

A RHETORIC OF BETRAYAL: MILITARY SEXUAL TRAUMA AND THE  
REPORTED EXPERIENCES OF OPERATION ENDURING FREEDOM AND  
OPERATION IRAQI FREEDOM WOMEN VETERANS

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## GLOSSARY

Theatre: Entire land, sea, and air area that may become or is involved in war operations.

Green Zone: Commonly referred to as a safe area in theatre.

Haze Gray Vessel: A United States Navy ship.

Vet Center: Government-sponsored center that provides mental health and wellness programs for veterans.

Service-Connected Disabled Veteran: A veteran who is compensated monetarily each month and is eligible for health care for an injury that was caused or aggravated by military service.

Enlisted Personnel: Military personnel that execute orders during military operations, a non-commissioned officer.

Officers: Commissioned military personnel, usually known for planning military operations.

Combat Veterans: Individuals who have deployed to a combat zone, such as Iraq or Afghanistan.

Mobilize: To move a unit from state side to a theatre.

Premobe: A pre-determined location where specific combat and mission oriented training is done prior to mobilization.

Morale Van: A military vehicle assigned to a military installation specifically for the purpose of transporting military personnel to locations such as a bowling alley or church for the purposes of “enhancing” morale and welfare.

## CHAPTER ONE

### Introduction

Currently, women are working in almost every capacity alongside servicemen, especially while deployed to Iraq and Afghanistan. More than 212,000 women servicemembers have been deployed during Operation Enduring Freedom and Operation Iraqi Freedom, making up 11 percent of our forces deployed (Mulhall, 2009:2). Over 120 of those women have given their lives, and more than 600 have been wounded in action (Mulhall, 2009). Many of them are serving in key combat functions, increasing the likelihood of stress-associated health conditions. Women veterans report experiencing stressful and traumatic events at rates much higher than nonveteran women or male veterans (Voght, Bergeron, Salgado, Daley, Ouimette and Wolfe, 2006:19). Historically, the Veterans Affairs (VA) health care system has served primarily the male veteran patient. The women veteran population uses VA health care at rates much lower than men; however, women who do use VA health care are now and have always been more likely to use it at rates more intensively than male veterans (Washington, Yano, and Simon, 2006). However, the rate and intensity of utilization ultimately depend on the referral from physicians.

Additionally, the health consequences for women in combat theatre are still largely unknown and no long-term studies on this topic have been completed (Mulhall, 2009:9). Although some studies suggest that women are more prone to mental health injuries than male servicemembers, the Army's Mental Health Advisory Team, monitoring soldiers in Iraq since 2003 found that "Female soldiers are no more vulnerable than male soldiers in how combat can affect their

mental health and well-being” (Mulhall, 2009:9). Due to the changing roles of women in the military, research regarding their experiences is warranted.

The majority of studies use quantitative methodology and lack exploration of interpretations and definitions of military life from the perspectives of women veterans. Therefore, the primary objective of this pilot study is to understand the military experiences of OEF/OIF women veterans. This project started with four specific aims:

1. to explore the military experiences of women veterans who served during OEF/OIF;
2. to explore the perceived impact military experiences have on the health, including the mental health, of women veterans;
3. to describe women veterans’ experiences; and
4. to develop an awareness training program for VA service providers.

However, during the interviews seven women veterans described accounts of sexual harassment and sexual assault, also known in the Veteran Health Administration (VHA) context as Military Sexual Trauma (MST). The prevalence and dialogue of MST both explicitly and implicitly throughout all the interviews justified examining MST on its own. A deeper examination of the nature of MST can offer insight that will assist in understanding the world of women who experience military sexual trauma. Therefore, this thesis explores the nature of MST in order to contribute to the sociology of gender and military culture and the social construction of the social problem of MST by examining narratives of OEF/OIF women veterans who seek health care services

throughout the VA system. It is important to note that this thesis project is one component of a much larger ongoing study.

The academic literature suggests that men and women generally experience different types of trauma (Freyd and DePrince, 2007). Historically, women are more likely to report sexual abuse than men. However, it is possible that women experience more trauma, but that trauma is less likely to be reported because women perceive the events differently (Freyd and DePrince, 2007). Therefore, by examining the narratives of women veterans, we may be able to identify elements that contribute to the complexity of MST.

Researching socially sensitive topics such as MST raises ethical concerns. Additionally, socially sensitive research refers to studies in which there are potential social consequences or implications, either directly for the participants in the research or for the class of individuals in the research, in this case women veterans or women serving in the United States military (Sieber and Stanley, 1988:49). It is recognized that knowledge used for human betterment can be used for exploitative or manipulative purposes (Sieber and Stanley, 1988:49). It is essential to communicate that findings in this study are intended to promote awareness about MST and its implications.

Furthermore, MST is viewed as a characteristic of society that is problematic and the act of MST as conduct that requires critical examination. The prevalence of MST is affirmation that lack of acceptance of and violence towards women in the military, a male-dominant institution, still exists. It is evident from my work with VA service providers that MST is rampant and seen as a social



problem. In fact one service provider that was not in the sample used in this thesis summarized the following:

I think they [women veterans] have a strong commitment to what they're doing but from what they would say to me—what they've said to me—is that many of them have been either sexually abused in the military or they've been approached or harmed some way physically by being pushed by the men. Also, usually put down by the men—verbally put down by the men. And then that's not addressed well. That's not addressed by the military that I can tell and then, or the women aren't also confident enough to bring it up to the military and confidence has to do with not being afraid. I think they're fearful.

Therefore this thesis focused on MST as a social problem. The descriptive accounts of MST are offered as a means for women to be empowered through verbal claims.

## LITERATURE REVIEW

To better understand the sociological significance of the women's reported experiences of MST analyzed in this pilot study, it is important to explore the background literature about (a) the changing roles of women in the military, (b) the prevalence of military sexual trauma and the associated stress-related health conditions, and (c) what the VHA is doing to address health sequelae of MST.

### Women and the Military

Although the integration of women into the military has occurred slowly over time, "women have carried arms or engaged the enemy in virtually every conflict ever fought by the United States, including and beginning with the War of Independence" (Murdoch, Bradley, Susan, Mather, Klein, Turner, and Yano,

2006:5). In 1901 and 1908 the Army Nurse Corps and Navy Nurse Corps were established. Nurses were not given benefits or rank similar to men service members, yet nursing was the first step towards integrating women into the Armed Services.

Typically during wartime a deficiency of servicemembers was likely and women were recruited to enlist. Majority of job positions available for women were administrative in nature or providing medical care for the injured and sick. Jobs specified as women's work were done with the intent of freeing up men to fill combat positions. During World War I, women received pay and rank similar to enlisted men and in World War II many more job opportunities for women in the military became available. As a result, nurses began risking their lives to help others on the battlefields and were frequently exposed to illness and disease. It is important to note that nurse's have accounted for most of women prisoners of war (POWs) (Murdoch et al., 2006:5).

Then, in 1948 the Women's Armed Services Integration Act was passed. This allowed women permanent status as active duty and reserves in all branches of the Armed Forces. However, many jobs were still restricted for women. Women were unable to be in charge of or delegate duties for servicemen, and advancement in rank was unlikely, especially within the officer ranks. Women who had children were not eligible to enlist in any military branch. In addition, women who got pregnant while on active duty or in reserve duty status were immediately discharged from the Armed Services altogether (Murdoch et al., 2006).

During the Korean Conflict women were not allowed to work in particular occupations, such as navigation, engineering, and intelligence. This made advancement in rank, promotions, and military privileges less obtainable for women. Similarly, issues pertaining to racial discrimination and segregation resulted in the reduction of recruitment rates for women (Dever and Dever, 1995).

