

Winter 12-13-2019

A Focus Group Exploration: Looking into the Female Veteran Service Experience

Raelisa Santiago

USF, santiagorae@gmail.com

Follow this and additional works at: <https://repository.usfca.edu/capstone>

Recommended Citation

Santiago, Raelisa, "A Focus Group Exploration: Looking into the Female Veteran Service Experience" (2019). *Master's Projects and Capstones*. 949.

<https://repository.usfca.edu/capstone/949>

This Project/Capstone is brought to you for free and open access by the Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Master's Projects and Capstones by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.

RUNNING HEAD: A FOCUS GROUP EXPLORATION: LOOKING INTO THE FEMALE
VETERAN SERVICE EXPERIENCE

A Focus Group Exploration: Looking into the Female Veteran Service Experience

Raelisa Santiago

Capstone Project for the Dual Degree of Master of Science in Behavioral Health and Master of
Public Health

University of San Francisco

San Francisco, California

August 2019

Abstract

Purpose: The purpose of this paper was to analyze focus group data from the 2017 Service Women's Action Network (SWAN) summit. Qualitative analysis focused on the barriers women veterans face with mental health issues from their service experience, with the goal to help better understand how to direct advocacy efforts for the population while identifying recommendations for process improvement.

Methods: Four focus groups with female service members were conducted. Group 1 consisted of Currently Serving (active duty and reserve) female service members; Group 2 consisted of women veterans 44 and under ; Group 3 comprised women veterans 45 and older; and Group 4 were retired female service members who receive some type of military pension. A thematic analysis using Nvivo statistical software for qualitative data was conducted

Results: Four main themes were identified as Uncertainty, MST, Sexism, and Service Experience. Uncertainty dealt with an individual's response from an illness related event or symptom which participants perceived as either a threat or an opportunity manifesting a response that is physical, psychological, emotional, behavioral, and/or social.

Service experience concerns how the environment of the service affected participants' experience within the military. Sexism was coded as gender bias.

MST was any unwanted verbal or physical action.

Discussion: : The findings demonstrate that many female service members cycle through different stages of readiness to seek help, acknowledge or identify a mental health issue and how they would respond to it based on service barriers. Implications for practice include continuing to

obtain feedback to improve the services of VA systems, and recommendations for improvement of current military policies for help seeking behaviors.

Keywords: Military Sexual Trauma, MST, Sexism, Gender Bias, PTSD, Uncertainty, Female Veteran, Fear, Stigma, Service experience

Introduction

The U.S. Department of Veterans Affairs (VA) was established in 1930, with a main reason to provide healthcare benefits to military veterans (VA, 2018). Veteran health care services offer primary care provider appointments, home health care, elder care, and access to specialists including mental healthcare services for posttraumatic stress disorder, substance abuse disorder, anxiety, and depression (VA, 2018). In 2017, the population of veterans in the United States was roughly 20 million, of which 10% were women (U.S Department of Veterans Affairs [VA], 2017). Statistics indicate that women veterans experience different and elevated challenges while serving and after service separation, compared to their male counterparts (Foster & Vice, 2009; O'Campo et al., 2011). These include: higher rates of suicide, military sexual trauma, posttraumatic stress disorder (PTSD), intimate partner violence, and homelessness (Foster & Vice, 2009; O'Campo et al., 2011). These issues require gender-specific care focused on female reproductive health, family planning, substance recovery programs, and mental health counseling. Given these high rates of health issues, more research is needed to understand the impact and provide specialized support for our female veteran population.

Bean-Mayberry and colleagues (2011) indicated that PTSD was more likely to occur in women returning from deployment than those who did not deploy as evidenced by Rivera & Johnson's (2014) findings. In the female population of veterans, the prevalence of PTSD was between 15 and 30% (Rivera & Johnson, 2014). A study done in 2014 found that 22% of active duty female military personnel experience some form of intimate partner violence (O'Campo et al., 2011). In addition, the California Department of VA has found that 40% of the total number of identified homeless veterans are female service members. (California Department of Veteran Affairs, 2013).

In 2016, the VA released a study that indicated the suicide rate for female service members was 14.4 per 100,000 person-years, and the rate increased to 17.3 per 100,000 person-years from 2001 to 2014 (VA, 2016). A common misinterpretation of this data in the mainstream media was to report this as 22 veterans die every day due to suicide (Kemp & Bossarte, 2013). In fact, the recent VA suicide study included active, reserve, and veteran individuals--indicating that the problem is within all military status divisions. Taking a further look at the suicide rates for women servicemembers between the ages of 18 to 29, these data showed they were 12 times more likely to commit suicide than their civilian counterparts (Hoffmire, Kemp, & Bossarte 2015; VA, 2017).

The rates of suicide are not the only alarming statistics. The Veterans Health Administration (VHA), a subdivision of the VA, recently adopted a new term to categorize a specific type of sexual assault experienced while serving in the military, called military sexual trauma (MST). Women servicemembers have reported an astounding 35% prevalence of MST (Rivera & Johnson, 2014).

There is limited data on the female service member experience when compared to their male counterparts. In fact, in 2004 the Department of Veterans Affairs indicated that only 2.6% of research investigations funded by public and private sources is focused on female veteran participants(US Department of Veteran Affairs, 2004). While some advances have been made toward the care of women veterans, their gender specific needs are still not fully embraced by most VA services, and other institutions' resistance or lack of knowledge for how to treat this population has caused a gap in care (Strong, 2017; VA, 2018). With the population of female veterans expected to grow, more research and educational training for providers and organizations are necessary to address the unique challenges of both mental and physical health

for this community. Mental and behavioral wellbeing represent the foundation of an interconnected framework that can create or impede healthy and productive lives when transitioning from military to civilian life, especially in consideration of women servicemembers. This paper will offer insight mainly through qualitative analysis of the barriers women veterans face with mental health issues from their service experience and help to better understand how to direct advocacy efforts for the population.

Background: Review of Literature

In 2017, the Female veteran population accounted for 10% of the entire US veteran population which is expected to double in the next 20 years to over 4 million female veterans (PEW Research Center, 2016). Military veterans are often categorized by their wartime service era; for example: Vietnam veteran, World War II veteran, Desert Storm, etc. Of that female veteran population, 57.4 % served during Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND), with 89.8% utilizing VA health care services more than once between 2002-2015 (Veteran Affairs [VA], 2017). VA health care services can only be utilized by either retired or disabled service members and qualifying family members. The average age of female veterans is 48 while the average age of those who served in OEF/OIF/OND is 42 years old. Female veterans are more likely to be married, have children, either enrolled in college or have a higher education, and employed than their non-veteran counterparts (U.S Census Bureau, 2015).

The Spectrum of Female Veteran Health Care

The aforementioned statistics look promising but female veterans show statistically higher rates than male veterans of Military Sexual Trauma (MST), with increased rates for comorbidities such as Secondary Victimization, Post Traumatic Stress Syndrome (PTSD),

Depression/Anxiety Disorders, and Intimate Partner Violence (IPV) (Schaffer, 2014; Hankin et al, 1999; Bean-Mayberry, et al., 2011; Suris, & Lind,2008). These issues make a unique case for female centered reintegration, identification of barriers and decreasing the burden of uncertainty of service barriers for veterans. Female veterans experience higher portions of comorbidities and disparities even though the military & VA have created more policies and regulations for MST-related prevention and behavior than the general public. A literature review of women veterans' health conducted between January 2004 to September 2008 found six key gaps in healthcare for female veterans. The findings were as follows: chronic physical or mental health conditions lacked clinical and intervention outcomes specifically for women, unaddressed health issues for female veterans on aging and pregnancy, gender specific care for traumatic brain injury or polytrauma, preventative healthcare maintenance, transitional assistance from military to civilian life, and the effect of military service on transitioning families (Bean-Mayberry, et al. 2011). While recent policy in the VA has tried to address some of these healthcare gaps, further outreach, advocacy, and healthcare literacy is needed for the veteran female population to gain access to these services.

Military Sexual Trauma

MST was adopted from federal law title 38 US code 1720D in 2017 to address the high rates of assault and provide a classification for military related sexual abuse and harassment experienced while serving in the armed forces (VA, 2017). A policy change by the VA to add MST as a specific condition illustrates the severity of incidence and prevalence for the military population. Women service members have reported a 35% prevalence of MST, with some studies estimating higher rates (Valdes, Kimerling, Hyun, Mark, Saweikis, & Pavao, 2011; Rivera & Johnson, 2014). Recent research studies found significant gender differences that

illustrated a higher prevalence of mental health comorbidities for women service members at a rate of 2 to 3 times higher when combined with MST; these data highlight that female veterans experience disproportionate physical and mental health challenges compared to male servicemembers (Kimerling, Gima, Smith, Street, & Frayne, 2007).

The estimated economic burden to treat MST for either gender in 2010 was estimated at \$872 million dollars based on a per victim amount of \$10880 (Francis, 2013). MST is an entirely preventable adverse event that is caused by the perpetrator. The future continued economic burden of a condition that is entirely preventable should be a top priority for advocacy efforts. VA disability compensation is not given for an MST-related event. However, veterans can file for conditions resulting from MST like anxiety, female arousal issues and PTSD. Determining female perception and point of care allows the development of policy for coping mechanisms and skills to prevent or mitigate certain risk factors and health outcomes to reduce economic healthcare burden or waste and gear that toward prevention and education. Addressing MST outcomes allows patients agency over their chronic condition or temporary illness and gives healthcare professionals the tools to promote adaptation of the patient's outcome measures. The experience of MST is related to secondary victimization.

