pre-deployment and post-deployment external health care establishments (Yan et al., 2013). This present study fills the gap in literature on the perceptions that U.S. women veterans have pertaining the impact their posttraumatic stress disorder diagnosis

has on their immediate families and will extend knowledge in the discipline by providing an opportunity to examine the characteristics of U.S. women veterans' experiences with their families via semistructured interviews.

Chapter 3 provides an introduction and expands on the phenomenological qualitative method that connects the gap in literature on the perceptions that U.S. women veterans have pertaining to the impact their posttraumatic stress disorder diagnosis has on their immediate families. The methodology in Chapter 3 expands on the participant selection logic, instrumentation, researcher-developed instrument, procedures for recruitment, data collection, and data analysis. In addition, Chapter 3 includes this study's research design and rationale, role of the researcher, issues of trustworthiness, summary, and conclusion.

Chapter 3: Research Method

The purpose of this qualitative phenomenology was to explore the lived experiences of U.S. women veterans living with posttraumatic stress disorder and how they perceive the impact of their diagnosis on their immediate families postdeployment. In addition to bridging the literature gap, this study contributes to positive social change by investigating these U.S. women veterans' experiences. In this chapter, the research design and rationale for this study, the role of the researcher, the methodology, issues of trustworthiness, and a summary of this chapter are provided.

Research Design and Rationale

For this qualitative study, I chose a phenomenology design. Phenomenology is focused on life experiences and an individual's perceptions of life events (Husserl, 2004). Phenomenologically designed studies entail data collection, writing, and analysis (Creswell, 2014). This design enabled me to study the lived experiences of U.S. women veterans living with posttraumatic stress disorder and how they perceive the impact of their diagnosis on their immediate families postdeployment. With this design, I answered the three research questions:

- Research Question (RQ) 1: What are the lived experiences of U.S. women veterans diagnosed with posttraumatic stress disorder postdeployment?
- Research Question (RQ) 2: How do U.S. women veterans perceive the impact of their posttraumatic stress disorder on their immediate families postdeployment?

- Research Question (RQ) 3: What are the experiences of U.S. women veterans' access to mental health care services?

Creswell (2014) urged researchers use narratives of study participants (e.g., comprehensive information regarding the background and culture of study participants) as part of them describing their experiences (Creswell, 2014; Staiti, 2014, p. 3). I used semistructured interviews to collect data, which I expand on in the Methodology section of this chapter.

Role of the Researcher

As the researcher of this qualitative phenomenology study, my role as a participant involved facilitating semistructured interviews with each volunteer participant in this study while collecting and analyzing data. I did not have any personal or professional relationships with the volunteer participants in this study. Therefore, there was no issue involving power as the researcher over each volunteer participant. However, prior to conducting the semistructured interviews, I ensured each participant verbally that their participation in this study is voluntary, that their responses during the semistructured interviews were confidential, and that they may decline answering any interview questions or withdraw participation at any time. In addition to ethical practices, I maintained a professional communication style and deportment for all meetings and sessions relevant to this study.

Regarding researcher bias related to this study, during the semistructured interview sessions, bias can be lessened or removed if the researcher's outcomes of interest have yet to occur (Pannucci & Wilkins, 2010). Research bias are errors that are

methodically linked to human beings, experimental circumstances or environments, and treatments, that often cause researchers to misjudge the extent of an individual's trait or behavior (Salkind, 2010). For this study, I managed research bias by utilizing member checking. At the end of each semistructured interview for this study, I used member checking to review a summary of responses with each participant to determine if my interpretations reflected their responses (Doyle, 2007). I noted which summarized responses were satisfactory to each participant while correcting errors for accuracy (Doyle, 2007).

Furthermore, with phenomenological studies, interviewing starts with casual conversation or a short reflective activity (Moustakas, 2014). Casual conversations or short reflective activities aim to develop a comfortable and trusting environment or atmosphere (Moustakas, 2014). As the researcher and interviewer, it was my responsibility to develop a climate in which each research participant feels comfortable and willing to respond comprehensively and honestly to each interview question.

Methodology

Participant Selection Logic

The population for this study were U.S. women veterans diagnosed with posttraumatic stress disorder and living with their immediate families. Purposive sampling enabled to simultaneously collect and analyze data (Mack et al., 2005). My use of a purposive sampling strategy that focused on exemplification or similarity (e.g., representativeness or comparability) also allowed me to decipher occurrences that are characteristic of a specific kind of circumstance relevant to this study (Teddlie & Yu,

2007). In regard to the sample number for this study, my goal was to initially recruit five participants (see Creswell, 1998). Saturation determined the number of participants needed once I collected enough data that supported all research questions.

An alternative sampling method to purposive sampling was snowball sampling. Snowball sampling is often considered as a referral or networking method for recruiting qualitative study participants (Parker et al., 2019). For instance, as the researcher I had the option to invite acquaintances to participate in this study that met the criteria (Parker et al., 2019). Next, I asked each recruited participant for this study via the snowball sampling method to recommend potential study participants who also fitted this study's criteria (Parker et al., 2019). When using the snowball sampling method, it must be repeated until saturation is attained or enough data has been collected to support all research questions (Parker et al., 2019).

Participants were recruited via social media and or distribution of flyers at community-based agencies that provide services to veterans in Florida. Each participant in this study met the criteria by answering "yes" to five questions. Each participant was contacted post their initial contact with me via phone and or email within 24 hours. I addressed each participant's questions regarding the processes. For example, I reviewed and addressed all questions to the best of my knowledge regarding relevant documents (e.g., confidentially and permission forms) and the use of an audio recording device during the semistructured interviews. As an incentive for participating in this qualitative phenomenology study and per approval of Walden University's IRB, I provided a total of $20.00 dollars via gift cards pre- and post-conducted semistructured interviews to each

volunteer participant. To avoid selecting gift cards that some participants may have had no interest in or a need for, I opted for bank gift cards.

Eligible and consenting participants received an informed consent form to review and sign prior to individual interview sessions I scheduled the semistructured interviews in advance (e.g., 1–2 weeks prior to appointments), sent reminders of telephonic or in-person scheduled interviews depending on social distancing restrictions relative to pandemic management, within 24 hours via email and or approved text messaging. Emails between myself and each study participant included confirmed contact information, and telephonic appointment times.

Instrumentation

Collecting data for phenomenological research studies typically involves interviews, with questions containing personal significance ad meaning (Moustakas, 2014). As the researcher for this study, I developed a semistructured interview guide or data collecting instrument for this study (see Appendix A). Each of the semistructured interview questions provided in the interview guide were open-ended questions that provided data that supported the research questions for this study. Open-ended questions generate relevant and expressive responses to research questions that are exact and carefully worded (Given, 2012). The method of semistructured interviewing provided for comprehensive face-to-face question and answer sessions (DiCicco-Bloom & Crabtree, 2006). There is no specific or required range of participant responses to semistructured interview question, but it is recommended that researchers develop and utilize a semistructured interviewing guide (Given, 2012).

Researcher Developed Instrument

I developed 10 questions for the semistructured interview sessions that were used to collect data (see Table 1), as recommended by Cohen and Crabtree (2006). According to Cohen and Crabtree, structured interviews provide study participants with the opportunity to express their living experiences openly. I aligned each interview question with the research questions for this study. Semistructured interviews provides researchers an opportunity to manage the process of obtaining information from each participant or interviewee while following new potential leads (Bernard, 1988).

Table 1

Semistructured Interview Questions for Research Questions

RQ 1: What are the lived experiences of U.S. women veterans diagnosed with posttraumatic stress disorder post- deployment?	1. What branch of the United States military did you serve and why did you select that branch?
	2. How long did you serve in the military and what events and or circumstances led to your retirement or separation from the military?
	3. What events and or circumstances initiated your receiving a posttraumatic stress disorder diagnosis from a licensed mental health professional?
RQ 2: How do U.S. women veterans perceive the impact of their posttraumatic stress disorder on their immediate families post-deployment?	1. Could you please share or highlight 2 -3 experiences on how your posttraumatic stress disorder diagnosis has impacted your immediate family (e.g., spouse and or children)?
	2. What are common practices that you and your immediate family utilize to manage challenges involving the effects of your posttraumatic stress disorder diagnosis?
RQ 3: What are the experiences of U.S. women veterans' access to mental health care services?	1. Were you able to receive clinical treatment (e.g., counseling and or prescribed medication) post receiving your posttraumatic stress disorder diagnosis and if so, when did your treatment begin?
	2. If you answered yes to question 1., did you receive mental health care services from the licensed mental health professional that diagnosed you with posttraumatic stress disorder or another mental health professional and how long did mental health care services last if applicable? Proceed to question 4.
	3. If you answered no to question 1., what events and or circumstances prevented you from receiving mental health services post receiving your posttraumatic stress disorder diagnosis? Proceed to question 4.
	4. If any, what are some improvements you would like to see regarding access to mental health care services for U.S. women veterans?