In the Vietnam Conflict when the numbers of military personnel became a dismal situation, the Department of Defense (DOD) resisted expanding women's roles and instead authorized the enlistment of 300,000 men with low aptitude scores. It was not until after the Vietnam Conflict restrictions were lifted, when women were allowed to advance in rank and pursue occupations other than clerical or nursing, with the exception of combat roles (Murdoch et al., 2006; Dever and Dever, 1995).

In 1992, during the Persian Gulf War, policies regarding combat roles for women underwent modifications for the first time in history. In Operation Desert Storm and Operation Desert Shield a variety of combat restrictions were lifted, allowing women to serve in combat support roles. According to Valente "over 33,000 women served in key combat support functions, driving trucks, flying planes and helicopters, running POW facilities, directing artillery, and serving in port security and construction battalions during this time" (2007:259).

The day after the terrorist attacks on September 11, 2001, the Global War on Terrorism (GWOT) began. Since the United States declared GWOT, women serving in OEF/OIF began working in nearly every capacity alongside

servicemen. They are wounded, captured, become POWs and even die as a result of carrying out their duties. Although women are not designated to work in ground infantry, armor or artillery units, and, according to the current policies, are confined to support combat roles, they are serving in some of the most dangerous jobs. These include convoys, guarding checkpoints, and neighborhood patrols through Iraqi cities like Baghdad, making the divide between combat and combat support duties increasingly challenging for military policy and officials.

In addition, distinct war zones or battle lines are lacking in this war. Roadside bombs known as improvised explosive devices (IEDs), mortars, small arms fire and missile attacks increased the likelihood of injury or death among our deployed military personnel ([www.va.gov](http://www.va.gov)). For the first time in United States history, we have the largest woman population serving in the military and now serving in key combat support roles while in Iraq and Afghanistan. As many as 1 in 5 enlisted troops in some service branches are women and they make up approximately 20% of new recruits into the military (Washington et al., 2006). In addition, 19.6% of the 140,000 reserve troops serving overseas and 14% of the 230,000 active-duty forces are women (Hall, Sedlacek, Berenbach, and Dieckman, 2007). Despite the ongoing presence of women in the military and the high prevalence of military sexual abuse, the health consequences of sexual abuse affecting servicemembers was not addressed until recently.

### Military Sexual Trauma

Military sexual trauma is a contributing factor likely to increase the prevalence of PTSD and depression among women veterans. In addition to combat stressors and usual military stressors, an additional enemy is present in “Theatre,” “Green Zones” or onboard “Haze Gray Vessels.” Despite the official integration of women in the Armed Forces in the early 1900s, the minority status of women and the hostility toward the presence of women in the military are known (Hall et al., 2007:230). Sexual violence within the United States military is a fact long recognized by military officials, policymakers, health care professionals, and the media (Kimerling, Gima, Smith, Street, and Frayne, 2007:2160).

However, it was not until the Vietnam era that interest concerning sexual abuse developed (Valente and Wight 2007:259). Unlike recent years, veterans serving in previous wars were not asked about sexual abuse nor did they report it. Shortly after the Tailhook incident in September 1991, sexual abuse of women in the military gained tremendous media attention. The Tailhook incident, along with reports of sexual abuse from active duty women who served during the Persian Gulf war, the Department of Defense (DOD) began to investigate the allegations of sexual abuse. Of the women who served during the Persian Gulf War, 8% reported being sexually abused while on active duty (Valente and Wright, 2007:259). As a result of the reported incidents of sexual abuse in the 1990s, the Veterans Health Administration adopted the term MST to refer to severe or threatening forms of sexual harassment and sexual assault sustained in military service.

According to the Department of Veterans Affairs National Center for Posttraumatic Stress Disorder, MST is “unwelcome verbal or physical conduct of a sexual nature that occurs in the workplace or an academic or training setting to include gender harassment, for instance: put you down because of your gender, unwanted sexual attention, offensive remarks about your sexual activities or your body, and sexual coercion, for example: implied special treatment if you were sexually cooperative” (Street and Stafford, 2008:1). In addition, MST also includes sexual assault and is defined as “any sort of sexual activity between at least two people in which one of the people is involved against his or her will, where physical force may or may not be used.” The VA definition of MST also includes “many different experiences including unwanted touching, grabbing, oral sex, anal sex, sexual penetration with an object, and/or sexual intercourse” (Street and Stafford, 2008:1). Recent studies suggest that sexual trauma which occurs in the Armed Forces has a greater impact due to factors exclusive to the military environment (Mulhall 2009 and Wolfe et al., 1998).

Today, one in every four women veterans who use VA Medical Centers reports a history of sexual trauma while serving on active duty (Suris, 2007:180). Hall et al. suggest that the prevalence of MST is as high as 78% in women active duty personnel and 60% in reserve troops (2007:229). Although MST occurs during periods of training, wartime and peacetime, the stress of war may be a factor in the increase in sexual assault, and both physical and verbal sexual harassment (Wolfe et al., 1998:41).

Additionally, less is known about the effects of sexual harassment, also included in the VA's definition of MST. Among women veteran patients treated at VA facilities, 90% reported experiencing frequent harassment during tours of duty (David, Simpson, and Cotton, 2006:556). Some studies report that verbal sexual harassment can have just as damaging effects as physical sexual abuse and result in depression, anxiety, job attrition, declining academic performance, difficulties with interpersonal relationships, and greater health complaints (Wolfe et al., 1998:41). Furthermore, servicemembers are discouraged from disclosing the event; fear of retribution and damagingly and negative consequences all contribute the underreporting of MST (David et. al., 2006:556). Very few military personnel who experience sexual harassment or sexual assault report the incidents to supervisors or designated victims' advocates within their military branch.

In addition, the majority of these women lived on government facilities, such as military bases and naval vessels, and work and live in the field or theatre while carrying out military duties and pursuing career goals. As a result, women who experience sexual harassment or sexual assault often work and live in the same environment as their assailants. In some cases, they may also have to collaborate or depend on their attacker to delegate or complete work tasks and depend on them for basic needs including medical, dental care and safety in theatre.

Unit cohesion may create environments where victims are strongly encouraged to keep silent about their experiences, have their reports ignored,

and then be blamed by others for sexual assault; and all of these conditions have been linked to poorer outcomes among civilian assault survivors (Kimerling et al., 2007:2160). As a result, the servicemembers may either forfeit career ambitions or have frequent contact with their attacker (Street and Stafford, 2008:2). In addition, cohesion factors, and fear of consequences associated with reporting sexual harassment or sexual assault may contribute to the lasting effects of trauma. Additionally, women often developed ways of managing until their separation from the United States military when psychological and physical health care services can be rendered.

#### PTSD and Associated Stress-Related Health Conditions

Posttraumatic stress disorder (PTSD) has typically been associated with combat and men, much less with women servicemembers (Wolfe et al., 1998:42). However, PTSD as a result of rape is long-term and has severe negative physical and social consequences on one's health (Yaeger, Himmelfarb, Cammack, and Mintz, 2006:65). Psychological symptoms as a result of sexual assault cause a decline in one's ability to trust and diminish perception of safety in the world, and increase shame, produce disturbances in interpersonal relationships, and result in poor sleep, and other symptoms of acute stress disorder and PTSD (Kakhonovets and Holohan, 2007:19). Wolfe et al. found that PTSD was an especially common outcome of sexual trauma with more severe types of sexual abuse such as sexual assault (2007). A recent study suggests that women who experience MST are at an equal or higher risk for developing PTSD compared to men combat veterans (Kimerling et al., 2007).