Secondary Victimization

Secondary victimization is the re-traumatizing of sexual assault survivors that involves three core principles of questioning, victim blaming, and victim shaming (Campbell & Raja, 1999). The three core principles further breakdown to a series of secondary victimization behaviors that include: encouraging the victim not to report the incident, refusal to take the report, notifying the victim the issue is not serious enough to pursue, questioning involving if the victim had a prior relationship with the assailant, questioning the victim on how they were

dressed, asking about the victim's sexual history, asking if the victim resisted the perpetrator, and asking the victim to take a lie detector test. Researchers have found that 70% of victims who experienced secondary victimization were encouraged not to report the incident and 65% of the victims who tried to report the crime encountered officials who refused to document a report (Campbell & Raja, 2005). The process of secondary victimization creates a barrier to treatment and care which could cause compounding or escalating factors relating to MST. Barriers compromise the well-being of MST survivors (Holland, Rabelo & Cortina (2016). A common theme on the perception of barriers to seeking help include the military misconception that sickness equals weakness.

Among the population of female veterans that experience secondary victimization and MST include a subpopulation of lesbian and bisexual women. A study determined that lesbian and/or bisexual women were more likely to experience MST and have more or worse mental health issues after a deployment and become a hazardous drinker (Mattocks et al. 2013). These behavioral health issues can lead to legal and social difficulties compounding an underlying issue.

PTSD

Victims who suffer from MST and sexual harassment or abuse have a stronger association with PTSD or likelihood of developing PTSD than those who experienced sexual trauma pre-military or post-military (Himmelfarb, Yaeger, & Mintz, 2006). The occurrence of a traumatic brain injury (TBI) from a related military sexual trauma incident and development of PTSD results in a polytrauma. However, research indicates that the strongest predictor of developing PTSD is experiencing a TBI during a deployment and is the most common mental health condition for those who served in Operation Enduring Freedom(OEF) and Operation Iraqi

Freedom (OIF) (DePalma and Hoffman, 2018, Hoge and Castro, 2014, Iverson, et al., 2011). The increase in PTSD cases may be attributed to the rise and expansion of women in combat related roles that increase the probability of a TBI further complicating traumatic experiences. A recent study analyzing the concurrent diagnosis of PTSD and TBI between both male and female participants indicated that there are sex differences with women more likely than men to report moderate to severe TBI, however no significant gender differences existed when measuring depressive symptoms, sleep quality, average pain and posttraumatic stress symptoms (Epstein, Martindale, & Miskey, 2019). The Health-Related Quality of Life (HRQOL) is a major concern considering that roughly 14% of women served in OEF/OIF (Katz, Bloor, Cojucar, & Draper, 2007). The Center for Disease Control and Prevention defines the HRQOL as a person's or group's perception of mental and physical health over time to include culture, values, spirituality, job satisfaction, housing situation, and environment among other determinants (CDC, 2019). PTSD creates a ripple effect on an individual's life including isolation, marital/partner and parenting stress, cognition, and physical health issues among others (Haun, Duffy, Lind, Kisala, & Luther, 2016). PTSD does not need to be accompanied by a TBI. Statistics conducted in 2015 by the VA indicate 62% of all OEF/OIF/Operation New Dawn (OND) veterans have utilized VA health care services with 58.1% of those veterans experiencing mental health disorders (VA, 2017).

A Call to Attention: Depression/Anxiety Disorders, Suicide & Intimate Partner Violence (IPV)

PTSD, anxiety disorders, and depression are not mutually exclusive yet the economic cost of treating these and other mental health disorders for the fiscal year 2008 from VA care accounted for \$36 billion and yet only represented 16.5% of the total VA enrolled population

(Watkins, et al., 2011). These statistics do not include the cost of services provided outside the VA system, which is currently unknown. Conversely, when looking at the annual estimated cost of depression related disorders from lost work the numbers range between \$30.1 billion and \$51.5 billion (Kessler, 2011). The decentralization of mental health systems has shifted the burden of care to emergency rooms and in some cases the taxpayer. At this time, an estimated figure could not be found on the uninsured mental health costs nor the unrecovered costs from female veteran psychiatric patients who do not receive VA benefits. However, during an interview, the Director of The National Institute of Mental Health, Thomas Insel was quoted as saying the US spends a minimum of \$444 billion a year on lost productivity and disability payments (Szabo, 2014). The cost of suicide in 2013 was estimated at \$93.5 billion to include lost productivity (Shepard, Gurewich, Lwin, Reed, Silverman, 2015).

Intimate Partner Violence (IPV) is a form of violence by an intimate partner that is expressed psychologically, sexually or physically. The occurrence of IPV is higher among female veterans when compared with their civilian counterparts, and women veterans also have a higher risk of heart health factors associated with IPV? (Dicher, Ceruilli, Bossarte, 2011). The VA reports that 18.5% of female veterans reported an occurrence/situation of IPV to their primary care provider (Kimerling, Iverson, Dichter, Rodriguez, Wong, & Pavao, 2016). Further complicating the complexity of IPV is housing instability for those veterans who are experiencing IPV. Often times intimate partners share the financial burden of living expenses and share similar social circles that can isolate those seeking a departure from the abuse. A study found that female veterans who reported IPV were four times more likely to experience housing instability than those who did not (Montgomery, Sorrentino, Cusack, Bellamy, Medvedeva, Roberts, & Dichter, 2018).

Reintegration: The dichotomy of the Female Veteran's Identity

As noted above, the statistics for mental health diagnoses are high within the VA system and include anxiety, depression, alcohol and substance abuse, eating disorders, and female sexual arousal disorder from related MST events. Managing the transition from a combat mindset to the civilian sector proposes many challenges for the veteran that they are not conditioned or educated on pre- or post-deployment. The education of the servicemember is mostly focused on being combat ready without the addition of mindfulness, coping factors or resiliency. The uncertainty of a transition proposes its own inherent challenges. Mishel's Uncertainty in Illness theory (UIT) explains how a person interprets the illness-related sensory experiences that produce a psychological, emotional, and physical response based on the person's perception of those occurrences as either a danger or an opportunity (Mishel, 1988). Four main themes emerge that relate to the female veteran experience adapting a framework from Mishel's UIT: (1) ambivalence of mental or physical illness associated with service; (2) difficulty accessing/acquiring care from discharge status or private health insurance; if any (3) insufficient healthcare literacy or severity of the condition; and finally the (4) unpredictable outcome of the mental or physical illness. UIT is a multidimensional issue for female veterans. If disease or illness leads to unpredictability than predicting when or who will a veteran seek help from will be a challenge that needs proactive advocacy pre-deployment, not only with communities and families but the veteran as well. A post deployment survey of 745 OEF/OIF veterans that included a 54% female participant pool provided results that indicated some difficulty with reintegration into civilian life and noted the demographics from race/ethnicity appeared to further compound the issues for non-white servicemembers (Sayer, et al., 2011).

A women's experience in the military is different from men's experiences and so is the reintegration process. In the United States, historically socially constructed gender identity of a woman were and still are perceived by some as the family caregiver, nurturing, timid, weaker than males, and feminine. In the military, a woman is expected to be part of the unit; a hard and disciplined, yet obedient loyal member of a team that accomplishes "the task." No whining, no failing, sucking up any emotion and expected to kill or be killed in situations during wartime that indoctrinates a masculine toxicity of gender norms placing the individual last.

Fieldwork Agency and Project

The Mission Continues is a service-driven organization that cultivates former service members to utilize asset-based community development principles to enrich their communities and underserved populations through acts of service. The Mission Continues partners with local nonprofit and community organizations by deploying volunteer prior servicemembers to enhance self- efficacy and determination of program goals through sustained community centered action. The organization was founded by former politician and Navy SEAL Eric Greitens, who created The Mission Continues in 2007 targeting post-9/11 veterans to continue their military humanitarian service within their own communities. Mr. Greitens formed the organization because he spoke with transitional veterans (prior service members that recently separated from military service) who expressed a need for the established military norm of a close-knit devotion and military community to volunteer. The organization initially started with three members and in subsequent years quickly spread to over 100,000 members with national squadrons in major cities all over the US.

The squadrons are run under the mentorship of The Mission Continues to engage veterans in community improvement projects like building/renewing parks, schools, and recently

the Puerto Rico squadron, mobilized to assist in the clean-up process from the devastation of Hurricane Maria. The core values of the organization center around: “hard work” to build communities; “trust” to guide commitment to promises; “learn and grow” to improve veterans’ lives and abilities; “respect” to cultivate innovation and growth; “have fun” to motivate each other’s accomplishments. The Mission Continues is non-profit, nonpartisan and is funded through grants, in-kind sponsors, other sponsorships, foundations, donations and other key stakeholders. A notable in-kind sponsor is Southwest Airlines that provides transportation for conventions and seminars. In 2014 leadership changed to Spencer Kympton, a Blackhawk and aviation pilot, who is also a West Point and MBA Harvard graduate. The organization is currently in a reconstruction phase and in the process of consolidating their squadrons to utilize limited resources in the most effective manner. The squadrons are still operational, and some will be consolidated into a larger group, rather than three small groups in the same city. The agency has a central physical office with the bulk of employees functioning via telework. They employ academic doctoral individuals, licensed clinical professionals, volunteers, interns, and other professionals. The organization provides leadership and fellowship programs to hone veteran skills toward community mobilization. A newly launched program directed by Dr. Kate Hendricks Thomas, called the Service Leadership Corps (SLC) focuses on teaching resilience, transformative leadership with an emphasis on Asset Based Community Development and LUMA Institute modules teaching Human-Centered Design.