Content validity is the degree to which testing items are equitably characteristic of the complete domain a testing instrument aims to measure (Salkind, 2010). For this study, the content validity was associated to the semistructured interview questions for data collection. According to Moustakas (2014), an individual's initial report of their life experiences is what generates valid phenomenological research. According to Moustakas (2014), important principles in phenomenological research include epoche, imaginative variation, phenomenological reduction, and synthesis. To expand, epoche are things that cannot be felt to be known without inner reflection and meaning or felt to be known in advance (Moustakas, 2014). Only an individual's perception can point to their truth (Moustakas, 2014). Phenomenological reduction describes what an individual sees internally and externally, notably the relationship between self and phenomenon (Moustakas, 2014)

Procedures for Recruitment, Participation, and Data Collection

For the sample of this study, my goal was to recruit U.S. women veterans who have been diagnosed with posttraumatic stress disorder (post-deployment) by a licensed mental health professional. According to Creswell (2015), recruiting a few individuals works best for phenomenology studies. Procedures for recruitment included connecting with U.S. women veterans via social media platforms such as Facebook. I also utilized the social media platform, Facebook social media platform to recruit study participants, and or distribution of flyers at community-based agencies who provided services to veterans in Tallahassee, Florida. Demographically, participants recruited for this study

had an immediate family that included (but not limited to) a spouse and a child. According to Leon County Veterans Services (2016), the most recent Department of Veterans Affairs report indicated that there is a population of 19,195 veterans residing in Tallahassee, Florida. My initial communication included an email and phone call to each volunteer for this study. I requested that each volunteer for this study contact me via phone or email to complete a confidential screening and to discuss their informed consent for participation. Initial communication with each volunteer established if they were eligible for this study. When the volunteers were determined eligible for this study, I requested signed and dated copies of their informed consents. Due to the Covid-19 pandemic, each volunteer had the option to digitally sign their informed consents or return them to me in a stamped envelope, where I would provide a mailed informed consent. Once I have obtained and secured each volunteer signed informed consent, I followed up via email and phone to schedule their semistructured interview appointments. I also provided each volunteer with a digital copy or mailed copy of their informed consent.

I digitally recorded each participant's responses to the semistructured interview questions in order to collect data (see Appendix A). The number of interviews completed depended on when saturation was attained. Duration of data collection lasted half an hour to an hour for one interview per each participant. According to DiCicco-Bloom and Crabtree (2006), semistructured interviews can last for thirty minutes or longer. The semistructured interviews or data collection for this study, occurred telephonically. The follow-up plan in case recruitment resulted in too few participants, would have involved

my redistributing additional flyers via local United States veteran community-based agencies and social media platforms.

I also debriefed each participant at the end of their semistructured interview. During the debriefing, I encouraged each participant to utilize their free mental health services that are offered by the United States Department of Veterans Affairs 24 hours and 7 days a week should they experience any distress (United States Department of Veterans Affairs, 2020. In addition, I performed the process of member checks. For example, I provided each study participant with a verbal summary of their responses to check for accuracy immediately following their interview session. According to Kornbluh (2015), member checks are a trustworthy process for researchers to identify their biases in order to endorse truthfulness or accuracy when describing participants' lived experiences. Lastly, each participant was provided with the results of this study per their request.

Data Analysis Plan

I utilized NVivo Software (QSR International, 2021) to analyze, transcribe, and code all data collected during the semistructured interview sessions connected to each research question for this study (see Table 1). NVivo is a computer-assisted software developed by QSR International (CAQDAS) that analyses and codes qualitative data by transcribing uploaded audio files (Wong, 2008). To establish sufficiency of data, utilizing NVivo Software I conducted a continuous comparative analysis of all data themes and codes (QSR International, 2021) that correlate with each interview question. MPEG Audio Layer 3 (MP3) recordings were collected via a digital audio recorder and uploaded

to NVivo for transcription. A MP3 is a form of digital audio compression that substantially minimizes an audio file's size (Meyers, 2020).

In addition, data analysis or organization of interview data involved processing all transcribed interviews and study of the materials through phenomenal analysis (Moustakas, 2014). For instance, data analysis consisted of my horizontalizing all the data (Moustakas, 2014). By horizontalizing data derived from each semistructured interview, every statement (or horizon) relevant to the research questions have equal value (Moustakas, 2014). Regarding the horizontalized responses, units of meaning were listed. Units of meaning are grouped into similar themes or categories. Overlapping and repetitive themes and categories were removed (Moustakas, 2014). Grouped themes and meanings were used to construct textural descriptions of each participant's experiences (Moustakas, 2014). Lastly, structural descriptions and an integration of textures and structures into the meanings and essences of the phenomenon, were constructed from the textural descriptions (Moustakas, 2014).

In regard to discrepant cases or responses for data analysis, I applied Collaizzi's (1978) descriptive phenomenological method to analyze the data collected from the digital audio recordings of the semistructured interviews for this study. Collaizzi's (1978) descriptive phenomenological method consisted of seven steps. They are familiarization of data, identifying significant statements in data, formulating the data, clustering data, developing an exhaustive category for data, producing the fundamentals of data, and seeking verification of the fundamental structure of data (Collaizzi, 1978).

Issues of Trustworthiness

Credibility

Credibility is the sureness in the accuracy of a study's results (Lincoln & Guba, 1985). In qualitative research, trustworthiness and transparency are critical in regard to utilization and integrity of each study's results (Cope, 2014). According to Lincoln and Guba (1985), trustworthiness is based on credibility, transferability, dependability, and confirmability. Strategies to establish credibility or internal validity for this study included triangulation, prolonged contact, member checks, saturation, reflexivity, and peer review (Lincoln & Guba, 1985). Triangulation involves using several data sources in order to generate understanding (Lincoln & Guba, 1985). Prolonged contact or engagement requires spending necessary time to attain knowledge of the phenomenon that is being studied (Lincoln & Guba, 1985). Member checks is the practice of testing data such as analytic categories, interpretations and conclusions with each research participant (Lincoln & Guba, 1985). According to Lincoln and Guba (1985), member checking is the most critical component of establishing credibility.

According to Malterud et al., (2015), saturation can be achieved by determining the conclusive number of study participants. For instance, saturation occurs when researchers no longer obtain data that increases or supports the developed theory (Malterud et al., 2015). In regard to saturation, researchers are to perform a data analysis on all remaining data and construct preliminary results (Lincoln & Guba, 1985). Reflexivity in research is the practice of attending methodically to the framework of knowledge construction (Lincoln & Guba, 1985). Lastly, peer review or debriefing is a

method of exposing oneself to an unbiased peer in order to explore a study's analytical perspective, while determining if the study's findings were implicit within the researcher's school of thought (Lincoln & Guba, 1985).

Transferability

For this study, transferability or external validity demonstrated that the findings can be applied in other frameworks (Lincoln & Guba, 1985). An appropriate strategy that was used to establish transferability for this study is thick description (Lincoln & Guba, 1985). Thick description involves detailing a phenomenon in adequate detail (Lincoln & Guba, 1985). Details of a phenomenon are than used to assess the scope to which the assumptions are transferable to multiple people, circumstances, and times (Lincoln & Guba, 1985).

Dependability

Dependability or the qualitative counterpart to reliability, demonstrated that this study's results are reliable and can be recurring (Lincoln & Guba, 1985). An appropriate strategy that was used to establish dependability for this study along with triangulation, were audit trails (Lincoln & Guba, 1985). Audit trails or external audits consist of non-acquainted researchers assessing both the method and product of a research study (Lincoln & Guba, 1985). The purpose for audit trails is to assess the accurateness and to determine if a study's results, analyses, and assumptions corroborate its data (Lincoln & Guba, 1985).

Confirmability

Confirmability or the qualitative counterpart to objectivity, is a degree of neutrality (Lincoln & Guba, 1985). For example, confirmability demonstrated how this study's results were formed by the respondents opposed to the researcher's predisposition, incentive, or appeal (Lincoln & Guba, 1985). Similar to establishing credibility, strategies used to establish confirmability include triangulation and reflexivity (Lincoln & Guba, 1985). Much like establishing dependability, audit trails are also used to establish confirmability (Lincoln & Guba, 1985).

As an intra-coder or the only person that will be coding all data for this study, it was imperative that I refrained from any judgement involving all participants throughout the course of this study. A coder's judgments regarding study participants' behaviors or other phenomena such as gender stereotypes, often vary during the collection of data (Lewis-Beck et al., 2004). According to Lewis-Beck et al. (2004), intra-coder reliability offers an estimation of relative consistency of judgments within a coder over a period of time. In addition, intra-coding evaluates the extent of inconsistency such as measuring errors that result from noise, mood, fluctuation, and fatigue over a period of time (Lewis-Beck et. al, 2004).

Ethical Procedures

In research, ethical practices involve Institutional Review Board (IRB) approval prior to data collection (Creswell, 2014). I applied to the Walden University IRB for permission to collect data for this study. Ethical practices are critical when conducting scientific inquires that involve vulnerable and non-vulnerable human participants.