Yaeger and colleagues found that 60% of those who experienced MST had PTSD (2007). Moreover, completed rape led to PTSD in as many as 90% of women at 4 weeks post-assault and remained as high as 47% at 3 months post-assault. Additionally, the VA suggests that military sexual harassment and military sexual assault, also known as MST, leads to 59 percent higher risk of mental health injuries (Mulhall, 2009:9). Similarly, another VA study found that women sexual assault survivors are at an increased risk for developing major depression, self-blame, anxiety, phobias, substance abuse, suicidality, and substantially increased health care use (Wolfe et. al., 2007:41). Although women veterans have substantially increased health care use, it is known that women veterans are more likely to seek mental health services for psychological injuries than their male counterparts (p. 9).

#### Veteran Health Administration

In 1992, MST was brought to the awareness of policy makers when several cases regarding sexual abuse specific to women were brought to the media's attention. As a result, in November 1992 Congress passed Public Law 102-585 that gave the Department of Veteran Affairs the authority to assist women veterans who experienced sexual trauma by providing counseling and treatment programs.

Sequentially, Public Law 102-452 was passed to include men as well. Later on in 1999 and then in 2004, Congress passed two more public laws, Pub. L. 106-117 and finally Pub. L. 108-422, which expanded the existing programs put in place within the Department of Veterans Affairs (Murdoch, 2006:6). MST

counseling and related health care services were expanded. The new Public Laws were extended to include active duty members in training, such as those in boot camp. Additionally, it gave the Veteran Affairs authority to provide services for MST-related health issues indefinitely (Veteran Health Administration Directive, 2005).

Through the initiation of the public laws passed by Congress, Veteran Health Administration (VHA) policy requires that veterans be notified of their ability to file a claim for service-connected disability compensation. It also requires that veterans be given additional contact information if needed. Also, an MST software program was implemented at each VA Medical Center and is used as a universal MST screening tool for all veterans as part of a nationwide tracking system to follow MST programs, services provided and rates of MST among veterans. Currently the VHA policy is to provide MST counseling, including appropriate care and services to overcome psychological trauma that resulted from a physical assault of a sexual nature, battery of a sexual nature or sexual harassment which occurred while the veteran was serving on active duty or training. As a result of recent and current military endeavors, each VA Medical Center has an MST coordinator designated to assist veterans, including OEF/OIF veterans. Each facility designated MST Coordinator is responsible for providing education for employees and ensuring that all new OEF/OIF veterans entering the VA health care system are screened for MST. Coordinators are then responsible for providing veterans with the appropriate clinic-based on information gathered during the intake process related to MST screening,

service-connected disability benefits, and annual income if not a service-connected disabled veteran.

According to the 2005 VHA Directive, veterans seeking care at VA Medical Centers for services not related to MST or veterans without service-connected health conditions or disabilities are responsible for co-payments and this can vary depending on the disability rating awarded to the veteran. On the contrary, counseling and health care received by veterans for MST-related issues are not billed for inpatient or outpatient services, nor are co-payments required for prescribed medications. Scheduling for outpatient sexual trauma counseling, treatment, and related services are supposed to be given precedence and scheduled within 30 days. Consequently, MST counseling is to be provided by a qualified mental health professional. If the VA medical facility is unable to provide a qualified MST counselor, the veteran is referred outside the VA system for fee-based services. If a veteran is ineligible for VA health care benefits as a result of limited time served in the Armed Forces, but reports MST and requests assistance, the VHA must grant MST counseling and related treatment. Due to the prevalence of MST, the VHA has initiated action by developing directives with intentions of providing appropriate and needed services (such as MST counseling) for veterans.

The Women Veterans Health Care Improvement Act of 2008 was passed on June 26, 2008, by the Senate Veterans Affairs Committee to prepare the VA Medical Centers for the increase of women veterans returning from Iraq and Afghanistan who will be using VA health care services. The bill authorized

research studies about gender-specific health needs of women and included research initiatives to determine the physical, psychological, and readjustment needs of women returning from Iraq and Afghanistan ([www.va.gov](http://www.va.gov)). As a result, the VA is now authorized and funded to conduct a comprehensive needs assessment to determine the barriers currently affecting the ability of women to access health care throughout the VA system. In addition, the VA is considering the availability of child care and the personal comfort of women veterans who use facilities that have historically provided health care for men veterans. This bill also authorized the VA to conduct evaluative research on the effectiveness of programs specialized in serving the women veteran population.

Furthermore, VA research is now aimed at women veterans health issues. All VA hospitals are currently required to have a full-time women veterans' program manager. Additionally, they require that a woman recently separated from the military serve on the VA advisory boards. The new bill requires that the VA implement a program to train, educate, and certify VA mental health professionals to care for women with MST and PTSD using evidence-based treatments. Moreover, each VA Medical Center is supposed to initiate a pilot program to provide readjustment counseling for women veterans in group settings.

In addition, the Center for Women Veterans met in Washington D.C. on June 20-22, 2008, for the National Summit on Women Veterans Issues. Some topics on the agenda included discussion about updating the benefits and compensation rates for women veterans, including health care and disability

benefits available to them. The bill included compensation for MST. Also, they discussed having gender-specific staff when rendering health care services. Awareness training for all VA staff to increase patient satisfaction in general was covered. More specifically, they identified the need for greater general awareness about MST when screening women veterans during the initial patient intake process at VA Medical Centers, when rendering mental health care services related to MST, and the need for same-gendered MST screenings. Outreach materials are now increasingly highlighting women veterans in hopes of encouraging them to use services within the VA health care system.

More research requirements, assessments regarding comprehensive health care needs of women veterans, and training of VA service providers treating women veterans suffering from PTSD as a result of MST and combat were brought to the Veterans' Affairs Committee in the spring of 2009. Child care programs and newborn care for qualified families were identified as needs. On June 10, 2009, H.R. 1211, the Women Veterans Health Care Improvement Act of 2009, was passed, providing additional funding for women veteran health research and a pilot program for child care and newborn care to eligible families.

Although the VA collectively appears to be taking steps to improve its health care for women veterans, seemingly their efforts are *damage control*. While new opportunities and doors have been opened for women in the services, they still face significant and unique challenges such as: slower career progression, underrepresentation in the military's senior ranks, inadequate military health care, and staggering rates of sexual harassment and sexual

assault, which reflect the military's inability to care for its own (Mulhall, 2009:1). Despite the lack of support and despite the betrayal these women experienced while in the military, they courageously served. While women are joining the military more than ever before in the history of the United States, they are also leaving the military at higher rates than men. Women veterans have expressed four main reasons for their decision to not remain in the military, they include; (a) concerns about the opportunities for career advancement, (b) balancing military career and family life, (c) inadequate military health care for women servicemembers, and (d) the prevalence of sexual harassment and sexual assault (Mulhall, 2009). Therefore, further examination of the unique challenges women veterans experience is warranted.

Due to the increasing number of women veterans, the changing roles of women in the military and the prevalence of MST, it is crucial that that the VHA increase its understanding of the lived experiences of women veterans, health sequelae and gender-specific health care and counseling service needs. Further sociological research on women in the military could lead to a useful knowledge base for those in the VHA determined to implement reform.

Social constructionists who examine social problems, like Miller and Holstein, suggest that the constructionist position emphasizes that the activities through which social problems are constructed can be both implicitly and intentionally examined by the use of rhetorics (1993:6). Recently, researchers of social problems, especially social constructionists, have analyzed social problems as moral discourses employing different types of rhetoric in claims-

making (Best 1990; Ibarra and Kitsuse 1990, 1993). This use of discourse and its associate vocabulary describes an argumentation over a wide range of conditions deemed “social problems” (Best 1990; Ibarra and Kitsuse 1990, 1993). In addition, rhetoric is an area of study that “seeks to develop a theory of the vernacular constituents of social problems” (Ibarra and Kitsuse, 1990, 1993).