The SLC program is six months long and partners with a service-based organization or individual to assist with underserved population issues like homelessness, telehealth, unbenefited veterans with PTSD, fighting islamophobia, and other issues. SLC had over 650 applicants of which only 50 were accepted, which included me. My assigned SLC team is working in

conjunction with Cohen Veterans Network to provide a program plan to expand tele-mental health services to rural communities and also develop a proposal for the tele-mental health initiative for mental health licensed providers to work interstate. Cohen Veterans Network is a nonprofit that provides mental health services to post-911 veterans and their families regardless of discharge status. I was the point of contact for the initial stage of the project and everyone will rotate through to gain the skills of transformational leadership. I also developed two program proposal outlines for the project team members to follow. Dr. Thomas is my preceptor who also works with Service Women's Action Network (SWAN), an organization advocating for service women centered needs. I have been given the opportunity to perform qualitative data with transcripts from SWAN focus group data. A SWOT, stakeholder analysis and project goals and objectives are available in the appendix section. (See Appendix).

Methods

Overview:

I conducted a secondary analysis of focus group data that was collected for the 2017 SWAN Conference and this project utilized a survey and focus groups with the main goals of assessing the knowledge of mental health and wellbeing for female service members. The primary objectives of the secondary focus group analysis were to (1) identify recommendations for process improvement and (2) suggestions for female veteran centered mental health services, outreach and advocacy for the general public, and healthcare providers. I conducted a thematic analysis with focus group data of the female service members using Nvivo statistical software. The focus group data creates a case for a lived experience of those women who served and are serving in the Armed Forces which provides the main basis for this data analysis. Group 1

consisted of Currently Serving (active duty and reserve) female service members; Group 2 consisted of women veterans 44 and under ; Group 3 comprised women veterans 45 and older; and Group 4 were retired female service members who receive some type military pension. The demographic data for the participants were not available, therefore the online survey data was used from SWAN that provided a subsample of those that may have participated in the focus groups. The main SWAN study consisted of a one-time self-report survey administered through an online survey application, SurveyMonkey and four focus groups. Recruitment for the survey took place through email communication of the SWAN members. The survey included questions from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) for population comparison data (SWAN, 2018, p 5). The survey also included qualitative data with four opened ended questions for participants to write in responses. Recruitment for the focus groups took place through email communication for attendees of the SWAN Summit of 2017 seeking volunteers. The focus groups were held at the SWAN 2017 summit in Washington DC. The Institutional Review Board was approved by Charleston Southern University.

Justification for research design:

The main justifications for the research design are as follows: (1) Place a humanistic value on the current statistics (2) Save time and money by having a group (3) Obtain information on perceptions and opinions of barriers (4) Provide a broader knowledge base of the population and or issue

Advantages/Disadvantages of Observational study

Advantages	<p>Convenience sampling</p> <p>Identify complex behaviors & changes in behaviors</p> <p>Humanistic element to research</p> <p>Contribute to existing statistical data</p>
Disadvantages	<p>Hawthorne effect if they feel their answers are being monitored</p> <p>May lack trust if they have a negative perception</p> <p>Self-selecting and may not be representative of the population.</p>

Participant description

Key facilitators conducted the focus group and were trained through the Collaborative Institutional Training Initiative (CITI Program) on Human Subjects Research and Social and Behavioral Responsible Conduct of Research. The mixed-method study was conducted in collaboration between principal investigator Dr. Kate Hendricks Thomas, an assistant professor

of health promotion at the Charleston Southern University including associate investigators using both quantitative (SurveyMonkey) and qualitative methods (Focus Group).

Population characteristics:

[Survey] The female active duty service members and veteran study population characteristics were analyzed using the self-reported anonymous survey via SurveyMonkey. The key characteristics of the SWAN data collection from the survey was comprised of 1,324 participants. Characteristics for the Focus group were not collected due to the anonymous nature of the interview but were members of SWAN. Service eras were broken down into four categories: Prior to 1961, 1961-1975, 1976-1989, 1990-2000, and September 11, 2001 to present because veterans are identified by the conflict they served during. Prior to 1961 is pre-Vietnam Era; 1961-1975 is Vietnam Era service; 1976-1989 was considered Peacetime/Post Vietnam service; 1990-2000 was the Gulf War Service and after the attacks on the World Trade Center veterans are categorized as 9/11 veterans, Operation Enduring Freedom, Operation Iraqi Freedom, or Operation New Dawn which is considered ongoing at the time of this publication. The following tables below list the three main demographics for the survey.

Table 1: Female Service Status from Survey

Currently Serving: Active, Reserve, Guard	225
Retired	290
Veteran	809

Table 2: Service Branch from Survey

Air Force	330
Army	619
Coast Guard	50
Marine Corps	99
Navy	225

Participant eligibility and exclusion criterion:

[Survey criterion] Must be a female service member or veteran aged 18 or older who served in the United States Armed Forces with access to the online survey link for SurveyMonkey.

[Focus Group criterion] Must be a female service member or veteran aged 18 or older who serviced in the United States Armed Forces with access to the SWAN Summit 2017 and agreed to Informed Consent. All volunteers also had to indicate a desire to participate in the survey or focus group as an anonymous individual

Recruitment procedures

[Focus Group & Survey] Recruitment was done through the SWAN database and email to members. Advertisement for participation was solicited online via veteran affiliated organizations/businesses, LinkedIn, Facebook and word of mouth.

[Focus Group & Survey] Participants were recruited via the SWAN summit attendance and sent an electronic communication prior to the start of the conference to volunteer for the focus groups.

Data collection procedures

The focus groups were audio recorded after obtaining informed consent from all study participants. The method was non-probability sampling using convenience sampling. The Number of participants for each group was not recorded, but each group numbered over 15 per session.

Day one of the focus group consisted of participant reactions to the results of the online survey. A series of open-ended questions was asked by the principal investigator (See Appendix D). On Day two, the focus groups were tasked with developing groups and a list of solutions they felt would collectively meet the needs of military women experiencing similar situations.

The interview guide was created collaboratively among Dr. Thomas and the study team (See Appendix E). The same script was used for each of the four focus groups. Each question assessed perceptions of the impact of military service on mental or physical health outcomes and challenges including self-reported mental health issues, the barriers around women's mental health and conversations about military sexual trauma. The focus group questions also focused on recommendations for service providers and community organizations to further engage the female veteran population in the delivery of female centered services.

Data analysis:

Steps for Qualitative Analysis:

The first step involved reading and drafting a code book for each theme, then importing the notes/transcripts into Nvivo, a qualitative software analysis program. Codes and cases were assigned using the software. As further analysis took place codes were combined under an overall theme. Each relevant transcription was coded into four main categories with additional sub themes listed below (Table 3). A report was then generated for each code to identify the frequency of occurrence within each group. A query summarized the codes for reference under each file for each node. Upon completion of assigning the nodes, the codes were arranged under a main theme. Functions of Crosstab Query, Node tally, Hierarchy of Nodes and Comparison Graphs were generated [See Appendix].

Code Book:

CODE	DESCRIPTION
Uncertainty (UN)	The illness response to unforeseen, perceived threats or opportunities.
MST (MST) <ul style="list-style-type: none"> • Personal perception • Harassment 	The unwanted sexual, verbal, or physical attention from an individual, or group of individuals. Personal perception of an event was included as well if an individual observed the incident.
Sexism (S) <ul style="list-style-type: none"> • Stigma 	Experiences that pertained to gender bias often from being female and often included stigma of being female in a military culture.

<p>Service Experience (SE)</p> <ul style="list-style-type: none"> • Trying to belong • Trauma experience • Secondary Victimization • Retaliation or fear • Reintegration • Mental health affected 	<p>Experiences or discussion either positive or negative involving health providers, law personnel, coworkers, chain of command or subordinates.</p>

Findings/Results

Dimensions of the Female Service Experience

Four main dimensions emerged from review of the four focus groups, including their service experience: uncertainty, MST, and sexism, and service experience. Details on each theme and illustrative quotes are shown below.

Uncertainty

The first dimension, uncertainty, refers to the individual’s response from an illness related event or symptom which participants perceived as either a threat or an opportunity

manifesting a response that is physical, psychological, emotional, behavioral, and/or social. For most groups, the uncertainty of the response caused a negative or fearful reaction to an event. A female member who is Currently Serving in the Armed Forces described her actions when taking mandatory mental health surveys upon admission to a routine healthcare appointment:

“Will people be honest on that? Probably not. I still am not honest on that if I know it's going to take up too much of my time. I've clicked the button where it says, "Do you have nightmares." Yes. Next question, next page, 42 questions [later]. I go back and I say no I don't have nightmares, 5 questions, alright that's my new answer because I know I'm talking to a psych doc and I know it's not the right thing to do but it saves time sometimes.” [Group 1: Currently Serving]

All four groups agreed that the uncertainty of checking yes on those mental health surveys created a stressful situation for them which also attached a negative stigma for help seeking behavior. One group participant pointed out that the use of the word “psych doc” was a negative connotation for the way mental health was discussed amongst them. The theme of uncertainty may be linked to military culture as an interpretation of mental health being a weakness and in the military the failure to perform duty functions is a weakness. Another Currently Serving member echoed the same sentiment for a different situation that described the uncertainty of seeking mental health services and the impact that would have on her career.