Walden University (2017) has that identified women veterans diagnosed with posttraumatic stress disorder are deemed as emotionally disabled persons.

It is imperative that all researchers understand the benefits and risks that are affiliated with vulnerable populations, such as individuals living with a clinically diagnosed mental illnesses (Weitlauf, 2007). Since this study involved vulnerable and volunteer human participants, each participant was provided a secured consent form approved by Walden University's IRB that includes a risks and benefits section. The consent form for this study will included information explaining that each participant can exit the study at any time. To protect each participant's identity, their identity remained anonymous and aliases were assigned to reduce potential risks. In addition, I provided secured letters of cooperation to administrative personnel via United States veterans community-based agencies in the state of Florida, that assisted in recruiting volunteer study participants and distribute flyers via social media platforms. Next, I submitted each letter of cooperation to Walden University's IRB. Once each letter of cooperation was approved by the IRB, I recruited participants for this study.

In research, ethical practices and trustworthiness are essential and critical counterparts pertaining to integrity (Connelly, 2016) and adverse events may develop. To manage predictable adverse ethical implications during the course of this study such as the slip of a participant's name, I protected their anonymity by collecting data during telephonic or online semistructured interviews in the privacy of my home office. For face-to-face interviews if social distancing was lifted, semistructured interviews would have been facilitated at locations such as a public library meeting room approved by

Walden University's IRB. If a study participant experienced or expressed distress during the course of this study, I reminded them that they can end their participation at any time and provided them with contact information for the Veterans Crisis Line and chat option. In addition, it was imperative that each participant could articulate their experiences (Connelly, 2016) during their semistructured interview. For instance, the eligibility sections of the consent form for this study indicated that participants must be able to articulate their responses to each question.

Data security is an important issue that can affect ethical practices (Connelly, 2016). To prevent security risks of data collected for this study, I was the only one that had access to all data. In addition, all collected data was stored via a password secured laptop and I only utilized online platforms that were authorized by Walden University's IRB to collect and store data. All data for this study will be destroyed no later than five years post the publication of this study. Another potential ethical issue involved my collecting data at my home office opposed to a secured office location. In response, I stored all related study materials such as audio recording devices, password protected data storage devices, and related documentation in a locked file cabinet.

Summary

Chapter 3 provided the research design, the role of the researcher, the methodology, and issues of trustworthiness. The research design section provided this study's research questions and a background on the phenomenology. The role of the researcher section focused on how semistructured interviews will be facilitated and the responsibilities of the researcher. In the methods section of this chapter, participant

selection logic, instrumentation and the recruitment strategy, target population, data collection methods, and data analysis were each discussed. Lastly, issues of trustworthiness involving ethical practices and concerns were addressed in Chapter 3. In Chapter 4, I provide this study's findings based on the methodology discussed in Chapter 3.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to explore the lived experiences of U.S. women veterans living with posttraumatic stress disorder (PTSD) and how they perceived the impact of their diagnosis on their immediate families postdeployment. The research questions addressed this purpose in addition to participants' experiences with access to mental health care. Chapter 4 presents the findings including the superordinate and subordinate themes derived from the data analysis, the setting and demographics for this study, and the collected and analyzed data.

Setting

Due to the COVID-19 pandemic, the semistructured interviews for this study were conducted over the phone (World Health Organization, 2022). Participants in this study appreciated the telephonic semistructured interviews for the safety of themselves and their loved ones during this COVID-19 pandemic. None of the participants reported concerns, issues, or conditions regarding COVID-19 or other events that influenced their overall experiences at the time of this study. Furthermore, there were no reports of any stressful or traumatic events that could have influenced each participant's interpretation of this study.

Demographics

The participants for this study were four African American U.S. women veterans and one biracial U.S. woman veteran, all from the state of Florida (see Table 2). Four participants are U.S. Army veterans and one participant is a U.S. Navy veteran. Each participant met the qualitative phenomenology study's criteria, having retired from their

military branches, having a postdeployment PTSD diagnosis, having immediate family members, and willingness to share their unique experiences accessing mental health care services. To preserve anonymity, each participant was given an identification English alphabet letter that was paired with the qualitative data derived from their semistructured interviews.

Table 2

Demographics of the Participants

Participant	Race	Branch	Years served	Immediate family members
A	African American	Navy	Reservist	Husband, One Child
B	African American	Army	Four Years	Two Children
C	Bi-racial	Army	Three Years	Widowed, Four Children
D	African American	Army	Five Years	Divorced, Two Children
E	African American	Army	Four Years	Birth Parent

Data Collection

The data collection for this qualitative phenomenology study was initiated immediately after attaining Walden University's Institutional Review Board (IRB) approval. Recruitment for participants included posting and sharing a Walden University IRB approved flyer via emails sent to community-based program administrators that serve Florida resident veterans and on various U.S. women veterans Facebook group pages, the majority of which are private groups. I opted to recruit participants using the snowball method as an alternate to a purposive method as mentioned in Chapter 3 due to slow responses, no interest responses, and not having sought use of Walden University's participation pool. Snowball sampling rendered me greater success for recruiting

participants, as it allowed for time-sensitive networking and referral methods (Parker et al., 2019).

Once participants were recruited and consent forms were fully signed, collected, and shared via email, I scheduled interviews with each participant telephonically. I used a semistructured interview guide (see Appendix A) for each telephone interview. Each interview was done on speaker and recorded on a password protected laptop recorder. Each interview was also recorded via a password-protected MP3 digital recorder as backup. The semistructured interviews lasted between 5 and 17 minutes and were conducted in my private study. Each participant completed their semistructured interview in the comfort of their personalized setting. Each participant also answered each applicable question from the semistructured interview guide (see Appendix A) in great detail and compassion as they related their life experiences with their responses.

The audio files for each semistructured interview were uploaded to NVivo for transcription. Each transcript was checked for errors and then analyzed for common themes. There were no technical or environmental disruptions during the semistructured interview sessions. There were no variations in the data collection as presented in Chapter 3, nor any unusual circumstances encountered during data collection to report for this qualitative phenomenology study.

Data Analysis

Through phenomenal analysis, MP3 recorded audio files for each semistructured interview were transcribed and analyzed using NVivo, which aided in establishing adequate data while conducting a continuous comparative analysis of all data themes and

codes that correlate with each interview question. I coded for similar phrases and words that I deemed significant or common per each unique transcript. This process is called open coding or analytical coding, which is a process for researchers to seek consistent information or responses from data, that present superordinate themes (i.e., immediate family members) and subordinate themes (i.e., sexual assault during active duty; Creswell et al., 2007). While determining superordinate and subordinate themes, I also determined saturation by confirming correlation between each superordinate and subordinate theme and the research questions for this qualitative phenomenology study.

Coding Procedures

With NVivo, I was able to determine key phrases and words derived from each participant's semistructured interview. These key phrases and words were identified as superordinate themes, subordinate themes, and codes based on their comparations and principal inferences. Using the process of horizontalizing all the data derived from each semistructured interview, every statement (or horizon) that was relevant to the research questions and shared equal value were abstracted (Moustakas, 2014). In addition, units of meaning were grouped into comparable themes or categories. Repetitive and overlapping categories and themes were removed (Moustakas, 2014). I utilized grouped meaning and themes construct textural descriptions according to each participant's experiences (Moustakas, 2014). Lastly, constructed from textural descriptions, structural descriptions and an integration of textures and structures into the meanings and essences of the phenomenon were analyzed (Moustakas, 2014). The derived superordinate themes and subordinate themes were based on the key concepts provided in Chapter 2: (a)

posttraumatic stress disorder diagnosis, (b) the effects of posttraumatic stress disorder on U.S. women veterans and their immediate family members, and (c) access to mental health care services for U.S. women veterans.

Quotes from each participant's semistructured interview were analyzed per each theme. Key words that emerged from quotations, emphasized the importance of how similar each participants responses were in the semistructured interviews and aligned with the themes and research questions (see Table 3). There were no discrepant cases or nonconfirming data founded during the analysis of this study. The Results section of this chapter provides a more in-depth analysis of the each identified superordinate theme, subordinate themes, and codes.