In other words, social constructionists examine rhetoric to identify how people affirm; reaffirm, and reproduce social problems in their everyday speech (and, perhaps, in their everyday actions and behaviors). In this regard, this thesis takes a strict constructionist view, concentrating on informants’ words as claimed actions and reports of experience that are versions of what “really” occurred or what is claimed to have occurred; informants’ words are neither necessarily accurate nor inaccurate.

However, it is worth noting that it is more difficult to obtain verbal reports of some kinds of incidents, incidents that are potentially more shaming, incidents the reporting of which is emotionally difficult for the informant, and incidents for which less public sympathy is known to exist—and military sexual trauma is just that type of action. Therefore, the sociologist of social problems might be more likely to trust reports of incidents like MST, incidents whose very reporting may be stigmatizing and perhaps emotionally taxing and painful. Evidence of social problems may also exist in “official” nonacademic literature, like military websites and printed literature, and it remains to examine all the: official, and all the popular, literature representing MST.

There is also a considerable academic literature utilizing rhetoric. Ibarra and Kitsuse suggest that the “rhetoric brings to the fore the sense in which the task for constructionism lies less with the referential aspects of claims than with the constitutive techniques and processes that are entailed in claims-making as such” (p. 34). The concept of rhetoric has been useful to many different scholars in order to examine the construction of social problems and has been used in: Gardner’s study of the rhetoric of endangerment to explain prospective disabilities in children and social control on mother’s. Phillips, et al. 2000; also used it in the examination of hate crimes, Miller and Leslie’s study of the rhetoric of harmony in violent families (1990), and Shortell, et.al. 2004, used the concept of rhetoric to explore abolition. Primarily we see the examination of rhetoric in ways such as with the rhetoric of loss, the rhetoric of calamity, and the rhetoric of unreason but rarely with victimization. The Spector and Kitsuse book *Constructing Social Problems* presents the general framework of social constructionism as a tool for analyzing social problems, a framework that implicitly accommodates rhetoric’s of social problems.

This thesis posits that an examination of rhetoric’s of the reported MST experiences is necessary to understand better the conceptualization of these experiences among the target population and to gain insight about this social problem. Sequentially, VA Medical Centers may be able to better develop, implement and evaluate VA health care services designed specifically for women veterans and enhance the delivery of health care services for the growing woman veteran population. Additionally, knowledge gained from this study can help



increase the general social awareness about some of these unique experiences of women in the military. This study can contribute to the academic literature about gender and military culture, and MST as a social problem by exploring the rhetoric of betrayal, the most prominent rhetoric used by these women veteran informants.

## CHAPTER TWO

### Methods

#### Sample

This study used a qualitative approach from a sociological perspective, involving semi-structured in-depth interviews with a total sample of eight study participants. The project included OEF/OIF women veterans enrolled in VA health care at a facility in the Midwest. Eligibility criteria for study participation were as follows:

- Women veterans (a) had to be currently enrolled in the VA health care system (b) must have served during OEF/OIF and (c) had to have utilized health care services from a VA Medical Center after serving in the United States military. Women veterans eligible to participate included veterans varying in age, race/ethnicity, sexual orientation, level of education, occupation, and financial income.

Although a total of eight women veterans were enrolled in this study, one informant disclosed that she had recently returned from theatre and had been diagnosed with severe PTSD. Due to her fragile state, as a researcher and nurse, and my ethical responsibility, I felt it was in the informant's best interest not to probe during the interview. The interview with this subject lasted approximately fifteen minutes. During the interview it was never determined finally whether this informant had experienced MST: There was no way in which I could have ethically obtained this diagnostic information.

The length of the seven other interviews lasted on average three hours. It is important to note that MST was not the only dialogue during the interviews, however; MST was excerpted from these seven interviews and the focus of this thesis. Therefore, findings are based on excerpted data from seven informant interviews and exclude one enrolled informant.

I also interviewed eight VA service providers who were identified by OEF/OIF women veterans during the first phase of interviews. All of the VA service provider subjects worked primarily with the women veteran population at the same Midwestern VA Medical Center where OEF/OIF woman veteran participants sought health care. The in-depth interviews with VA service providers solicited their perceptions about the health care needs of women veterans, barriers to utilizing services and awareness of MST associated with their OEF/OIF women veteran patients. However, for the purposes of this thesis project, data from interviews with VA service providers will not be included, but will be used at a later time.

### Research Design

In order to understand the stated meanings and experiences associated with the military experiences of OEF/OIF women veterans, qualitative methodology was the best means for data collection and analysis. The aim of the study reported in this thesis is not to test relationships between operationally defined variables, but to explore the nature of the social phenomena that informants described when asked about their negative experiences in the military. Interviews promoted rich data, getting beneath the surface of social and

subjective life (Charmaz 2006:13). Interviews in this study presented verbal accounts of sexual harassment and sexual assault that occurred while participants were serving in the United States military and included related experiences, such as attempts at reporting MST to military supervisors or describing their current health conditions, which they perceived to be the result of MST. In this study, the concept of narrative or descriptions of sexual trauma is used to describe the way individuals and society organize, evaluate, construct, and remember experience (Richardson, 2008). Social constructionists agree that exploring the social meanings of interaction can capture the reported feelings and perspectives of individuals (Herman and Reynolds, 1994). Therefore, examination of the rhetorical forms of these experiences may provide insight about the barriers facing women servicemembers.

Grounded theory methods were chosen due to the exploratory nature of this pilot study and in order to fully capture the lived experience of OEF/OIF women veterans according to the women themselves. Consequently, in this case, “grounded theory is used, theory based in the reported real-life experiences of the actors themselves” (Charmaz 2006:15; Glaser and Strauss, 1967). Grounded theory research may be understood to be a type of symbolic interactionism, which focuses on how persons view their circumstances, how they interact, and how these processes change (Wilson and Hutchinson et al., 1992).

Charmaz’s version of grounded theory techniques are described in *Constructing Grounded Theory; A Practical Guide through Qualitative Analysis*

(Charmaz, 2006). Sentence by sentence coding was used to determine emergent themes. Themes and gathered information from interviews were used to guide the interviews that followed, allowing emergent themes to direct interview questions (Charmaz, 2006). Memos that I developed from the transcribed data were used to complete the analysis. My own coding is reflective of and reproduces Gruber's (1989) themes and I have adapted Gruber's typology in my analysis of the MST management when dealing with harassment (although not when dealing with sexual assault or rape). Emergent themes are supported by quotations from the interviews and imbedded throughout the text presented in Chapter Three.

### Recruitment Strategy

The first phase of this study included interviews with OEF/OIF women veterans and was the primary focus of this thesis. Advertisement flyers were posted at several local VA facilities, including the VA Medical Center. These flyers were posted in the women's clinic, primary care clinics, the speech pathology clinic, and OEF/OIF clinic at the VA Medical Center in a large mid-western city. Advertisement flyers were also electronically distributed on a veteran listserv through a local university. While subjects were completing a survey for a different VA Medical Center study, they were given this pilot study advertisement flyer.

It is important to note that women veterans were identified solely by self-referral. They contacted me by work phone number or work email, which were included on each advertisement flyer.

## Human Subject Concerns

The risks of participating in this study were minor. All interviews were conducted at the VA Medical Center or an affiliated University. In addition, each interview was done at the preferred location of interviewees; both interview sites were approved by the Internal Review Board and VA Research and Development Department. However, subjects could have felt uncomfortable while answering the interview questions. Discussing potentially sensitive subjects such as emotions and stressful military experiences occurred during the interviews. Even so, study participants had the option to refuse to answer any questions they found objectionable or that they were not comfortable discussing.