“I didn't want to lose my flight status; I also didn't want to lose my TSSCI (Top Secret / Sensitive Compartmented Information) security clearance so for about 6 years I failed to

go to mental health because I was afraid until somebody told me that I needed to go.”

[Group 1: Currently Serving]

One example of what many female participants experienced details the great lengths of time a service member will wait to seek help based on the uncertainty of administrative action even with policies in place to encourage mental health services. However, the accounts from others Currently Serving have created a juxtaposition to seeking help when one member discussed that:

“I do qualify for PTSD and for to be a wounded warrior actually. I have not applied for that program and she [therapist] has not indicated in my records a diagnosis of PTSD because it will also start the process potentially for a med board.” [Group 1: Currently Serving]

If the uncertainty of an illness or diagnosis will hinder a Currently Serving member’s career, what would be the benefits of seeking help? The uncertainty of how one’s social network will react to a mental health condition was discussed extensively within the focus group as other members expressed concerns on how family members would react if they aren’t feeling well at that point-in-time. The members from all groups mentioned failure to adapt, a discharge normally reserved for those under 180 days of active duty service, and a general discharge fear if someone found out about their internal struggles. This led to a discussion about MST.

MST

For the purposes of coding, MST included two sub themes labeled personal perception and harassment. The two sub themes were necessary in order to describe differentiating experiences from MST. Personal perception included witnessing an act or perception of harassment, or MST. All groups discussed either knowing someone or having been the victim of MST or some sort of related trauma. Some members made note that other branches of the service were worse than others. The transition of conversation for the Retired group members noted how they have seen MST survivors, “both men and women who were discharged by the command with personality and adjustment disorders under other than honorable conditions [leaving them ineligible for benefits; GI Bill, etc][Group 4: Retired].

Some members did identify their branch during the focus group and unilaterally from the discussion indicated that the Air Force had the best applied practice of current Department of Defense policies towards MST and harassment. The mention of MST across all four groups was fairly consistent with the retired group and the currently serving noting the most mention of MST as a barrier to service. Safety appeared to be the biggest issue for reporting MST related incidents as one member mentioned that they found out they were the second of three victims by their offender in Afghanistan.

“These men have a nasty habit of videotaping things and then trying to use it to actually play against women. One of the women was a nurse from Florida and [the video] got sent to her husband. Yeah and those things are public record the minute they go to criminal investigation division. You are no longer safe.” [Group 4: Retired]

Participants expressed fears for their safety in discussing consistent and frequent harassment during combat deployment. For those who were Currently Serving they noted that women were instructed “to not drink at parties and not dress provocatively” [Group 1: Currently Serving] by unit commanders and master chiefs during trainings. Those Currently Serving continued to mention fear as an obstacle but also indicated that the sexual assaults have not decreased but women are more willing to come forward. While some others Currently Serving indicated in their personal experience that “You gotta keep it under wraps because you don't want to hurt your career” [Group 1: Currently Serving] and another member added, “No one will ever respect your leadership as a woman because your men will all want to sleep with you” [Group 1: Currently Serving]. There was a lot of discussion around sexual harassment or assault as the normal culture and that policy is practical in theory but not necessarily applied in real life situations.

For the focus group of 44 and under, members expressed MST as wearing a mask in which they could not come to terms with the things that happened to them. Masking was used as a terminology to describe wearing of certain identity traits. For example, being strong because others are counting on you, or a type of avoidance as not to deal with those situations or memories. One member from the 44 & under group expressed how she felt dealing with PTSD from her experience with MST. “I feel that mask was worn so much that I could not even come to terms with the things I had experienced but also those things that I was dealing with in the real world” [Group 2: 44 & Under]. All four groups expressed the stigma of reporting the incident, the Retired group stated they were never briefed on how, or who to report those issues to because at the time the language around MST was not developed.

The 45 & Over group expressed positive views upon returning to the VA for healthcare services that addressed MST, such as saying there is “better health care...better providers...but I am not saying everything is perfect” [Group 3: 45 & Over]. This was a noted reference in two of the four groups that they wanted to have more veterans as service providers so they could have empathy for their military experiences without the need to explain all the military jargon. Group 2: 44 & Under expressed the need for more women’s centers in all VA facilities or a female provider, but as noted by one participant if there is a woman therapist the caseload is large, and if you are doing okay then you will get pushed to other providers whom are males. She detailed her feeling of not being welcome by a provider because of his religious views and refusal to refer her to reproductive services or birth control [Group 2 44 & Under].

MST, PTSD, and harassment can all be interpreted very differently by each individual who experiences it, with some individuals having lifelong symptoms, while others find a way to cope or adjust through therapy. MST was mentioned in some form over 72 times within all groups during the focus group sessions. This leads to a separate main theme of sexism that is still related to MST, and PTSD.

Sexism

“Stop acting like a girl...you’re a soldier suck it up” [Group 2: 44 & Under] Sexism is the conscious or unconscious and intentional or unintentional discrimination and treatment that impacts all aspects of work, home, school, and social life. It can be manifested in the form of stereotypes and systemically is often applied to women and girls. The previous comment implied that girls are weak, and soldiers are strong. It was an experience that a Group 2 member used when describing how her identity as a service member and now as a civilian identity intersected without finding a “happy medium” [Group 2: 44 & Under]. Gender bias manifests itself in

socially constructed gender roles so that expressing feelings such as displays of anger for women are contraindicated, while men are allowed to be angry, or strong. Another member expounded upon the theme of sexism.

“In particular, as a woman I feel like I'm not allowed to be mad. I'm not allowed to show anger or rage and men can totally get away with it. Like they can punch walls and throw massive temper tantrums and get away with it in a professional environment, but women if we show any hint of emotion, we're hysterical and this need to constantly be controlled. When sometimes I deserve to be angry and I should [be] allowed to be angry but I can't. I can't publicly show the rage that we all deserve to feel right now [because] things are terrible” [Group 2: 44 & Under].

One participant described her story of going to a school and working with freshmen students who did not believe she was in the military.

“No, you weren't.” And I was like “Yeah, I was.” And he's like “There's no way. Prove it!” I mean he tells me to my face prove it and I'm like “Okay,” so I had to bring in pictures. I think the cool part of it was that some of the adults in the area realized that a lot of the kids just didn't believe that women were in the military (laughs) and they had me actually come in and do a presentation on my time in the military and stuff but it was so weird to like have a kid who just could not believe that like a woman would be in the military and I was like “wow, alright. [Group 2: 44 & Under]

Sexism is out in the public sector but can also be more difficult to navigate within the military. Sexism may also be attributed to the disproportionate number of males in the military compared to females. Two Currently Serving members expressed how they were placed into male only units and endured the uncomfortable culture of males making jokes about women, and how the males had to take extra training because of the females. Identity also came under fire, with three groups commenting on how if they acted like men, they were called “slurs,” if they gave attention than they were also labeled provocatively, and if they didn’t give attention to the men they were labeled lesbians with no middle ground of acceptance for their qualifications as their rank implied.

The types of sexism most participants experienced in order of most frequently mentioned were: double standards, judging women in authority positions, boys will be boys to catcalling. For explanatory purposes double standards meant that women were led to different standards than men, which included examples of being expected to prove themselves, or be more polite, or accommodating to requests. Judging women in authority positions often faced backlash for normal requests, or kickback with derogatory comments. Boys will be boys were incidents males would be excused from their actions, or how women perceived their actions. “Oh, I’m sorry you took it that way. You’re the only one who did.” [Group 1: Currently Serving]. Lastly catcalling where females were verbally harassed.

Currently Serving participants noted they felt things were improving to some extent. There is a need to have men act as advocates for women when they see sexism and to intervene. One such story of an ally appeared during training.

“A male in the room who was a reservist and worked for the state department...[spoke] up... and back[ed] us up and eloquently back[ed] us upWe should train men not to be animals. Not train women to dress a certain way. It's ridiculous. But if he hadn't backed us up though, it would have been a different conversation...”[Group 1: Currently Serving]

The training in reference was for sexual assault or MST, which also was a main theme within Sexism, in which all four groups discussed how “not to get raped” [Group 4: Retired] It is categorized under sexism for the burden being placed on the female as a bias to prevent an assault, instead of the perpetrator. A Retired Group member communicated that “commanders [have] the decision-making authority in crimes like sexual assault, domestic violence-- they are out of their element” [Group 4: Retired].

She may have been referring to the good ol' boys' system; a tight-knit group of male friends who will help each other out if they feel like one of their own is in trouble, even if it is immoral which would let the perpetrator off the hook from prosecution. Commanders still have the authority (as of July 30, 2019) to designate whether or not a case will go to trial. In 2013, Senator Gillibrand (D-NY) introduced Senate Bill 1752, Military Justice Improvement Act (MJIA), which would turn over the decision of prosecution for sexual assault/harassment cases, and investigation over to a designated agency outside the chain of command. However, Senator McCaskill (D-MO) introduced a competing bill that would leave the authority with commanding officers with oversight. The bill is still currently undecided and leads into the findings for the overall Service Experience.