Table 3

Research Questions, Superordinate Themes, and Subordinate Themes (Codes)

Research Questions		
RQ1: What are the lived experiences of U.S. women veterans diagnosed with posttraumatic stress disorder postdeployment?	RQ2: How do U.S. women veterans perceive the impact of their posttraumatic stress disorder on their immediate families postdeployment?	RQ3: What are the experiences of U.S. women veterans' access to mental health care services?
Superordinate Themes		
Participants A, B, C, D, E	Participants A, B, C, D	Participants A, B, C, D, E
posttraumatic stress disorder diagnosis (PTSD)	U.S. women veterans experienced effects of posttraumatic stress disorder on themselves and their immediate family members	Access challenges to mental health care services for U.S. women veterans
Subordinate Themes (Codes)		
Participants A, B, C, D, E	Participants A, B, C, D	Participants A, B, E
History of traumatic events during active duty (i.e., sexual assault)	Communicative challenges, elevated verbal exchanges/angry outbursts with immediate family members	Lengthy process of claims to begin Veterans Affairs mental health services
Participants A, B, D		Participants B, C, D
Anxiety/panic attacks		Difficulty rescheduling therapy sessions and/or distractable teletherapy sessions due to the Covid-19 pandemic
Participants A, C		Participant E
Prescription medication to treat PTSD symptoms		Denied VA mental health care services due to peacetime service
		Participants A, B, C, D, E
		Desire for improved U.S. women veterans' mental health care services

Evidence of Trustworthiness

Credibility

Credibility was achieved by triangulation, prolonged engagement, member checks, saturation, reflexivity, and debriefing. Data for this qualitative phenomenology study were collected via telephonic and recorded semistructured interviews. Each participant responded to each question listed in the interview guide (see Appendix A). Triangulation and prolonged engagement involved my review of data sources that provided the basis and general understanding of the phenomenon being studied (Lincoln & Guba, 1985). Member checks consisted of my analyzing categories and reviewing conclusions (i.e., semistructured interview responses) with each participant (Lincoln & Guba, 1985). This addressed research bias and helped determine saturation of data for this study (Malterud et al., 2015). The next step in establishing credibility was reflexivity, which consisted of my determining if the data for this study methodically aligned with the framework (Lincoln & Guba, 1985). Lastly, debriefing involved my reviewing the free mental health services that are provided by the U.S. Department of Veterans Affairs 24 hours and 7 days a week, with each participant should they experience any distress (U.S. Department of Veterans Affairs, 2020).

Transferability

Transferability may not be possible due to the nature of this study and its participants, but its results may certainly inform future research, especially relating to women of color who are vets with PTSD. Likewise, the ample details of this study's

phenomenon were utilized to assess the scope of assumptions and are transferable to further research. For example, further research that involves retired U.S. police women living with a PTSD diagnosis and the effects of their PTSD diagnosis on their immediate family members. However, researching a larger population of U.S. women veterans and or the inclusion of United States male veterans living with a PTSD diagnosis, with their immediate family members can possibly affect transferability.

Dependability

Dependability for this qualitative phenomenon study indicates that the results are reliable and can be reiterated (Lincoln & Guba, 1985). For instance, paired with triangulation and member checking each participant's responses to their semistructured interview questions, an audit trail conducted by Walden's University IRB (e.g., non-acquainted researchers) assessed the qualitative method and product of this study (Lincoln & Guba, 1985). In addition, the audit trail assessed if this study's results, analyses, and assumptions, validated its data (Lincoln & Guba, 1985).

Confirmability

As mentioned in Chapter 3, confirmability is an aspect of neutrality (Lincoln & Guba, 1985). For example, confirmability was demonstrated for this study by my neutrally analyzing the results (or findings) for this study based on each participant's responses. In addition, triangulation paired with reflexivity and an audit trail aided in my establishing confirmability (Lincoln & Guba, 1985). Next, as an intra-coder (e.g., the only person coding data for this study), I refrained from judgement involving all participants throughout this study (Lincoln & Guba, 1985). Lastly, the role as an intra-

coder allowed me to evaluate inconsistencies that result in measuring errors, such as a participant's mood change during their semistructured interview (Lewis-Beck et. al, 2004).

Results

Superordinate themes and subordinate themes (codes) were compared among the semistructured interview transcripts of the five participants in order to determine similarities and dissimilarities in their responses in regard to the three research questions for this qualitative phenomenal study. The emerged superordinate and subordinated themes derived from the analysis results supported each research question. The superordinate themes that emerged from each participant's semistructured interview provided significant understandings on the perceived impact of each participant's experience living with a posttraumatic stress disorder diagnosis (PTSD) and the effects their PTSD diagnosis had on their immediate families postdeployment. In addition, the subordinate themes stipulated in-depth details of each participant's experiences accessing Veterans Affairs (VA) mental health services. Additionally, quotes from each participant's semistructured interview transcript that supported this study's research questions, superordinate themes, and subordinate themes (codes) were included to personify their lived experiences.

RQ 1: What are the Lived Experiences of U.S. Women Veterans Diagnosed with PTSD Postdeployment?

The emerging superordinate theme is posttraumatic stress disorder diagnosis (PTSD), which Participants A, B, C, D, and E identified with. The emerging

subordinate themes (codes) were (a) history of traumatic events during active duty such as sexual assault, (b) anxiety and panic attacks, and (c) prescription medications to treat PTSD symptoms. Participants A, B, C, D, and E identified with history of traumatic events during active duty such as sexual assault.

Subordinate Theme: History of Traumatic Events During Active Duty

Regarding the tremendous pressure and stress due to rigorous scheduling during active duty that led up to her PTSD diagnosis, Participant A stated,

> I almost fell asleep driving at the wheel at one point, um, in the military we have watches. They're twenty-four-hour watches, in conjunction with our job and in having PT [physical training] like 5:00 in the morning. So, I was just really, really tired.

Regarding Participant B's PTSD diagnosis, she stated, "I served four years and I got out due to me being assaulted when I was in." When sharing on her experience retiring from the U.S. Army via the early out option for classified reasons and the overwhelming stress during 3 years of active service that led up to her PTSD diagnosis, Participant C stated, "I was kind of shocked, but not surprised" when she was diagnosed with PTSD. Participant D opted not to disclose what led to her PTSD diagnosis. However, Participant D did express how depression is one of her primary symptoms of PTSD post separation from the U.S. Army. Participant E stated the following regarding traumatic events during active duty that contributed to her PTSD diagnosis:

> Some of us [U.S. women veterans] may feel that the military has done more damage than just physical, physical, um, physical damage to us or whatever. So, we go to look for benefits from the military, from the VA.

Subordinate Theme: Anxiety/Panic Attacks

Participants A, B, and D identified with anxiety and panic attacks. When discussing her initial experiences with anxiety and panic attacks associated with her PTSD diagnosis, Participant A shared,

> The worst situation I had was December of last year [2020]. I was in the emergency room and one month, I went to the emergency room six times. And at one point we didn't know that was my first time having a panic attack. And it was so bad we didn't. And I kept having them, but we didn't know what was wrong with me. And I honestly didn't think it was a panic attack. I thought something was really wrong with me...Oh yeah. Um, one is my daughter now, I had when I was pregnant, I had two anxiety attacks. One happened when I was driving and I happened to be by myself and I felt like I couldn't breathe again. And luckily, by the grace of God, it was a hospital on the next exit. So, I just called my best friend to try to meet me. I didn't want to call my husband to, like, make him nervous because he has been through this with me and he knows, you know. I knew he would be panicky; you know me being pregnant. So, I was able to go to the hospital, check myself into the emergency room again. They told me everything was fine. It was just a panic attack.

Participant B shared the following during her semistructured interview regarding her PTSD diagnosis and presenting symptoms (e.g., panic attacks), 10 years after she retired from the U.S. Army,

> So, my PTSD did not present itself right away. But I started noticing, like, I didn't like closed-in spaces with majority males, like in my personal space. I didn't like going places where it's crowded, certain things like that. Or I was irritable. I was easy to anger. I started having flashbacks. Certain smells brought back memories. So, it was something my mind was just underlined that I didn't notice that first and I couldn't stay on a job long. If the job was majority males, I didn't feel comfortable. I started hyperventilating. I had panic attacks. And so that's when I said, you know what. Something's going on here and that's when I was diagnosed with severe PTSD.

Participant D shared the following regarding anxiety she experienced, a symptom of her PTSD diagnosis, after separating from the United States Army, having served two deployments within five years,

> I was having a lot of anxiety, didn't really understand what it was. My sister who is in the health care field, kind of told me that I needed to go see somebody and explain to me exactly what anxiety is and PTSD was.

Subordinate Theme: Prescription Medication to Treat PTSD Symptoms

Participants A and C identified with prescription medication to treat PTSD symptoms. Participant A shared the following during her semistructured interview on prescribed medications to treat her PTSD symptoms:

> Okay, so they (VA) do prescribe medication. They (VA) prescribe multiple medications. But I just opted not to do that. And the reason being was, because I think December [2020] was really rough for me, because the medications when it comes to PTSD is trial and error. So sometimes it can be, one of the medications I know they try to put me on was Xanax, and I just knew Xanax. What it did to other people. I opted out, after trying two. I don't remember the name of the other two. I just stopped. And I was like, okay, I'll just take a holistic approach and just do the therapy.

Participant C shared the following during her semistructured interview on prescribed medications to treat her PTSD symptoms,

> I think that I'm the only person that's really trying to handle the effects of it (regarding her immediate family members). And I think that they're (the VA) trying to manage mine with medications.

RQ 2: How do U.S. Women Veterans Perceive the Impact of Their PTSD on Their Immediate Families Postdeployment?

The emerging superordinate theme is “U.S. women veterans experienced challenging and negative effects of posttraumatic stress disorder on themselves and their

immediate family members" and participants A, B, C, and D identified with this theme. Followed by the emerging subordinate theme (code), (a) communicative challenges such as elevated verbal exchanges and angry outbursts with immediate family members.