In addition, the study involved a risk of loss of privacy and confidentiality. I used procedures carefully designed to protect the privacy and confidentiality of all study participants. All interview transcriptions were assigned a code number. The master list linking names to this code number was kept in a secured location that was accessible only to the principal investigator and me. This master list was kept separate from the coded research transcriptions and notes. Due to the sensitive nature of the data collected during interviews, descriptive characteristics of the women are accomplished by describing the sample as a whole, especially with regard to age, location of duty assignments and military branch.

The strategy I used was the correct one for maintaining anonymity for very small samples. This was a situation where harm could impact one of the participants, especially since one of my informants was still on active duty at the

time of the study. Additionally, all of the study participants could potentially be called back to active duty and return to environments where if identified could potentially be at risk for harm or at worst, fratricide (defined as killing one's brother or sister, this term is used in the military to describe servicemember on servicemember violence). My decision not to use pseudonyms was a very common choice for small samples to protect subjects and maintain anonymity (Charmaz 2009: Personal Communication; Morse, 1998; Nespor, 2000; Cherot, 2009; Boman and Jevne, 2000; Karnieli-Miller et.al., 2009). In addition, IRB and VA HSR&D's enforce the protection of subjects per HIPPA guidelines.

The informants are at greater risk of identification due to their gender and occupation. A hypothetical example where a study participant may be easily identifiable would be an OEF/OIF woman veteran Navy nurse educator stationed at Little Creek Amphibious Base and then later states in the thesis "during my time in Norfolk." Writing even with pseudonyms could easily result in the exact identification of informants. Therefore, presenting characteristics of the small sample in general rather than talking about assigning each pseudonym was acting in informant's best interest.

Personal information may be disclosed if required by law. Authorized persons may include regulatory agencies such as the Office for Human Research Protection (OHRP), as well as members of the research administrative staff of VA Organizations that may inspect quality assurance and data analysis. This includes groups such as the investigator and his or her research associates, the

study sponsor, the affiliated Institutional Review Board or its designees and the VA.

There was no financial cost to subjects who chose to participate in the research study. Eligibility for medical care at a VA Medical Center is based upon the usual VA eligibility policy and was not guaranteed by participation in this research study. The study did not involve any medical care or services. However, study participants did receive a \$20 gift card to Wal-Mart for their participation. Monetary funds for the Wal-Mart gift cards were provided from a \$400 grant that I was awarded through my affiliated university.

In an instance of medical emergency, VA medical facilities would have provided necessary medical treatment to a research subject for medical problems that occurred as a result of participation in this study, since it was approved by the affiliated VA Research and Development Committee and conducted under the supervision of one or more VA employees. By signing the consent form, study participants did not give up their legal rights to seek compensation through the courts for injury.

Participation in this study was voluntary. Subjects could refuse to participate at any time during the study. Refusal to participate involved no penalty or loss of rights. Informants were able to withdraw from the study at any time without penalty or loss of VA health care or other benefits. Each study participant received a copy of the required VA consent form. In case there were any medical problems or questions, the principal investigator's contact information was provided to study subjects. Also, five additional phone numbers



for VA services, including: contact information for the mental health clinic, MST counselor, local Vet Center, local VA Medical Center's main phone number and the Women Veterans Coordinator were provided to each study participant [see glossary].

### Potential Benefits of Participation

This study may have provided a modality for women veterans to share their personal experiences and views about the military and VA health care with someone interested in their opinions. Additionally, research indicates that emotional disclosure has health benefits, leading to reduced rates of physical illness and increasing feelings of control over disturbing events (Pennebaker et al., 1989, 1997). Pennebaker also suggests that "talking freely about negative past events allows people to confront their problems, rather than avoid them or be ambushed by unhidden memories and images related to their problems" (1989). Subjects may have felt empowered by participating in this research study since it provided an opportunity for them to convey their experiences, opinions, and health care needs with a Department of Veteran Affairs researcher, but also with a researcher who is an OEF/OIF woman veteran.

Additionally, through disclosure some participants may have gained confidence in their coping strengths, felt greater personal coherence, and experienced a heightened sense of control (Keough and Markus, 2006:52). The rich and detailed rhetoric enables the framing of an awareness training model that can be used to inform the general public, military personnel, and VA Medical Center personnel about MST.

## Researcher Role

An underlying assumption of the qualitative paradigm is the relationship of the researcher and the researched (Bresler, 1995:1). The qualitative paradigm manifests the construction of multiple realities, which suggests that neutrality is impossible (Bresler, 1995:1). Therefore, the researcher has to consider how their role may influence the interviews and data collected. In this case, as an OEF/OIF veteran, I embraced the insider researcher role as having many advantages. Before starting each interview, I disclosed to study participants my educational background and veteran status, which was also included on my advertisement flyer. If specifically asked about my experience with MST, I offered to share my history after the interview was completed, and I did so. I found that my insider researcher role acted as catalyst in gathering rich data that otherwise would not have been obtainable if I was not a woman and an OEF/OIF veteran.

However, the insider role posed several challenges during the interviews and may have been a disadvantage as well, while conducting interviews and writing this thesis. A disadvantage of the insider role may have been that I was “too close” to the topic being researched due to my veteran status. During the analysis, I actively tried not to impose my own meanings on the data. I continuously revisited the transcribed interviews to detect any bias or influence that I may have imposed during the interview and then made necessary corrections in the interviews that followed.

In addition, I ensured that I asked women veterans each question on the interview guide. It is important to note that, due to the sensitive nature of the

women veteran's experiences, repetitiously hearing accounts of trauma became emotionally draining at times. There were two instances that I put the project aside for approximately two weeks to reflect. During these times I did not work on the study in any way, but focused on clearing my head to prevent any bias that might impact the study. Additionally, I discussed the research process and challenges I encountered during this project with my thesis chair and principal investigator, while still maintaining the confidentiality of study participants by not disclosing names, locations or service branches study participants may have revealed while describing accounts of MST.

Several of the interviews lasted more than three hours. In one case an informant requested that the audio recorder remain off but gave me verbal consent to take notes. It is important to note that I had prior approval from the IRB to include "paper notes"—interview notes taken when the tape recorder was off but specifically allowed by an informant-- from the interviews per the Summary Safeguard Statement, Section X: Confidentiality and Safeguards. Furthermore, turning off the tape recorder indicated that I was more sensitive to the concerns of my informants who specifically gave me verbal consent to use the notes but not record their voices. This was for them an important ethical consideration and in this decision the highest ethical concerns were upheld by following the wishes of my participants.

All of the women said that they were interested in participating in future research if given the opportunity and granted me permission to contact them at a later time. Most of the women asked if I would be willing to share my thesis,

future work and any publications that may come out of my research efforts. I agreed. Since conducting these interviews I have seen two of the women who participated in this study. Both of the women hugged me, and one shared pictures of her granddaughter while we stood in the hallway at the VA Medical Center.

Moreover, since I am a veteran working with the research department at the VA Medical Center, subjects may have perceived their participation in this study as an opportunity to provide detailed narrative about their experiences with the health care system they utilize. This element may have been empowering for the women. Additionally, I viewed my research role as a means for women to candidly share their experiences with confidence that their identity would be protected.

## CHAPTER THREE

### Findings

Seven OEF/OIF women veterans described experiences of sexual harassment or sexual assault and related experiences while in the military. The eighth woman veteran was not included among participants who described experiencing MST. She had recently returned from a deployment, and reported being traumatized and diagnosed with PTSD; I did not do a full interview with her due to her apparently fragile state. Using my judgment as a veteran and a nurse, I chose not to probe during the interview since it could have potentially triggered a PTSD episode or, at the very least, distressed someone already distressed.