Service Experience

This is a particularly difficult category to quantify because it is so broad. However, the main feature of this theme concerned how the environment of the service affected participants' experience within the military. Subthemes in the Service Experience were categorized as an accumulation of negative and/or positive experiences that involve trying to belong, trauma, secondary victimization, retaliation or fear, reintegration, and how mental health was affected. Reintegration was the main conversation for all groups with some conversation still centered around MST encapsulated within the Service Experience.

One member described positive progression with mental health services when being paired with a female practitioner.

“For me personally, I needed a female. I needed a female who had military experience and I needed someone who had empathy - I needed somebody that fit me and she does and I'm lucky but before that it took four different people to find that person and you don't always have that opportunity”[Group 1:Currently Serving]

A conflicted response as to whether or not the military experience affected their health negatively, or positively stated:

“...The experiences in the military affected me adversely because I was put up against some very intense, stressful situations, but being in the military, having that community,

my mental health was also improved because of the people I had around me, the facilities, the support and different things like that.”[Group 1:Currently Serving]

Among all groups the comradery and importance of the mission, and feeling like they belonged were strong sentiments. The mental health stigma still continued to be a service experience because “unless you're ready to see mental health you're not going to get anything out of it” [Group 1:Currently Serving]

Reintegration focused around what most groups described as a culture shock, involving the transition from a deployed area to a home base in order to decompress from the deployed experience and learn how to be a member of society again. Since no terminology exists for this experience, it is hard to define. For the purpose of this paper, the transition will be referred to as an adjustment of identity where one may wear a mask in order to readjust to a type of normalcy.

“Seeing everybody in their tan uniforms for six months a year and now all the sudden back -- dating myself here -- is wearing ya know their BDUs, their green-green uniforms. You don't see it so much anymore and you see flight suits and you're like holy bajesus the world is in color all of the sudden. It's a shock to the system. There's dogs, there's children, there's laughter that is not about farts and death”[Group 1: Currently Serving]

Some members expressed loneliness, with no one to come home to. Others expressed resilience: “So when things in my life were like at their absolute hardest, I would say it like a mantra. Like ‘If I could do a year in Iraq; I can do this.’ ‘If I could handle that, I can handle anything.’” [Group 2: 44& Under]

And some expressed the strain on personal relationships.

“I'm really good with friends when I can keep them at bay and manage how close or how distant I am with them but with regards to my children and any kind of love life it's a crap shoot from day to day sometimes.”[Group 4: Retired]

In fact, as these lived experiences have shown, adjusting back to the civilian sector whether it is from deployment or discharge there are unique challenges women face. The struggle with identity of being a mother, wife, partner, or provider can be difficult. Even though the military provides reintegration trainings to family members, more attention needs to be focused on the member deployed. An awareness around mental health issues the member may encounter depression, PTSD, and loneliness, are needed. Group 1: Currently Serving members held a discussion:

“For example, I wish I knew that a lot of people get depression when they come back from deployment. I mean they kind of told us that but not really.”

“They didn't explain why?”

“Right. Or even when you leave the military and you lose that sense of purpose, you have that lack of fulfillment, that lack of tribe, a lot of people get depression after they leave.”[Group 1: Currently Serving]

It is very common for service members after they leave the service to feel lost and isolated without a community purpose or mission.

Identity also hovered as a theme as some participants in Group 3: 45 & Older admitted to not identifying as a veteran until much later after their service because of the experiences they had while servicing. One participant noted that she wanted to destigmatize mental health and her veteran status by being:

“very open and vulnerable in most situations because I do not wanna normalize it [service experience] but I also feel the need to walk that fine line of being vulnerable yet still seeming like I don't want to be the veteran who's on edge or something.” [Group 2: 44 & Under]

The effort she is put in to destigmatize veteran mental health status is how many members across groups felt while discussing the main themes.

Discussion

Summary:

Research studies have documented and assessed the stages of change, or transtheoretical model of behavior, to gauge the readiness of a person to act upon changing a behavior. Meaning that unless the person is ready to act, they will only do what they want to until they are at a readiness level that supports such change. The findings of these focus groups show many barriers to seeking care within the military system. The findings demonstrate how many of the service members cycled through different stages of readiness to seek help, acknowledge or identify an issue and act upon it based on uncertainty, fear, stigma, and service experience.

Within the modified framework of Mishel's UIT discussed in the literature review, the focus group findings were consistent with the UIT hypothesis. Members noted that they wish they were taught about symptoms of mental health issues related to deployment in conjunction with coping mechanisms and command support. Therefore, the ambivalence of mental or physical illness may be associated with service through lived experience and insufficient healthcare literacy or severity of the condition contributed to military service experience. The members also experienced difficulty accessing/acquiring care during and upon discharge status. One Currently Serving focus group member expressed suicidal ideation and waited over three weeks for an appointment due to capacity issues. Lastly, all group members displayed some fear from the unpredictable outcome of the mental or physical illness upon completion or during their service experience. Not surprisingly, MST dominated the conversation along with calls for advocacy and improvement of VA services.

What makes this different than other literature? In these particular focus group discussions, all groups acknowledged either knowing someone or having been the victim of MST, while studies only report that 35% of women serving reported MST (Valdes, Kimerling, Hyun, Mark, Saweikis, & Pavao, 2011; Rivera & Johnson, 2014). It stands to reason that given fear of career-ending decisions, this number is much, much higher. A RAND study estimated that 52% of women reporting MST related events experience retaliation in some form, which was echoed throughout the focus groups (Morrall et al., 2015). The findings indicated the service member must either face the uncertainty of reporting the assault or remaining in the military. Other focus group members told stories of survivor accounts setting this research apart from others. This research also indicates that there is a clear distinction between reporting, retaliation, and accessing health benefits. It is difficult to prove the event occurred during reporting, and

after the incident with he said, she said, (if a report was even taken) and also because the wounds suffered by survivors of MST are often, but not always, invisible.

Accessing benefits and navigating the VA system propose some challenges for service members, but also contributes to a larger and more pressing public health concern for those who do not qualify for VA health care and must seek services elsewhere, if the individual can overcome barriers to access. The incidence of MST, PTSD, and other related main themes will only increase as the population of female service members increase in the coming decades. If policies are left unchecked or applied in their current form the problems will continue to percolate. MST and its related symptoms are caused by the perpetrator, not the victim. Across the service eras from Retired to Currently Serving and those in-between, all groups repeated the same sentiment about retaliation, reporting crimes/harassment, and career sacrifices. From the focus groups comments, the number of cases appear to be the same throughout the continuum of service eras. A hard stance on MST must include an applied, not theoretical, cultural shift of reporting, education, and prevention to include all members of the armed forces and contractors for a code of conduct that is ironclad.

The findings revealed that many women expressed self-reported and clinically diagnosed mental health comorbidities and expressed challenges in association with MST. If those experiencing MST are 2 to 3 times more likely to develop mental health comorbidities and each member responds differently either having lifelong stressors from the event or successfully coping with the event, then it would reason that MST must be stopped (Kimerling, Gima, Smith, Street, & Frayne, 2007). The condition is 100% preventable, and the burden should not lie with the victim.

Participants across the groups who suffered from depression or PTSD, either in relation to combat or MST, expressed the complications of daily tasks and damaged or low social interactions. It was not surprising or new to find that this affected their partners, friends, and family when the service member expressed both cognition, and physical health issues among others previously confirmed by research studies (Haun, Duffy, Lind, Kisala, & Luther, 2016). For Group 1: Currently Serving & Group 2: 44 & Under they would be considered OEF/OIF/Operation New Dawn (OND) along with those who retired or served from September 11, 2001 to present. The literature review indicated that 62% of all OEF/OIF/OND veterans have utilized VA health care services with 58.1% of those veterans experiencing mental health disorders (VA, 2017). The surprising factor was those who are Currently Serving mentioned using mental health services but still had fears of discharge. The different stressors the service members experienced demonstrate the necessity to consider the perspectives of all service eras along the continuum struggling with PTSD, depression, and/or anxiety disorders to develop a comprehensive picture of how stigma affects the quality of life, and treatment outcomes of female service members.

It was interesting to note that the conversation around IPV was framed as knowing someone else who experienced the event and trying to help that individual. However, it appeared that the ensuing repercussions either emotionally, or through the chain of command, caused a barrier to help seeking behaviors. The victims discussed were not interested or were afraid of help seeking behaviors. IPV was only mentioned in half of the groups. The underlying theme of secondary victimization highlighted the consideration to further understand the aspects of reporting that hinder victims from coming forward and how it is interpreted by the chain of command. These lived experiences from the focus groups created a foundation for cause for

further research on the compounding causes that exacerbate or escalate symptoms for survivors of MST, those suffering from reintegration, and mental health disorders. In the current political climate, it may be difficult to convince those suffering that the VA is there to help those in need providing they meet certain qualifications. But, therein lies the problem of qualifying for services: members who are survivors of MST should be entitled to services regardless of their discharge status. Recent studies agree that the stigma of mental health utilization goes beyond the individual level (Clement et al., 2015).