Subordinate Theme: Communicative Challenges

Participants A, B, C, and D identified with communicative challenges such as elevated verbal exchanges and angry outbursts with immediate family members. Participant A shared the following regarding her communicative dynamic with her father and husband while living with a PTSD diagnosis postdeployment,

> My father has one hundred percent PTSD and he and I do not have a relationship because of his decision to pursue his military career. So, I never wanted that to happen to me (reflecting on her decision to have a family post her military career while living with a PTSD diagnosis) ...We (she and her husband) talk more. I talk a lot more. Before I was like super private about a lot of things about work or just things that bother me. I'm a type person that always care about helping other people and not so much myself. But now I speak up and open up; we talk more just about my day or anything that's going on, and then we just; we also do things like take walks. Like I get out of the house. Like we try to take my mind off of whatever happened throughout the day that I had myself consumed on, like, you know, just getting worked up on one event. So, I try to just have myself spread thin through, through other activities. I love to work out, but that's part of the reason why I work out, it's the outlet for me. So, I just

> keep myself busy. And then communication. And then just continue to do my therapy.

Participant B shared the following regarding her family communicative dynamic while living with a PTSD postdeployment,

> When we're, when we're having disagreements, they know to give me my space. They know not to do certain hand motions in my face, because I feel like you're attacking me. And I'll fold you up in three point four seconds. If I tell you, you know, I need a break from my kids because I just need to mentally let down. We do long road trips. We do weekly park visits where I could just get away and just enjoy nature and just want to clear my mind. Every other weekend, someone is coming to the house to get the kids to give me that me time. They know if they call my phone and I don't answer, I send them a text. You know, I'm not with it today. I don't want to be bothered pretty much. They just respect my boundaries and they respect my voice because sometimes your family, they're so; when you go into the military, you go being a person they known their whole life. And when you come home, you may not be that same person, because a lot of things going on in the military that people don't tell you, because it's not just the commercial that makes people want to enlist. That's not, that's not a military. That's a fairytale side. But you deal with real-life situations and real-life issues. And it's just when you come home, they have to be able to accept that you're no longer the same and it's not a bad

> thing. But for people that are just close minded, they don't want to accept change; it becomes, it becomes a struggle. And you will find yourself not even wanting to be around your family because they are triggers to your PTSD.

During her semistructured interview, regarding the effects PTSD has on her family communicative dynamic postdeployment, Participant C shared the following,

> I think that it (PTSD) has made my immediate family more distant due to arguments. Arguments within the family. You know, I think one of my children has been born with some kind of PTSD; anger management issues.

Participant D shared the following regarding the impact her PTSD diagnosis has on her immediate family members postdeployment,

> So, for my family, I would say that sometimes interacting and doing things outside of my immediate family was impacted because I didn't feel like doing things or being around people. And when your family is used to you being around them, and you automatically withdraw, that’s a red flag for them and that affected them. Another, another affecting my family would have, is probably the yelling and screaming from getting so worked up and not knowing how to work through that. So that would be an immediate effect that it had on my family because I learned how to work through that and learn how to not get so anxious all the time, so very quickly. And that they were negatively affected by, my kids, particularly.

RQ 3: What are the Experiences of U.S. Women Veteran's Access to Mental Health Care Services?

The emerging superordinate theme is "there were challenges in accessing mental health care services for U.S. women veterans", and participants A, B, C, D, and E identified with this theme. Followed by the emerging subordinate themes (codes), (a) lengthy process of claims to begin VA mental health treatment, (b) difficulty rescheduling therapy sessions and or distractable teletherapy sessions due to the Covid-19 pandemic, (c) denied VA mental health care services due to peacetime service, (d) and the desire for improved U.S. women veteran's mental health care. Participants A, B, and E identified with the lengthy process of claims to begin VA mental health treatment. Participants B, C, and D identified with difficulty rescheduling therapy sessions and or distractable teletherapy sessions due to the Covid-19 pandemic. Participant E is the only one that identified with denied VA mental health care due to peacetime service. While participants A, B, C, D, and E each desired improved U.S. women veteran's mental health care services.

Subordinate Theme: Lengthy Process of Claims to Begin Veterans Affairs Mental Health Services

Participant A shared the following regarding lengthy process of claims to begin VA mental health treatment postdeployment,

> It takes a while for your claim to be completed. So, when I was doing those therapy sessions I've taken, I paid for that because my claim didn't actually complete until the next year. So, it just took a really long time for

> my claim to be processed. I started my claim [prior to the therapy sessions] when I came back from [overseas].

Participant B shared the following regarding her claims experience prior to accessing VA mental health services postdeployment,

> Well, when I first went to submit a claim, anything that you do through the VA, you have to do a claim. It has to be documented. You have to provide the proper documentation that backs up your story. And so, I went down to our local VA office and I told my story to one of the representatives and filled out the forms. And I think within four months I had my first psych eval. And due to Covid, they actually did a Zoom call. So, it's called my um, my VA dot com, my vet VA dot com. Like, it's like a doctor website that you do your messages and stuff on. And so, I did that and then they did my eval over like Skype like. So, we did that. And after that I think it was probably. Twenty days I started receiving paperwork stating that, you know, I will get this, I was coded this PTSD level and that I would be getting this amount for traumatic stress disorder. And they have to do a lot of background check. And they had to go back into my military or medical records to prove that I was active duty at the time and that my injuries were sustained during active duty.

Subordinate Theme: Difficulty Rescheduling Therapy Sessions and/or Distractable Teletherapy Sessions Due to the Covid-19 Pandemic

In regards to experiencing difficulty rescheduling therapy sessions and or experiencing distractable teletherapy sessions due to the Covid-19 pandemic, Participant B shared,

> Sometimes being heard because, for instance, like a lot of the people there, they're working from home. So, you know, you're trying to have a counseling session and they got to tell you to hold off because they're trying to get their kids situated. They're trying to cook dinner. They're trying to do a lot of things. So, it's like they really weren't paying attention to you because of the pandemic, because they are so lax at home, versus if you were going in the office with them and, you know, you were sitting down doing a one-on-one consultation with them. Their position, it would be a whole lot different. So, I just say that pretty much being heard and being taken seriously, because if you don't say, you know, I'm having thoughts of suicide or, you know, I'm having thoughts of killing somebody that they um, they really don't take it seriously.

Participant C shared that it is difficult for her to reschedule therapy sessions with VA mental health services. Participant D shared the following regarding barriers scheduling and accessing virtual (teletherapy) sessions with VA mental health services in comparison to in-person therapy sessions with VA mental health services,

> So current state, they (VA mental health services) do more virtual appointments now, based off the pandemic. Well so, before that was a bit of a deterrent, a barrier trying to get to those appointments. So, if they continue to do those electronic appointments, I think that would be very helpful for women to be able to access these services... I think for other people, the barrier could be transportation and getting there on time.

Subordinate Theme: Denied VA Mental Health Care Services Due to Peacetime Service

Similar to Participants A and B claims experiences to access VA mental health services postdeployment, Participant E is the only participant in this study that was not eligible for VA mental health services, due to her peace time active duty in the United States Army. Participant E stated the following regarding her discouragement in requesting VA mental health services at the onset of her claims process,

> They wouldn't allow me to do that. I tried. Because I have served in peacetime and you know, this is post war times now. And the people that are coming out and this is, this is only assumption. This is my assumption; you know being in the military. I can only assume that it is fact in the mental; the actual actions of why the person decided not to allow me to take that test. However, the soldiers coming out nowadays are extremely traumatized. You know, they were made to kill and to kill children and women, whomever else over there across the water in Iraq. In peace time,

> you don't do that. So, when I go holler PTSD or test for PTSD, I was immediately told you don't need that.

Subordinate Theme: Desire for Improved U.S. Women Veterans' Mental Health Care Services

Lastly, concerning the desire for improved U.S. women veteran's mental health care services, each participant provided significant feedback during their semistructured interviews. For instance, Participant A shared the following,

> I would like to see more while I'm in the service, while people are in, whether it's the reserves or active duty, that they have therapy as an option, while you're in. The VA is mostly when you separate. And I think to avoid people having these, you know; PTSD can last your entire life. And I mean, especially me now having a child. It was, that was my main concern, was having an anxiety attack or what would happen. So, I just think specifically, especially for Black women, if there could be things that are implemented in our daily workday. A lot of times the military only cares about giving you a medication to get through the job they want you to complete. They need to also take care of people, and you know, that needs to be available to people, not just after the service is done.

Participant B shared the following regarding her desire for improved U.S. women veteran's mental health care services,

> You have to have a female battle buddy. I feel like if it's a female, they need to do an intake with another female, because you don't want to sit

> there and tell a guy how another guy sodomized you and forcefully raped you, and did all these things to you because you're already dealing with mental issues and mental health; and then you're kind of reluctant from having to tell people certain things. You feel awkward. You feel like they're judging you. Then on top of that, you don't know if they smirk or something like that. You automatically feel like they're laughing or they're condoning what happened to you. So, I just say same sex intakes need to be set in stone. And then it's like if you're not comfortable with a site that you, that you're given, they need to listen; and sometimes it's almost like a call center, where we all answer the phone. It's who you talk to.