The themes comprising a rhetoric that are presented in the findings are supported by quotations of the narratives from the women veterans and are for the most part based on frequency in all of the interviews during the study. Narrowing the focus to these experiences has provided an opportunity to aid in the exploration of a rhetoric related to sexual harassment or sexual assault that occurred in the military. In some instances, women were stationed where they were the only woman on that military base, assignment, command or unit in that country or geographical region which could make them easily identifiable. Therefore, to protect further the identity of study participants, the locations disclosed during the interviews were omitted and pseudonyms and ages have not been assigned to women veterans. Rather, their experiences are discussed in broader terms. The following paragraph contains characteristics of the study sample.

Of the sample population, represented military branches include: Army, Army National Guard, Air Force, Navy, and Marine Corps. In addition, two of the women were honorably discharged from the military and then later re-entered the Armed Forces, having breaks in their military service for at least two years. Three of the women had served in more than one military branch. For example, they may have been in the Navy, fulfilled their enlistment obligation, were discharged, and then later enlisted into the Army. Two women in this study have already retired from the military, serving between 20 to 30 years of active duty service. All of the women in this study are service-connected disabled veterans. Women veterans' health care service-connected disability benefits ranged from some who were able to use VA health care for any health care need, while others were only eligible to utilize VA medical care for health conditions related to injuries, disabilities that occurred in the military or aggravated by military service and for MST-related health care.

Each of the OEF/OIF women veterans identified as white, and their ages ranged from 26 years old to 49 years old. Six of the eight women had at least some college education. Of the women, six were enlisted personnel and two women were officers. Five of the eight women had children. Three had been divorced and six were married at the time of the study. Two of the seven women reported being medically discharged from active duty as a result of psychiatric medical conditions that were diagnosed while they were in the military; these two women reported during the interview that they had been raped while on active duty.

Moreover, five of the informants were combat veterans. One of the women flew over 17 combat flight missions in theatre. Two of the women participated in convoy operations while in Iraq or Afghanistan, and one of these women had completed two tours in Iraq.

### The Nature of MST

To understand the experiences of these women veterans, questions during the interviews included: “What does it mean to be a woman in the military?” “What was your most negative/positive experience in the military?” or “What were some of your negative/positive experiences as a woman in the military?” It is important to note that I never asked participants if they had been harassed, assaulted, raped or if they had experienced MST. Despite the courageous participation of these women veterans in combat operations, participation in convoys or flight operations in theatre and their numerous accomplishments, awards and military achievements, evidence of the rhetoric of betrayal that I note was overwhelming during the interviews.

Often times, women used the term “negative experience,” verbiage echoed from the questions themselves to indicate sexual trauma. For example: “My one year experience in [omitted] was a very negative one [Silence]. I had about a five-year break from the military and lots of counseling to get over the experience that I had there.” Although this statement does not technically describe the occurrence of sexual assault or rape, “linguists and others studying human communication systems have repeatedly pointed out, silence is actually part of our communicative system comparable with speech” (Zerubavel, 2006:8).

Throughout the interviews, women consistently paused while describing their experiences, “yet it entailed neither muteness nor mere absence of audible sound as it filled their discourse; rather their silence had unmistakable sound and which spoke louder than words (Zerubavel, 2006:8). These silences were profound; unmistakably they could only imply what one woman referred to as the “unsaid thing.” After these “pauses” or “silences” women would continue on with rhetoric such as; “being on an isolated base was very negative because men behave badly.” All of the women described events leading up to or after sexual harassment or sexual assault that they experienced, or related experiences such as factors about the military environment or chain of command relevant to these experiences.

Throughout the interviews, betrayal was conceptualized as the primary characteristic women reported in their experience of sexual harassment and sexual assault (MST), which provides insight about the nature of MST. “We didn’t have anything like chain locks and he pushed his way in the door and covered my mouth. I couldn’t scream or anything.” Statements pregnant with meaning often followed this initial disclosure, such as: “and then you can guess what happened” or “and then, you know.” One of the seven subjects did not immediately acknowledge that she was raped until later on in the interview. Only two women actually used the term rape during the interviews. One woman said: “When I deployed and when I was back at base camp, I had an incident where I was basically fighting to keep from being pulled out of a bathroom stall. I came



home shortly after that.” This participant disclosed further details about the sexual trauma she experienced:

I hate that my whole military career of [many] years of service has been defined by this one incident and is the most substantial memory of my entire career...it's in my mind every day...I reminded my female soldiers to walk with their battle buddies, to be aware of their surroundings, to be cautious when I perceived them as being too friendly with the males soldiers on our camp...that morning I fought for my life to keep that bathroom stall door closed...there were two of them...I look back on it now and they must have known my routine. I would work out in the gym with my battle buddy every morning and then head to the latrine.

The military incorporates the “buddy” system as standard protocol for all servicemembers, officers and enlisted. Typically two servicemembers will “buddy up” with someone of equivalent rank or within two pay grades and is usually a person of the same gender. They are required to travel in pairs while deployed, especially in theatre. However, due to this woman’s rank and being the only woman in her unit, she had a male battle buddy with whom she is “still friends with to this day.” The location of the incident occurred in theatre at a military camp in an area called a green zone. These military camps are considered safer areas where servicemembers return from being in the field, typically from convoys. At the camp they have the opportunity to eat food from the mess hall, work out, shower, and get medical attention if needed until they are given a new assignment.

Women servicemembers are reliant on the performance of others, subject to the decisions of mere acquaintances or even complete strangers (Lahno,

2001:172). Subjects described the ability to adapt to a changing work environment, including sudden alterations of leadership and peers within the chain of command, as crucial. Women were reliant on other servicemembers at times for their safety and were required to have what Henslin (2001) refers to as “trustability.” Trust is a fundamental aspect of any day/everyday-life-in-society, however, for servicemembers it is a vital necessity (p. 183). And, for these women, the trust that was required for unit cohesion and efficiency was betrayed. One study participant who identified as being raped, disclosed in detail how her rapist used deception (a key component of betrayal) as a way to gain entry into her barracks room late one night on base:

There were tornadoes all the time in the spring and so they would knock on the door with a cue ball and that’s what it sounded like...so I got up and I opened the door.

During the interview this informant explained how a cue ball was used as part of the protocol by the watch stander to rap on every barracks room door during tornado drills because of the distinct sound. This was an additional alarm for each soldier in the unit to ensure they would wake up and get into formation with their unit.

When women veterans were recalling accounts of harassment they said that “harassment was a daily thing” or referred to it as “comments they [men servicemembers] would make.” I asked the women for an example of the comments and most of the women would try to provide actual examples of what the men had said to them. One woman described sexual harassment as something that was commonly implied and rarely unconcealed:

Most of the people were really careful how they worded things. Because it's such a big issue in the military...it's just innuendo kind of things like, "Well can I do anything for you?" "Well sure you can."... It's not overt, it's not overly obvious. But it's just implied.

Accounts of MST varied and were described by the women veterans and included statements such as, "I was asleep and someone was banging on my door and I opened it up and it was an officer wasted [intoxicated] in the enlisted barracks and he was like, 'Let me come in'...I just slammed the door in his face...Yeah, he was married with kids." Another woman stated: "One guy in the warehouse tried to grab me." They also suggested that MST not only occurred during wartime but that "it didn't matter just at war, it was my whole career I had to put up with comments." In most instances women veterans would pause at times when they reflected on these experiences, and for many of them it was as if this was the first time they had spoken of these experiences: "I never had anybody force themselves on me. [silence] Well, I had a couple people try, but as soon as I said no, they stopped."

During the interviews three women cried while disclosing MST and related experiences. In these cases I asked the women if they wanted to discontinue the interview and I offered to move on to questions about VA health care instead. However, all of these women continued to recount their experiences, and one woman communicated that she had not realized how much those experiences affected her. All of the women in this study were provided contact information for MST counseling and other VA health care services during each interview.