Implications for Practice:

The focus group data create a case for continuing emphasis on education and obtaining feedback to improve the services of VA systems, as well as reviewing current military policies on help seeking behaviors. Although efforts have been made to curtail the issues service members face, the literature and statistics indicate a cultural shift must be applied in order to encourage reporting. The final decision-making process of prosecution should be removed from the commander. The analysis of the focus groups pointed out areas of concern that could result in a preventable economic burden to those who do not qualify for benefits. There should be an appeals process and review when a member is discharged with other than honorable discharge by an outside agency from the command, considering the percentage of retaliation members have experienced. While the results seem to focus on negative experiences, this offers a unique opportunity for process evaluations and a chance to target those components for improvement.

Female service members' experience statistics should be gathered annually and anonymously for those whom are currently serving as a longitudinal gendered study to assess if policies are being applied. Surveys with qualitative and quantitative feedback should be issued..

Strengths & Limitations:

There were several limitations to this project. First, it was impossible to gain an idea of which branch of service each member represented unless they self-identified within the transcript. Therefore, each focus group may have had a disproportionate amount of one service branch or may have been missing representation entirely. However, some members spoke highly of the services offered at some VA clinics and mentioned the positive Air Force response to reporting and education of MST. Second, the focus group participants were not counted for each session but were comprised of over 15 participants each. Unfortunately, not every member contributed to the conversation and anonymous assigned numbers to each participant were repeated across focus groups. Third, the information may not be generalizable to every female experience in the military but the comparison of those Currently Serving and other veteran groupings provide a setting for a reevaluation and information on how to better direct advocacy efforts to identify change agents for future generations of those serving. Fourth, the subjective nature of assigning codes was a limitation because while each code had a defined experience attached to it, the main themes could often be cross-identified or intersected with the occurrence of MST. This limitation may also include the lack of a definition for the psychological and physical stress from the issue of the intersectionality of experiencing sexism, trauma, possibility of assault from the enemy and from your own team, while still maintaining the embodiment of a soldier getting the job done, and integrating back into society. Another coder would improve this situation.

The strengths of this project come from understanding the lived experiences of these women and the vulnerability of speaking on these issues so that others should not have to experience these issues. These data offer insights for how to target education and provide the ability to identify change agents and drivers to alter military culture-- which seems to be the

same from all focus group analysis. One finding suggests that female service members who had more females in their command and in their units appeared to have a protective factor against the main themes of..., but still experienced similar main issues while deployed. Further research is needed to identify what factors change in the command and unit when individuals are deployed that appear to increase the experience of these issues.

Recommendations

Main Recommendation

Women veterans from all service eras should have the right to serve without incidence of MST, gender bias, stigma or fear of retaliation. Those who enlist know the burden that they may make the ultimate sacrifice for their country, but it should not be at the hands of our fellow soldiers. Military service for men and women should not include the fear of sexual assault or trauma from fellow service members. The US military excels because there is recognition that each individual brings a skill set that allows a critical component of the mission to succeed. Rank and position are a structure of meritocracy that is earned through hard work, excellence, and skill. Soldiers will thrive when both physical and mental health needs are met. Change agents are prevention and building coping skills for a resilient population of service members that will become future civilians.

Programmatic recommendation

The first recommendation is to provide more female veteran representation in what?. Some military members may find it difficult to share their story with who, to what end? for a variety of reasons. Imagine a client that must stop a therapy session to educate a therapist or provider about military culture. It is a daunting task and the interruption causes a potential dissatisfaction or disturbance in building the rapport needed to achieve positive mental health

outcomes ;the client may feel misunderstood and possibly less likely to open up further about their military service. MST is a different classification of sexual trauma as noted earlier, and understanding the military jargon creates cultural humility and competency. PTSD may be experienced differently during combat situations and is a growing epidemic among all service members. However, having multiple female therapists accessible for appointments at all VA locations will help female service members feel more welcome and accepted in a male dominated military.

Secondly, all health providers at both VA and non-VA facilities should implement military sensitivity training, culture and language to provide for smoother reintegrations among the general public. The training will help to identify more quickly those who need and want assistance for mental health services. Third, adequate funding needs to be allocated for those who have other than honorable discharge status with mental health or physical conditions. A pathway to services must be established for those who are in the process of appealing a discharge status for mental health issues instead of waiting three years to overturn the discharge. Fourth, create a quick pathway for prior service members to serve as trained social workers or therapists to meet the demand for counselors. Those with master's degrees in psychology, behavioral health, and public health could be fostered into the fast-track one-year program for a master of social work with a five year contract for state or federal government, thereby helping decreasing the current shortage of therapists.

Lastly, provide social workers to veterans for navigation of local health care services free of charge, regardless of discharge status on a monthly basis.

Research recommendations

More research is needed to understand the navigation of change within military culture. Research focused on case studies should include the gendered experience of service members, reintegration from overseas deployments, formerly other-than honorable discharge service member experiences with mental health, health care, and social support systems. More qualitative research will lead to effective and improved programs toward coping skills, policy change and protocol for those in both combat and non-combat situations. Research on the length of deployment in the five branches of military service and quality of life indicators will provide insight toward developing deployment standards across all branches of service. Every level of the government must be involved in a cultural shift to apply a systemic and institutional change toward encouraging mental health seeking behaviors.

Policy recommendations

First, an amendment or passage of Senate Bill 1752 must be processed to increase protections for survivors of MST and increase the penalties of retaliation upon reporting. Stiffer punishments for military personnel caught covering up crimes, or committing crimes of a sexual nature may provide as a more serious deterrent. To remove undue bias the authority prosecution for a crime should not be determined by commanders. Instead, a separate outside agency should complete a full investigation and proceed with prosecution if the event warrants enabling the reduction of bias.

Lastly, advocate for a policy that involves service members (upon entry) receive counseling services by a certified behavioral health provider concerning the risks of serving in the military. Mental illness signs and symptoms should be discussed and service members should be required to identify them and have a designated individual of their choosing to check in for mental health and wellness.

References

- Bean-Mayberry, B., et al. (2011). Systematic review of women veterans' health: Update on successes and gaps. *Women's Health Issues, 21(4S)*, S84–S97
- Campbell, R. and Raja, S. (2005). The sexual assault and secondary victimization of female veterans: Help-seeking experiences with military and civilian social systems. *Psychology of Women Quarterly, 29(1)*: 97–106
- Center for Disease Control and Prevention. (2019). Health-related quality of life (HRQOL) Retrieved from <https://www.cdc.gov/hrqol/index.htm>
- Clement et al. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45(1)*, 11-27.

DePalma, R., and Hoffman, S. (2018). Combat blast related traumatic brain injury (TBI): decade of recognition; promise of progress. *Behavioural Brain Research*, 340, 102-105,
10.1016/j.bbr.2016.08.036

Dichter, M., Cerulli, C., Bossarte, R. (2011). Intimate partner violence victimization among women Veterans and associated heart health risks. *Women's Health Issues*, 21(4), S190-S194,
10.1016/j.whi.2011.04.008

Epstien, E., Martindale, S., & Miskey, H. (2019). Posttraumatic stress disorder and traumatic brain Injury: sex differences in veterans. *Psychiatry Research*, 274, 105-111
<https://doi.org/10.1016/j.psychres.2019.01.097>

Frances, D. (2013 30, April). Military Sexual assaults cost more than \$872 million. *The Fiscal Times*. Retrieved from <https://www.thefiscaltimes.com/Articles/2013/04/30/Military-Sexual-Assaults-Cost-More-Than-872-Million>

Hankin, C., Skinner, M., Sullivan, M., Miller, D., Frayne, S., & Tripp, T. (1999). Prevalence of depressive and alcohol abuse symptoms among women VA outpatients who report experiencing sexual assault while in the military. *Journal of Traumatic Stress*, (4), 601

Haun, J. N., Duffy, A., Lind, J. D., Kisala, P., & Luther, S. L. (2016). Qualitative Inquiry Explores Health-Related Quality of Life of female veterans with Post-Traumatic Stress Disorder. *Military Medicine*, 181(11), e1470–e1475. <https://doi.org/10.7205/MILMED-D-16-00064>

Himmelfarb, N., Yaeger, D., Mintz, J. (2006). Posttraumatic stress disorder in female veterans with military and civilian sexual trauma. *Journal of Traumatic Stress, 19*, 837-846.

Hoge, C., & Castro, C. (2014). Treatment of generalized war-related health concerns: placing TBI and PTSD in context. *Journal of the American Medical Association, 312* (16), 1685-1686,
10.1001/jama.2014.6670

Holland, K. J., Rabelo, V. C., & Cortina, L. M. (2016). Collateral damage: Military sexual trauma and help-seeking barriers. *Psychology of Violence, 6*(2), 253-261.
<http://dx.doi.org/10.1037/a0039467>.

Iverson, K. et al. (2011). Psychiatric diagnoses and neurobehavioral symptom severity among OEF/OIF VA patients with deployment-related traumatic brain injury: a gender comparison. *Women's Health Issues, 21* (4S), S210-S217

Katz L.S, Bloor, L.E, Cojucar, G, Draper, T (2007). Women who served in Iraq seeking mental health services: relationships between military sexual trauma, symptoms, and readjustment. *Psychol Ser, 4*, 239 – 49.