Concerning her desire for improved U.S. women veteran's mental health care services, Participant C stated, "More personalized and more one-on-one kind of mental health treatment is needed". Likewise, Participant D expressed the need for "after five services" for U.S. women veterans, that are not able to schedule regular business hours in-person or virtual therapy sessions with the VA mental health care services. Lastly, Participant D shared the following regarding her desire for improved U.S. women veteran's mental health care services,

> I say women, but I think all of us (women and men veterans). We, I think everybody should receive at least a minimum of twenty five percent (VA benefits), once they get out. And that's my opinion. It is not just because we serve and we hear, oh, that's because we serve our country. No! We are, once we get into there, we have to be what everybody knows. The

> notion is we've been brainwashed. You know, we have to have our mind transformed over to be soldiers, whether it be peace time or whether it be war time. We have to we have a mindset to be in the United States government, no matter what branch of the military you are in. You have to be trained to serve. You have to be trained to do as you're told. You have to be trained to be a soldier for the United States. And when you come out, there is no going back to quote unquote normal, because your normal is a soldier's mindset. That's your normal. You are a soldier. No matter where you go now. You get out, you know, you're a soldier. That's what you've become. They made you that. So that clashes with regular people (civilians). You know, who are not. Who've never been soldiers. So even in the workplace, you go to work every day. You have a totally different mindset. You do everything in a military manner. And it could be very offensive to people that you work for.

Summary

In summary of this chapter, I presented the analysis and results of this qualitative phenomenology. Data was derived from individual semistructured interview transcripts, with five U.S. women veterans living with at PTSD diagnosis postdeployment. From the participants' responses to the semistructured interview questions emerged three superordinated themes and eight subordinated themes (codes), that supported each research question for study. For the first research questions, the emerging superordinate theme is "posttraumatic stress disorder diagnosis (PTSD)", and participants A, B, C, D,

and E identified with this theme. The emerging subordinate themes (codes) were(a) history of traumatic events during active duty such as sexual assault, (b) anxiety and panic attacks, and (c) prescription medications to treat PTSD symptoms. Participants A, B, C, D, and E identified with history of traumatic events during active duty such as sexual assault.

For the second research question, the emerging superordinate theme is "U.S. women veterans experienced challenging and negative effects of posttraumatic stress disorder on themselves and their immediate family members" and participants A, B, C, and D identified with this theme. Followed by the emerging subordinate theme (code) (a) communicative challenges such as elevated verbal exchanges and angry outbursts with immediate family members.

For the third research question, the emerging superordinate theme is "there were challenges in accessing mental health care services for U.S. women veterans", and participants A, B, C, D, and E identified with this theme. Followed by the emerging subordinate themes (codes) (a) lengthy process of claims to begin VA mental health treatment, (b) difficulty rescheduling therapy sessions and or distractable teletherapy sessions due to the Covid-19 pandemic, (c) denied VA mental health care services due to peacetime service, (d) and the desire for improved U.S. women veteran's mental health care. Participants A, B, and E identified with the lengthy process of claims to begin VA mental health treatment. Participants B, C, and D identified with difficulty rescheduling therapy sessions and or distractable teletherapy sessions due to the Covid-19 pandemic. Participant E is the only one that identified with denied VA mental health care due to

peacetime service. While participants A, B, C, D, and E each desired improved U.S. women veteran's mental health care services.

In addition, quotations were included in this chapter from each participant's semistructured interviews, to personify their experiences living with a PTSD diagnosis post-deployment and the effects their PTSD diagnosis had on their immediate family members. Chapter 4 also provided the setting, demographics, and data collection process for this study. Additionally, Chapter 4 provided the credibility, transferability, dependability, and confirmability regarding the evidence of trustworthiness for this study. In Chapter 5, based on the research questions for the study and the results provided in Chapter 4, I will provide an interpretation of findings, limitations of this study, recommendations, implications, and a conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative phenomenological study was to explore the lived experiences of U.S. women veterans living with posttraumatic stress disorder (PTSD) and their perception of the impact on their immediate families postdeployment. U.S. women veterans who receive a delayed PTSD diagnosis often experience lower disability ratings and fewer treatment benefits, which have resulted in growing anxiety and depression diagnoses (Conard & Armstrong, 2016). The key findings of this study demonstrated the need for improved access to mental health care services for U.S. women veterans living with PTSD postdeployment. This was demonstrated by the three superordinate themes that emerged from the data (a) posttraumatic stress disorder, (b) U.S. women veterans experienced effects of posttraumatic stress disorder on themselves and their immediate family members, and (c) access challenges to mental health care services for U.S. women veterans. The eight subordinate themes that emerged from the data are (a) history of traumatic events during active duty (e.g., sexual assault),(b) communicative challenges such as angry outbursts with immediate family members,(c) lengthy process of claims to begin Veterans Affairs mental health services,(d) anxiety and panic attacks,(e) difficulty rescheduling therapy sessions and/or distractable teletherapy sessions due to the Covid-19 pandemic,(f) prescribed medication to treat PTSD symptoms,(g) denied VA mental health care services due to peacetime service, and (h) the desire for improved U.S. women veterans mental health care services.

Interpretation of the Findings

In this section, I describe what ways the findings confirm, disconfirm, or extend knowledge in the discipline by comparing them with what has been found in the peer-reviewed literature. The interpretation of findings involving the superordinate themes of this study are (a) posttraumatic stress disorder diagnosis, (b) the effects of PTSD on U.S. women veterans and their immediate family members, and (c) access to mental health care services for U.S. women veterans. In addition, I will analyze and interpret the findings in the context of the theoretical framework, as appropriate. Interpretations will not exceed the data, findings, and scope of this study.

Findings Related to U.S. Women Veterans Living with a PTSD Diagnosis

The findings for RQ 1confirmed previous research and was presented in Chapter 2 (Albright et al., 2019; APA, 2020; Farmer et al., 2020; Gaska & Kimberling, 2018; Mankowski et al., 2015). Participants A, B, C, D, and E identified with having a PTSD diagnosis. Participants A, B, C, D, and E identified with history of traumatic events during active duty, such as sexual assault, which led to their PTSD diagnosis postdeployment. In addition, Participants A, B, and D reported experienced anxiety attacks, whereas Participants A and C reported use of prescribed medications to treat their PTSD symptoms. Previous research has indicated that it is probable that the inception of significant health problems begins post entrance military entrance or during active duty (Gaska & Kimberling, 2018). Military traumatic experiences for U.S. women veterans significantly result in PTSD, anxiety, and depression (Albright et al., 2019). U.S. women veterans have reported focusing challenges, panic attacks, and anger management, as

symptoms of their PTSD (Mankowski et al., 2015). Symptoms of PTSD may involve nightmares of traumatic experiences and or flashbacks, accompanied with emotions of detachment from others, depression, rage, and terror (APA, 2020; Farmer et al., 2020). In addition, persons diagnosed with PTSD experience extreme distress and thoughts associated with their traumatic experiences that persist long after their traumatic experiences ended (APA, 2020). Transition from the military for U.S. women veterans, and PTSD symptoms and depression that they endure necessitate considerable adjustment to a civilian lifestyle (Mankowski et al., 2015).

Findings Related to the Effects of PTSD on U.S. Women Veterans and their Immediate Family Members

The findings for RQ 2 again confirmed previous research presented in Chapter 2 (Mankowski et al., 2015; McGaw et al., 2019; Ray and Vanstone, 2009; Yambo et al., 2013; Yan et al., 2013). Participants A, B, C, and D identified with experiencing the effects of PTSD on themselves and their immediate family members. The emerging subordinate theme (code) included communicative challenges, such as elevated verbal exchanges and angry outbursts with immediate family members. Participants A, B, C, and D reported these experiences. Similar research has confirmed that U.S. women veterans' symptoms of PTSD adversely affect family relations, which often results in emotional withdrawal that should be closely monitored by mental health care professionals (Ray & Vanstone, 2009). Also confirmed by this study's findings are research results that indicated how spouses of U.S. veterans characterized their spouses as changed or no longer the person they used to know (Yambo et al., 2016). U.S. women

veterans must adjust to civilian life, which involves constraints of several responsibilities accompanied by their post-traumatic/postwar experiences and often solicits incomplete or defective communication between U.S. women veterans, their partners, and or other family members and friends (Mankowski et al., 2015). U.S. women veterans have conveyed difficulties in their romantic and familial relations (Yan et al., 2013).