A theme or set of themes in women's descriptions of the social problem MST was identified as betrayal. In considering the nature of betrayal, it can be noted that betrayal is broken trust from others, and in the context of the military, betrayal occurs in a dangerous profession that the individual has freely chosen and cherished. Although betrayal is a theme of what people say, sometimes historically they have experiences which include; sexual harassment, sexual assault, and rape. With regard to MST, the gendered part of the self whose bodily components constitute the most basic and shaming portions of one's identity were initially betrayed.

Within the military context, betrayal makes a greater impact due to the military environment, since experiencing ongoing betrayal from the military institution is evident. Men offenders were not punished or chastised even when they committed sexual assault or rape. Nor were women seen as victims; rather, they were labeled as persons with psychological defects and discharged from the military if they had difficulty managing the betrayal they had experienced.

### MST Management

The following section is about the way women veterans managed MST in the workplace. In an article entitled "How Women Handle Sexual Harassment: A Literature Review," published in *Sociology and Social Research* (1989), James E. Gruber classified victims' individual responses to harassment into four categories: *avoidance*, *defusion*, *negotiation*, and *confrontation*. Each category is suggested to be a way in which these women managed to work in an environment where they experienced sexual harassment and even sexual

assault. Gruber's (1989) typology is incorporated to support targeted responses from the women veterans.

### Avoidance and Defusion

Throughout the interviews the rhetoric about MST and related issues was described as ways of managing betrayal. One of the retired women veterans said that "being in the military one learns not to bond with men servicemembers because they may misunderstand one's intentions." She described the men in the military as often perceiving friendship as an opportunity for the "unsaid thing," that is, for a sexual relationship. She felt that she had learned lessons early on about the military environment and as a result incorporated ways of managing the military environment in an effort to limit the likelihood of experiencing MST:

I had already been in the military about nine years so I had those lessons learned about bonding too quickly with males. You know, miscommunication, where you want to be a friend and that person thinks something else is going on.

Another woman veteran stated that she avoided social gatherings and any non-work related communication with male servicemembers in an effort to avoid any potential opportunity to be sexually harassed or sexually assaulted. The strategy of choice for many targets is to avoid the perpetrator and, in this case, potential perpetrators (Knapp 2007; Gruber 1989). In these particular instances, women avoided establishing friendships with males and even avoided non-work related conversation

altogether. Also noteworthy is the considerable effort women made to minimize their interactions with male servicemembers, which seems logical if one is fearful of being sexually harassed or sexually assaulted.

In addition, they talked about being confident in their job performance “in spite of the criticism that I lived daily” and “I knew my stuff” or “I knew my job well.” One woman seemed to sum up all of the women veterans’ perceptions by saying: “You always have to work twice as hard to prove yourself.” Although women conveyed that they continuously had to prove themselves, one of the women stated:

I think the military is more accepting of female leadership now than they have been in the past. I think that the United States was attacked and we started going to Afghanistan and Iraq women have kind of proved their mettle in combat and that has changed the whole idea and the power balance for female leadership in the Army.

The same woman communicated that as a result of the current war (OEF/OIF) she felt the way men viewed women in the military has changed:

Before, men would resent women because they don’t have the ability to go to combat and therefore aren’t real soldiers. That was kind of the perception but world events have kind of changed that.

Four of the seven women veterans who experienced MST described as their management strategies “taking on extra duties” and “paying close attention to detail” in their work, and one of the women veterans even volunteered for a deployment to Iraq in order to avoid daily interaction in her working environment

with the male servicemember who raped her. Knapp (2007) suggests that avoidance behavior includes doing nothing or altering the job situation. Primarily women veterans described altering their working environments as a way to manage by taking on extra work, volunteering for additional responsibilities, cross-training and gaining qualifications in additional military jobs different from their own, and volunteering for as many leadership positions as possible.

These are what Knapp (2007) refers to as “hyper-alterations.” However, despite their service in combat, taking on extra duties and making hyper-alterations to their workplace, none of their efforts seemed to provide these women with the ability to work in an environment free of MST, nor earn the favor of the military institution to protect them from sexual abuse.

Five of the seven women veterans said similar comments indicating ways of managing, such as “You just kind of deal with it and move on” and “you try to brush it off.” One woman summed up what most of the women said when she stated: “It can be done with hard work.” Despite their MST experiences, and the challenging elements of being in the military as women, all of the women communicated that they were hopeful the military environment for women would improve because women are joining the military, working in combat support roles and are now in jobs usually performed by men.

Similarly, many of the women would say “it was little things like that” when talking about sexual harassment. Although they described dealing with sexual innuendos and overt statements as “frustrating” they called them “little things,” which Gruber (1989) refers to as defusion but can also be thought of as

apologetically minimizing. One woman simply stated: "Being in the military you have negative experiences." Another woman said that "I spent a long time in the military and accepted the good and the bad," acknowledging these behaviors as bad but minimizing so she could perceive them as tolerable. Yet another woman veteran said: "People don't like to take female officers very seriously, so it is a challenge." In some instances women referred to MST as simply a challenging part of being in the military as a woman. Women never identified gender harassment as sexual harassment, although it is included in the VA's definition of MST. Rationalizing assailants' behaviors although defusing or avoidance, Gruber's (1989) first and second response to harassment, were incorporated by these women veterans in order to survive the betrayal they experienced and, in some cases, that they had had to live with every day.

### Military Environment

#### Negotiation

Gruber's (1989) third response to sexual harassment is negotiation. Negotiation is a passive response to harassment which involves "asking" the harasser to stop the behavior. However, due to the factors exclusive of the military environment, negotiation was not a feasible response for these women veterans. Many of the women described being stationed at military installations, or working in units where they were the only woman or one of very few, especially when women worked in jobs primarily performed by men, such as translators or intelligence work. This woman in particular was the only woman on this military base as an instructor. Her interactions with other women



servicemembers were limited to the lone woman student who attended the military training class which occurred about every three months. One woman described the environment while stationed for a year at a location where she was usually the only woman: "I didn't have anybody really to lean on, you know, girl-stuff lean on. I was the only woman on the camp except for the occasional woman student that would come through about every third class." Another woman described her experience while deployed for a year: "We were at an isolated base where we could not leave base... I don't know the exact ratio of men to women, but I think it was something like one to fifty [sic]." One woman felt that "everything is catered to [designed for] the men" making it "a very hard place to be." For example:

The morale van was used to go down into wherever they were picking up dancers and bringing them to the club that was on our camp. There were women dancers that were very minimally dressed and they were the local gals brought there for the male students and instructors.

In this situation such women were often sex workers and the perception was that they had hoped to become a soldier or sailor's future bride. In addition, four of the women veterans claimed that "the way they [men] viewed women" exacerbated their already existing sense of isolation.

Four of the women talked about feelings of exclusion from their unit or command. They indicated that behavior or comments were used to reinforce the outsider role of women within their working environment. The outsider role was considered a dangerous place to be, increasing the likelihood for one to experience MST, betrayal that typically occurs from a superior of a higher rank

(Mulhall, 2009). In many instances, being the “outsider” provided an opportunity for that person to be an easier person to target. One woman summed up the perception of all of the women I interviewed when talking about the “outsider” role within the institutional circumstances that perpetuated an environment likely for MST to occur: “The command is supposed to fix things, but the command is sometimes the perpetrators of the problem. How can they fix the problem that they are causing?” Exclusion was described as part of the social process of becoming the outsider and reinforced women as easy targets for sexual violence; betrayal is therefore magnified by the perception that the trusted institution is the causative institution.