Kessler, R. (2011). The Costs of Depression. *Psychiatric Clinics of North America, 35*(1) 1-14. doi:
10.1016/j.psc.2011.11.005

Kimerling, R., Iverson, K., Dichter, M., Rodriguez, A., Wong, A., & Pavao, J. (2016) Prevalence of intimate partner violence among women Veterans who utilize Veterans Health Administration primary care. *Journal Gen Intern Med*, 31 (8). 888-894, 10.1007/s11606-016-3701-7

Mishel, M. (1988). Uncertainty in Illness. *Journal of Nursing Scholarship*. 20(4), 225-232.

<https://doi.org/10.1111/j.1547-5069.1988.tb00082.x>

Morral, A., et al. (2015). *Sexual Assault and Sexual Harassment in the U.S. Military: Volume 2.*

Estimates for Department of Defense Service Members from the 2014 RAND Military

Workplace Study. Retrieved from https://www.rand.org/pubs/research_reports/RR870z2-1.html

Montgomery, A. E., Sorrentino, A. E., Cusack, M. C., Bellamy, S. L., Medvedeva, E., Roberts, C. B., &

Dichter, M. E. (2018). Recent intimate partner violence and housing instability among women veterans. *American Journal of Preventive Medicine*, 54(4), 584–590.

<https://doi.org/10.1016/j.amepre.2018.01.02>

PEW Research Center. Profile of U.S. veterans is changing dramatically as their ranks decline. (2016).

Retrieved from: https://www.pewresearch.org/fact-tank/2016/11/11/profile-of-u-s-veterans-is-changing-dramatically-as-their-ranks-decline/ft_16-11-11_veterans_profile/

Rivera, J. C., & Johnson, A. E. (2014). Female veterans of Operations Enduring and Iraqi Freedom:

Status and future directions. *Military Medicine*, 179(2), 133–136.

- Sayer, N et al., (2011). Military to Civilian Questionnaire: A Measure of Postdeployment Community Reintegration Difficulty Among Veterans Using Department of Veterans Affairs Medical Care. *Journal of Traumatic Stress*, (6), 660
- Schaffer, B. (2014). Female Military Veterans: Crime and Psychosocial Problems. *Journal of Human Behavior in the Social Environment*, 24(8), 996–1003.
<https://doi.org/10.1080/10911359.2014.953415>
- Shepard, D., Gurewich, D., Lwin, A., Reed, G., & Silverman, M. (2015). Suicide and suicidal attempts in the United States: Costs and policy implications. *Journal of the American Association of Suicidology*, 1-11.
- Suris, A., & Lind, L. (2008). Military sexual trauma: A review of prevalence and associated health consequences in veterans. *Trauma, Violence, and Abuse*, (4), 250.
<https://doi.org/10.1177/1524838008324419>
- Szabo, L. (2014, May 12). Cost of not caring: Nowhere to go. The financial and human toll for neglecting the mentally ill. *The New York Times*, Retrieved from
<https://www.usatoday.com/story/news/nation/2014/05/12/mental-health-system-crisis/7746535/>
- U.S Census Bureau. (2015). Early-Career Aged Female Veterans More Likely to be Employed, Married and Have Kids Than Their Nonveteran Counterparts. Retrieved from
<https://www.census.gov/newsroom/press-releases/2017/women-veterans.html>

U.S. Department of Veterans Affairs. (2017). Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans. Retrieved from <https://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2015-qtr3.pdf#>

U.S. Department of Veterans Affairs, Veterans Health Administration, Office of Research and Development . (2004). VA R&D women's health research conference. Retrieved from http://www.research.va.gov/programs/womens_health/conference/default.cfm

U.S Department of Veterans Affairs. (2017). Women veteran population fact sheet.
<https://www.va.gov/womenvet/docs/WomenVeteransPopulationFactSheet.pdf>

Valdes, C., Kimerling, R., Hyun, J., Mark, H., Saweikis, M., & Pavao, J. (2011). Veterans health administration mental health treatment settings of patients who report military sexual trauma. *Journal of Trauma and Disassociation*, 12(3), 232-243.

Watkins, K. et al., (2011) Veterans Health Administration Mental Health Program Evaluation: Capstone Report, RAND Corporation, TR-956-VHA, 2011 Retrieved from (http://www.rand.org/pubs/technical_reports/TR956.html)

Appendices

SWOT

SWOT Analysis of Fieldwork



Strengths

Advisor Support
Applied Research Skills
Networking Connections



Weaknesses

Missing data
New Qualitative software
Unknown



Threats

Analysis results may create
negative perceptions
Sensitive nature of results

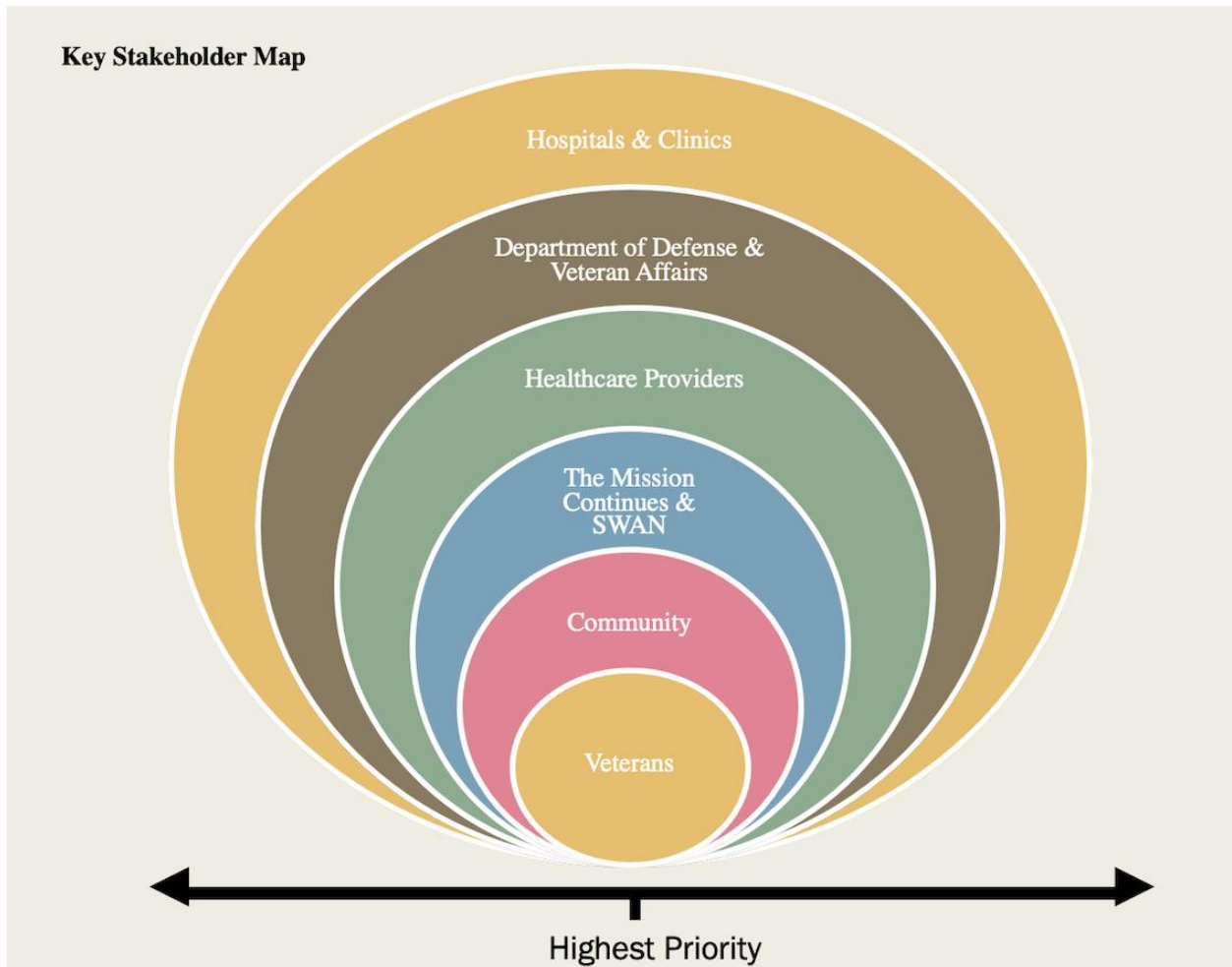


Opportunities

Policy
recommendations for
target population.

Increase awareness
of issues.

Stakeholder Map



Personal/Project goals & Objectives

Personal Learning Goals, Objectives and Activities

Personal Learning Goal #1: Hone interpersonal communication skills and effectively communicate ideas in professional settings

Personal Learning Objective: By the end of the spring semester I will have implemented various strategies to increase my ability to effectively communicate in professional settings that involve business meetings, online or tele conferencing.

Activities:

1. *Complete a cultural competence assessment and identify systemic bias*
 - a. Who is responsible? Rae
 - b. Start Date: February 8, 2019
 - c. End Date: March 15, 2019
 - d. Tracking Measure: Document on the Service Leadership Training database
2. *Participate in a group meeting with my advisor and other academic professionals*
 - a. Who is responsible? Rae & Kate
 - b. Start Date: March 1, 2019
 - c. End Date: May 1, 2019
 - d. Tracking Measure: Document meeting minutes toward a conversation agenda
3. *Address conflict of interest with Vulnerability and Curiosity*
 - a. Who is responsible? Rae
 - b. Start Date: January 24, 2019
 - c. End Date: continuous
 - d. Tracking Measure: Address issues and assess my strengths and limitations to increase innovation toward the project/program goal.