Findings Related to Access to Mental Health Care Services for U.S. Women Veterans

The findings for this study presented in Chapter 4, confirmed in thick description what has appeared in previous research and was presented in Chapter 2 (Evans et al., 2019; Hundt et al., 2018; Kotzias et al., 2019; Pyne et al., 2019). In review, this study's third research question reads "What are the experiences of U.S. women veterans' access to mental health care services?" and the emerging superordinate theme is, "there were challenges in accessing mental health care services for U.S. women veterans to mental health care services for U.S. women veterans". Participants A, B, C, D, and E identified with this theme, followed by the emerging subordinate themes (codes) (a) lengthy process of claims to begin VA mental health treatment (b) difficulty rescheduling therapy sessions and or distractable teletherapy sessions due to the Covid-19 pandemic, (c) denied VA mental health care services due to peacetime service, (d) and the desire for improved U.S. women veterans mental health care. Participants A, B, and E shared their experiences of lengthy process of claims, such as waiting for three months to begin United States Department of Veterans Affairs (VA) mental health services. Participants B, C, and D shared challenges with rescheduling therapy sessions or experiencing

distractable moments and possible breach of confidentiality during teletherapy sessions due to the Covid-19 pandemic (e.g., therapeutic Zoom sessions when the therapist pauses the session to verbally redirect their children making noises in the background). Hundt et al.'s (2018) research is confirmed by this study's findings, as their results concur on how substantial hindrances reported by U.S. women veterans included adverse experiences with VA staff and providers, uneasiness with the VA atmosphere, and complications circumnavigating the VA system.

Also, in agreement with this study's findings, Pyne et al.'s (2019) research findings stressed issues with health care access for veterans as follows: (a) being directly billed for mental health care services, (a) lacking coordination care and communication amongst the VA and mental health providers, (c) transportation challenges with traveling to VA facilities for filling of prescriptions, (d) delayed authorizations for mental health care services. Participant E shared during her semistructured interview that she was denied VA mental health care services due to her peacetime active-services. Mattocks et al.'s (2018) qualitative research results agree U.S. women veterans using the Veterans Choice Program (VCP) care found the eligibility conditions confusing and access to care was extremely taxing. Participants A, B, C, D, and E each desired improved U.S. women veterans' mental health care services, such as gender sensitivity during claims processing for VA mental health services and therapy sessions, when history of sexual assault contributed to a PTSD diagnosis.

Correspondingly and confirming Mattocks et al.'s (2018) research findings, numerous U.S. women veterans reported their dissatisfaction with the insufficient

communication of care options among the VHA and non-VHA providers. In agreement with this study's findings, Evans et al.'s (2019) research results coincided on U.S. women veterans' insufficient knowledge regarding their eligibility for VA services, no accessibility to VA mental health care services or facilities, and adverse experiences and perceptions involving poor quality of gender-sensitive care. Kotzias et al.'s (2019) research findings also agreed with this study's findings on the need for improved communication of VHA health care provisions, noting there are multiple opportunities for the VA to explore culture changes that intersect mental health care awareness and social media platforms. Moreover, Ritchie (2019) contended that the administrating policy for accessing VHA health care services are extremely convoluted, as two years of active-duty is obligatory for VA eligibility (Ritchie, 2019). To that end, Hundt et al. (2018) contended that the VA should construct a more patient-centered approach for the care of United States veterans.

Findings Related to Theoretical Framework

The superordinate themes that emerged in the data analysis presented in Chapter 4 were (a) U.S. women veterans living with a PTSD diagnosis, (b) the effects of PTSD on U.S. women veterans and their immediate family members, (c) and access to mental health care services for U.S. women veterans. These findings aligned with Heider's (1944) causal attribution theory (CAT) as a framework, introduced in Chapter 2. As a theoretical framework, Heider's (1944) causal attribution theory (CAT) was effective and supported this study and all three research questions, based on the attributional findings stemming from each participant's responses during their semistructured interviews. In

review, CAT expounds that an individual's emotions and needs are significantly governed by attribution (Heider, 1944). Generally, attribution is a method used for deciphering what information is accumulated and how it is amalgamated to establish a causal belief or perception (Fisk &Taylor, 1991). For example, for various groups of people internationally, variances in PTSD occurrences can be attributed to trauma surrounding the loss of personal or joint assets (Yehuda et al., 2015). Similarly, PTSD for veterans has been linked to numerous risks such as frequent deployments and brain injuries (Hoge et al., 2008; Pietrzak et al., 2010; Reger et al., 2009; Seal et al., 2009; Skelton et al., 2012).

Largely, I believe that the findings of this qualitative phenomenological study contribute to the gap in literature, involving the plight of U.S. women veterans' access to mental health care in general. More specifically, I trust that the findings for this qualitative phenomenological study contribute to the gap in literature on the critical need for gender-sensitive policies in VA mental health and health care services and eliminating delays in posttraumatic stress disorder diagnoses, so that U.S. women veterans can receive time-sensitive mental health care services. I believe that time-sensitive mental health care services for treating PTSD symptoms, would increase the success of U.S. women veterans managing PTSD symptoms resulting from traumatic experiences such as sexual assault, while also addressing the communicative challenges that U.S. women veterans experience with their immediate family members. Lastly, the findings of this qualitative phenomenological study incite the need for improved and progressive

communicative systems, that will alleviate exasperating rescheduling processes concerning mental health appointments for U.S. women veterans.

Limitations

The data for this qualitative phenomenological study derived from the participants' semistructured interview responses, will not be transferable to the generalized population of non-veteran women in the United States, living with a post-traumatic stress diagnosis (PTSD). The nature of this study and its findings exclude women that did not serve in any branch of the United States military (e.g., The United States Marines, The United States Navy, The United States Army, and The United States Airforce), during war or peacetime, living with a PTSD diagnosis and experiencing challenges accessing mental health care services.

Bias in purposive sampling was another limitation, as it cannot be ascertained or controlled (Acharya et al., 2013). Purposive sampling allows researchers to select participants for their studies, instead of recruiting participants randomly (van Manen, 2016). Correspondingly, as the researcher of this study, I governed research bias by applying member checking. The process for member checking allowed me to validate, verify, or assess the trustworthiness of qualitative results (Doyle, 2007).

Another limitation involves potential lack of integrity or truthfulness regarding each study participants' recorded responses during their semistructured interviews. To address integrity and truthfulness at execution for this qualitative phenomenological study, the data collection for this study involved encouraging each participant to reply honestly during their semistructured interview.

Recommendations

The primary goal of this study is to contribute to positive social change in the lives of U.S. women veterans living with posttraumatic stress disorder (PTSD) and their immediate family members. Based on this qualitative phenomenological study's findings, I recommend that future researchers conduct a qualitative, quantitative, or a mixed methods study, on the experiences of U.S. women veterans' access to mental health care services in general. I also believe that future qualitative, quantitative, or mixed methods research findings on the experiences of U.S. women veterans' differential between trauma induced by "friendly" rape and that induced by enemy combat, per this study's participants semistructured interviews and satisfaction surveys responses, will contribute to the gap in literature on the experiences of a generalized population of U.S. women veterans' access to mental health care services. It is also probable that qualitative, quantitative, or a mixed methods study on the experiences of U.S. women veterans' differential between needs of women and men veterans in the mental health treatment space, will hopefully inspire improved access to mental health care services on a larger scale for U.S. women veterans. Such as, faster approval for benefits and mental health care services through both VA and non-VA providers.

In addition, probable qualitative findings on the experiences of U.S. women veterans' access to mental health care services will hopefully contribute to positive social change for U.S. women veterans as a whole, by promoting the practice of assigning gender sensitive case managers and therapists for U.S. women veterans, who are victims of sexual abuse. Correspondingly, conditions that either substantiate or deter women

veterans' reintegration progression consist of: (a) obtainability of Veterans Affairs policies, resources, and services that are gender-specific; (b) employment and education provisions; (c) specific and supportive resources that address both military sexual trauma and mental health; and (d) social degradations related to being women veterans (Strong et al., 2018).

As mentioned in Chapter 1, this qualitative phenomenological study will impact social change by increasing awareness and understanding for the need of rapid response and access to mental health care services for U.S. women veterans living with PTSD. The results of this study will hopefully contribute to positive social change by supporting the daily challenges often experienced by U.S. women veterans living with PTSD and their immediate family members, by providing a compelling assertion for quality mental health care services. I contend that society operates best when awareness and transparency supersede silence and ignorance in matters affecting communities. The recommendations for this qualitative phenomenological study, do not exceed the boundaries of this study.

Implications

Positive Social Change and Policy Implications

Regarding the implications of positive social change and policy related to this qualitative phenomenological study, the interpreted findings demonstrate the significance of improving mental health access, resources, and communications for U.S. women veterans diagnosed with posttraumatic stress disorder (PTSD) post deployment. For instance, the distribution of this study's findings to mental health care policy administrators may be useful in an effort to advocate for improved access to mental

health care, mental health care resources, and communications regarding mental health care services for U.S. women veterans diagnosed with PTSD is paramount. The implications ae especially compelling, since more than 12% of U.S. women veterans screening positively for PTSD, conveyed they had not received mental health services (Washington et al., 2013) and as the administrating policy for accessing veterans' health care services remains relatively arduous (Ritchie, 2019).