Personal Learning Goal #2: Complete extra leadership training courses before the end of the Spring Semester.

Personal Learning Objective: By the end of the spring semester, I will participate in two lean sigma six courses for certification in white and yellow belt and will start the certification for Program Management Professional Certification Program (PMP) or Certified Associate in Project Management (CAPM).

Activities:

1. Enroll and complete White Belt Sigma Six

- a. Who is responsible? Rae
- b. Start Date: February 8, 2019
- c. End Date: February 17, 2019
- d. Tracking Measure: Achieve certificate of completion from Lean Sigma Six

2. Enroll and complete Yellow Belt Sigma Six

- a. Who is responsible? Rae
- b. Start Date: February 17, 2019
- c. End Date: October 1, 2019
- d. Tracking measure: Get supervisor approval for coursework and completion of in-person session for certification.

3. Enroll in PMP and complete coursework toward exam

- a. Who is responsible? Rae
- b. Start Date: February 16, 2019
- c. End Date: November 1, 2019

- d. Tracking Measure: Completion of course modules.

Project Goals, Objectives and Activities

Project Goal #1: Analyze focus group data.

Project Objective: By May 1st, I be able to analyze group data using NVivo.

Activities:

1. *Read through research articles about focus group data analysis*
 - a. Who is responsible? Rae
 - b. Start Date: February 1, 2019
 - c. End Date: April 18 , 2019
 - d. Tracking measures: Create a excel sheet with a brief literature review to learn more about analysis of focus group data.
2. *Read through focus group data and begin analysis with my preceptor*
 - 2.1 *Catalog and document focus group data by group, age and veteran status.*
 - a. Who is responsible? Rae & Kate
 - b. Start Date: February 1, 2019
 - c. End Date: April 18 , 2019
 - d. Tracking measures: Review main ideas to identify themes and categories
3. *Create a matrix with categories and themes for each main idea*
 - a. Who is responsible? Rae
 - b. Start Date: March 1, 2019

- c. End Date: March 30, 2019
 - d. Tracking measures: Document a google drive excel matrix and submit for review
4. *Summarize findings*
- a. Who is responsible? Rae
 - b. Start Date: March 30, 2019
 - c. End Date: April 30, 2019
 - d. Tracking measures: Create a google drive word document and submit for review

Project Goal #2: Develop recommendations for policy to increase current resources to increase women veteran service unitization

Project Objective: By May 1st, I will have developed and analyzed the focus group data and report my findings to my preceptor.

Activities:

1. *Find the gaps in service utilization from the focus group analysis.*
 - a. Who is responsible? Rae
 - b. Start Date: April 30, 2019
 - c. End Date: June 1, 2019
 - d. Tracking measure: Document results and develop the recommendations for preceptor review that increase awareness of research of women service members and awareness of services women veterans are seeking and research national current resources.

Interview Questions/Guide

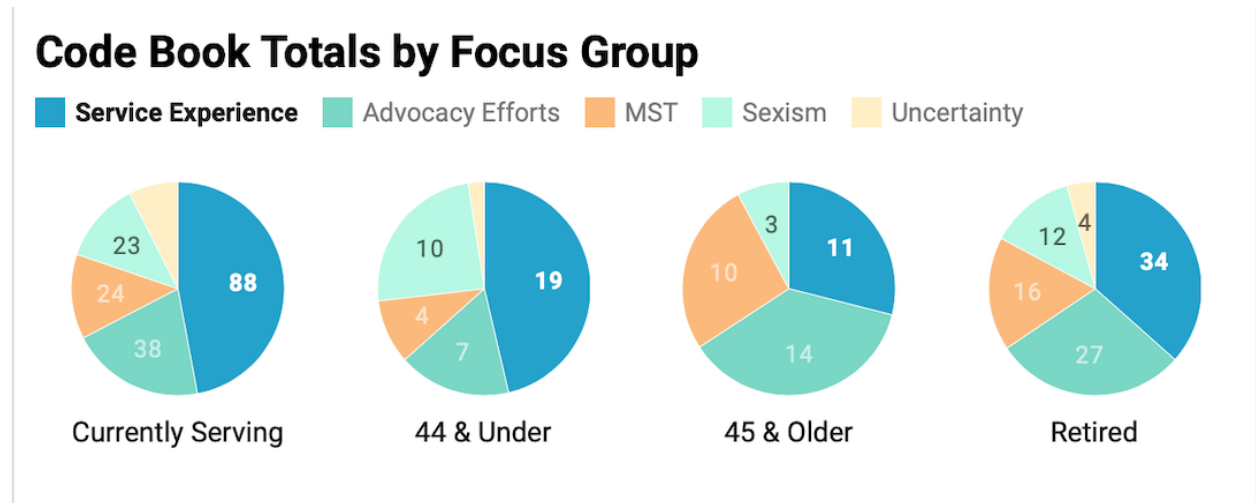
Start recording. "We would like to record this discussion to be sure to collect everything that is said, is that ok with you?" (Be sure all have affirmed)

Questions for Focus Group discussion:

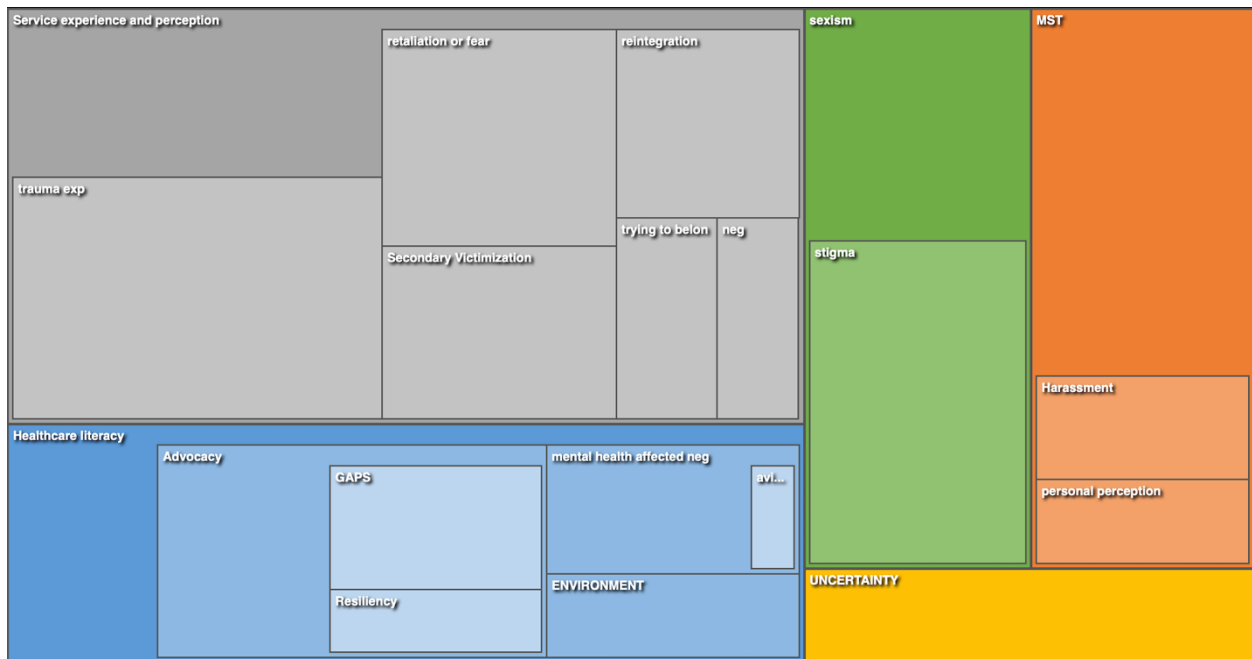
1. The results of our survey indicate that service makes women more resilient, but also can create mental or physical health challenges. What do you think about this?
2. How does this impact you? How would you prioritize the self-reported mental health issues facing military and Veteran women?
 - a. Probe: what are the most important issues to address at this time?
 - b. Probe: what are the least important issues to address at this time?
3. Where do you see gaps between what the self-reported mental health issues for military and Veteran women and existing programs to address these needs?
 - a. Probe: what are the most important gaps to address at this time?
 - b. Probe: what are the least important gaps to address at this time?
4. What are some ways to improve existing mental healthcare programs to fill the most important at this time?
5. How do we as women service members and veterans appreciate how different everyone's experiences are? How do we represent the experiences of diversity and begin talking about it?
6. What are your thoughts about trying to move into a productive conversation about women's mental health?
 - a. What about this is so hard?
 - b. What are barriers?
7. How do we incorporate conversations about MST?
8. How should we share recommendations with policy makers at the Department of Defense, Veterans Affairs, Members of Congress, veteran service organizations and mental health care organizations?
 - a. How do we engage these organizations?
 - b. Can we use any tools to improve the delivery of our message?

Thank you so much for your time and sharing your opinions about this topic!

Crosstab Query/Node Tally



Hierarchy of Codes



Comparison of Focus Group by Codes (Relationship graphics)