Methodological Implications

As relating to methodological implications for this qualitative phenomenological study, the interpreted findings demonstrate the importance for researchers to review the accuracy of each participant's semistructured interview responses to determine saturation. For example, it was imperative that each participant's audio recorded responses for this study were accurately transcribed in order to determine the superordinate and subordinate themes throughout the analyzation process. Accurate analysis of data ensures a study's empirical standing in ethical and scholarly research. Essentially, the findings of this study imply that a qualitative phenomenological method is a practical approach to explore the lived experiences of U.S. women veterans living with posttraumatic stress disorder and how U.S. women veterans perceive the impact of their posttraumatic stress disorder diagnosis, on their immediate families post-deployment.

Empirical Implications

The generated empirical data for this qualitative phenomenological study has implications for research and practice moving forward. For instance, the generated empirical data for this qualitative phenomenological study can possibly inform and

engage mental health providers on the challenges that U.S. women veterans face accessing mental health care services. By developing and or improving mental health care services and policies for U.S. women veterans in general, U.S. women veterans will hopefully experience faster processing of claims for approved mental health care services, regardless of wartime or peacetime served, paired with gender preferred clinician care. In addition, the interpreted findings for this qualitative phenomenological study should compel VA and non-VA mental health providers, to become more gender sensitive by pairing U.S. women veterans in general, with same gender caseworkers during their case planning medical and mental health appointments.

Theoretical Implications and Recommendations for Practice

Supported by Heider's (1944) causal attribution theory (CAT) as a framework, this qualitative phenomenological study's findings have implications for research and practice moving forward. Attribution is a method expended for ascertaining what information is accumulated and how it is compounded to establish a causal perception (Fisk &Taylor, 1991). For example, gender sensitive case managers and therapists that are prioritized to assist U.S. women veterans that are victims of sexual assault during active duty, may present a safer perception of care during the claims process for mental health care services with both VA and non-VA providers. Next, variances of posttraumatic stress disorder (PTSD) pervasiveness are often attributed to exclusive valuations of traumatic types and severity (Yehuda et al., 2015), such as the participants in this study, that shared their traumatic events during active duty and sought mental health care services as veterans, post receiving a PTSD clinical diagnosis. In practice, the

recommended improvements to access mental health care services, such as VA gender sensitive case managers and therapists, will improve U.S. women veterans' perceptions of access to mental health care services, quality of mental health care services, and as a benefit, strengthen the communication between U.S. women veterans and their immediate family members.

Conclusion

The experiences of military women, often go unnoticed, as focus is largely placed on United States military men, in response to their being the foremost group in the military (Boyd et al., 2013). As mentioned in Chapter 1, despite United States Navy women and men exhibiting similar combat experiences, posttraumatic stress disorder (PTSD) is substantially higher amongst United States military women (MacGregor et al., 2017). It is my hope that this qualitative phenomenological study on the lived experiences of U.S. women veterans living with PTSD and their perceived impact of their PTSD diagnosis on their immediate families postdeployment, will not only help begin filling the literature gap on U.S. women living with a PTSD diagnosis, but also impact positive social change, by promoting improved mental health care services for all U.S. women veterans. Based on the documented findings of this study, it is imperative that U.S. women veterans' experiences and needs be prioritized through a greater lens of urgency to promote more prompt access to mental health care services through the VA and non-VA mental health service providers. Hopefully, such a heightened sensitivity and response will help to mitigate the dire effects of trauma and symptoms of PTSD in the lives of U.S. women veterans and the adverse impact on their families.

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Appendix A: Interview Guide

Interview Details:

Researcher and Interviewer _____

Interviewee_____

Interviewee Alias _____

Interview Date /Time _____

Interview Location _____

Preliminary Interview Activities:

1. Verify that a signed and dated informed consent letter is collected.

2. Offer a signed and dated copy of the informed consent letter.

3. Introduce the study, provide a short background of the researcher's connection to the study, and offer a signed and dated copy of the confidentiality agreement.

4. Inform the participant that a copy of the results of the study will be made available to them if requested.

Interview Questions

1. What branch of the United States military did you serve and why did you select that branch?

2. How long did you serve in the military and what events and or circumstances led to your retirement or separation from the military?

3. What events and or circumstances initiated your receiving a posttraumatic stress disorder diagnosis from a licensed mental health professional?

4. Were you able to receive clinical treatment (e.g., counseling and or prescribed medication) post receiving your posttraumatic stress disorder diagnosis and if so, when did your treatment begin?

5. If you answered yes to question 4, did you receive mental health care services from the licensed mental health professional that diagnosed you with posttraumatic stress disorder or another mental health professional and how long did mental health care services last if applicable? Proceed to question 8.

6. If you answered no to question 4, what events and or circumstances prevented you from receiving mental health services post receiving your posttraumatic stress disorder diagnosis? Proceed to question 7.

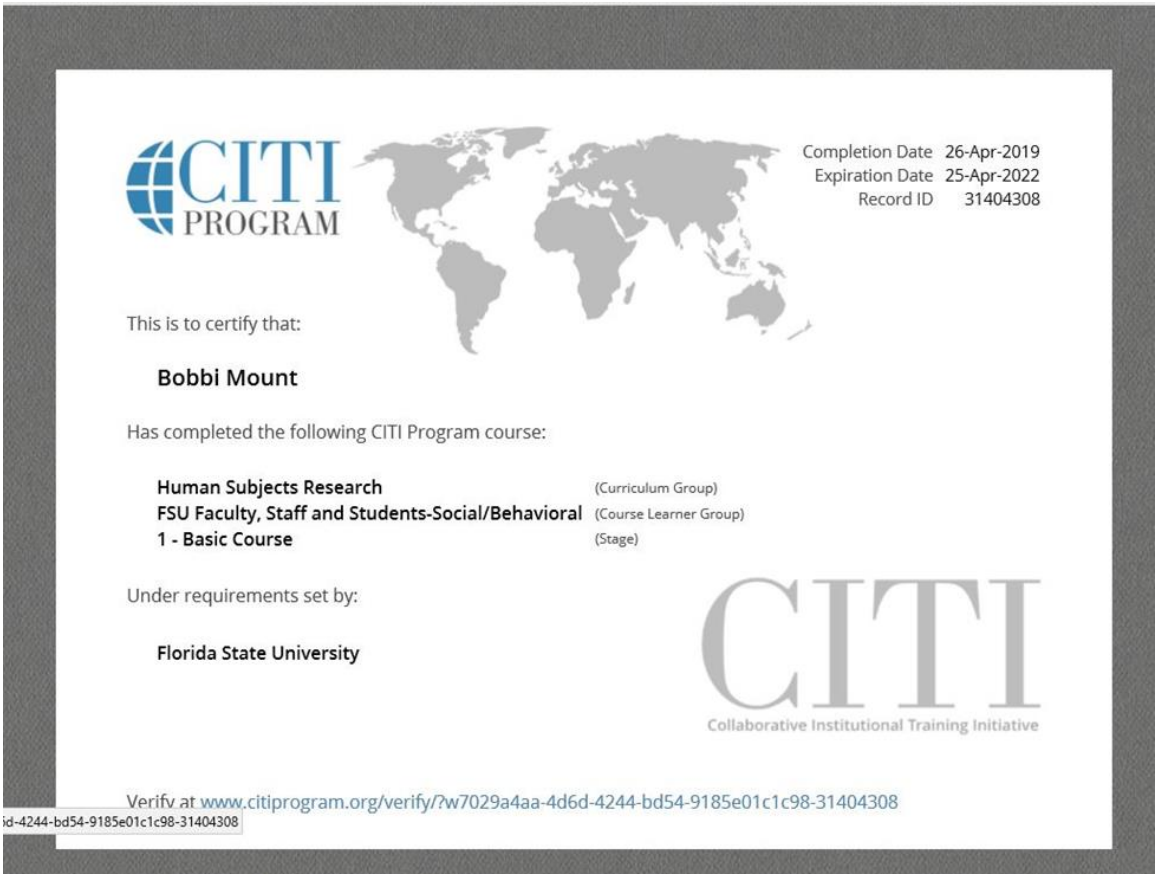
7. If applicable, what are one or more obstacles you have experienced on attaining mental health care services?

8. If any, what are some improvements you would like to see regarding access to mental health care services for U.S. women veterans?

9. Could you please share or highlight two-three experiences on how your posttraumatic stress disorder diagnosis has impacted your immediate family (e.g., spouse and or children)?

10. What are common practices that you and your immediate family utilize to manage challenges involving the effects of your posttraumatic stress disorder diagnosis?

Appendix B: Human Subjects Research Certification



CITI PROGRAM

Completion Date 26-Apr-2019
Expiration Date 25-Apr-2022
Record ID 31404308

This is to certify that:

Bobbi Mount

Has completed the following CITI Program course:

Human Subjects Research (Curriculum Group)
FSU Faculty, Staff and Students-Social/Behavioral (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Florida State University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w7029a4aa-4d6d-4244-bd54-9185e01c1c98-31404308

id-4244-bd54-9185e01c1c98-31404308