One woman stated: “The way they [men servicemembers] viewed women [as sex toys]” was very negative. Six of the women veterans went on to remember instances where their marginalization within the military was emphasized: “I was told that I didn’t belong in the military.” One woman recalled an occasion where she was in a morning meeting with her commanding officer, executive officer and direct supervisor when “One of the officers said, “What are you going to do when you get out of the military?” She said, “What do you mean?” And he replied, “There’s no way you’re going to make it.” Another woman felt that not being able to be a member of the “Good Ol’ Boys Club” was always an issue. All of the women described instances where supervisors would say “I like you as a person, but I don’t like you as a military person.” Another woman seemed to sum it up when she stated: “I had to eat a lot of crow when I was mobilized and keep my mouth shut when I didn’t want to because it wouldn’t

have accomplished anything.” In addition, one woman described her perception about changes that were made by the unit commander prior to being mobilized:

We had soldiers attached to us from other units to bring our unit up to full strength so we had twelve females and before we ever left our premobe site he cut nine females. He didn't want any women with them at all and it's not like we were going to the field.

By establishing women's thoroughgoing marginalization, men prepared a path for discounting any troubles women did experience. Brownmiller (1976) suggests that: “War provides men with the perfect psychological backdrop to give vent to their contempt for women. The very maleness of the military—the brute power of weaponry exclusive to their hands, the spiritual bonding of men at arms, the manly discipline of orders given and orders obeyed, the simple logic of the hierarchical command-conforms for men what they long suspect, that women are peripheral, irrelevant to the world that counts, passive spectators to the action in the center ring” (p. 24). Previously a large majority of women were denied the opportunity to deploy or participate in combat operations. However, in today's military, women are no longer “passive spectators,” they are indeed in the “center ring.”

Many of the women described the military institution as reinforcing what I will refer to as gender hostility. Gender hostility is a modality of betrayal, similar to the varying behaviors that have been reported. Many of the women described the gender hostility they encountered “as increasing the likelihood of experiencing sexual harassment or assault.” When women reflected on their negative experiences during their military service, they typically illustrated the risk

of experiencing behaviors that constitute MST as common knowledge among all women in the military. They conceptualized this component of their military environment as contributing to the sense of betrayal women experienced and described it as the result of “being a female in a male dominant place” and viewed it as contributing to “men behaving badly” making it a “very hard place to be as a female.” Due to the lack of support from the military institution and potential fear of retaliation, women in this study never identified as negotiating with the perpetrator.

### Confrontation

However, in three instances when women were sexually assaulted they did report it to their chain of command, which is similar to Gruber’s (1989) fourth response to sexual harassment known as confrontation. In one incident, a woman went to her supervisor but was scolded for being insubordinate and accused of having a problem with authority. The three women who reported sexual assault to their supervisors communicated that they were unsatisfied or disappointed with how their chain of command handled the incident(s). It is important to note that other instances of betrayal included the belief that their chain of command would protect them from sexual abuse and support them if they reported sexual harassment or sexual assault. These women had to find ways to manage with the betrayal from the MST but also had to draw on their own inner resources to manage out of necessity since the military institution did not provide protection or resolution for them.

When I asked one woman during the interview if she reported being sexually assaulted, she replied: "Of course. I was told that I had a problem with authority. I was reprimanded." Nothing happened to the attackers. One woman stated that if the guard on duty had not seen her attacker enter her barracks room, the command would have perceived her as a troublemaker for reporting it and her co-workers within her command would not have believed the attack occurred:

Everyone in my unit knew what had happened, so the only reason I think why I wasn't ostracized is because someone in my unit witnessed him coming in my room and got the guard on duty. If it had just been me accusing him then I don't think anybody would have talked with me for the rest of the time I was there. It's sad that it has to almost be eye-witnessed for it to be credible.

Of three women veterans who reported sexual assault, two of these women in the study said that they were required to continue working with their assailant on active duty in the same environment. Five of the other women experienced sexual assault and/or frequent sexual harassment but never reported it and continued to work alongside their assailants. One woman said: "I was used to having to deal with things my whole career." Another woman said "I just assumed that's the way life was and that I had to deal with it." In addition, characteristics of the organization must be considered; trust and reliance must be used synonymously and are interdependent when considering factors exclusive of the military environment.

Also noteworthy is that four women described reporting harassment as being discouraged because it would “rock the boat” or negatively impact unit cohesion. All of these women continued to work in the same environment, with the exception of one woman. Their words are also testament to the high regard in which they hold the military and their faith ultimately, in the institution of defense. Freyd (1997) suggests that suppression of sexual abuse, usually in cases of childhood sexual abuse, is common when one relies on their abuser for basic physiological needs; here, the military environment is often compared to the family. These women were dependent on other servicemembers and even their assailants for leadership, safety, food, shelter, and medical and dental care. Therefore, such betrayals produced conflict between external reality and their necessary system of social dependence (Freyd, 1997). Betrayal trauma typically occurs when people or institutions we depend on for survival violate us in some way (Freyd, 1997). Soldier on soldier sexual abuse is often compared to incest because of the structural and functional similarities between the Armed Forces and families (Street and Stafford, 2008:1). With the same family imagery, the term “fratricide” is used to refer to situations where a servicemember has killed another servicemember.

Some of the military environments these women described included the confinement of a Navy vessel out at sea in hostile waters, working at times in hostile airspace, on the battlefield, in a green zone while deployed, or even stationed at a military base in the United States for six months to even two years at a time. Due to factors exclusive of the military environment and military

culture, these women were unable to go through Gruber's third and fourth responses of harassment; negotiation and confrontation.

## CHAPTER FOUR

### Discussion

Within the rhetoric of these women veterans' experiences we have seen a transition occur. The experiences of women veterans provided insight about the social process in which these experiences develop and change over time (Emerson et.al., 1998:291). Sexual harassment and sexual assault that women experienced in the military was characterized as simply part of being a woman in the military and was taken on as a private trouble, and in four cases never reported. Emerson and Messinger's framework (1997) suggests that, when women make claims, they publicize, explicate, and radically change a purely individual trouble, and the source of the trouble may be brought to light. When women underwent the transition from the military environment to their current veteran status they were able to frame this phenomenon as a public problem, rather than as a private trouble. Although sexual harassment and sexual assault that occurs in the military has been elevated and given a name, MST, it is terminology used by the VA health care system and was never used by study participants to describe their experiences. Spontaneously during the interviews a rhetoric began to frame the social problem of MST, more properly identified by women veterans as betrayal.

Zembylas (2008) suggests that the examination of rhetoric is not to take on the "burden of trauma and suffering of others." Rather, it is to identify social meanings which aid in the identification of social problems (p. 2). Kitsuse and Spector define social problems as "the activities of groups making assertions of



grievances and claims with respect to some putative conditions” (1993:6). As an alternative to tracking new cases of MST, this thesis provides an examination of the rhetoric of betrayal and suggests that objective knowledge of MST does not exist apart from such social conditions and one’s interpretations of them (Ibarra and Kitsuse, 1993:7). Betrayal is a common concept that can be found in accounts of phenomena as diverse as adultery and espionage, lying to children about Santa Claus, and con games, and betrayal emerged here as the way in which women veterans understood and made meaning of their MST experiences during the claims-making process. None of these women were asked if they had experienced MST; therefore, findings from this study suggest that the way we approach and understand MST as a social problem needs to be reconsidered and further examined. Ibarra and Kitsuse (1993) suggest that social problems are not objective conditions to be studied and corrected; rather, they are interpreted processes that constitute what comes to be seen as oppressive, intolerable, or unjust. In this case findings suggest that the system should seek to genuinely address MST with the intent to prevent betraying its women servicemembers by providing management strategies for MST that truly exist within the military.

### Management

Women veterans incorporated strategies to manage the sexual harassment and sexual assault they experienced while in the military environment, since reporting MST was actively discouraged. All of the women described incorporating strategies to make their workplace manageable, which

include “brushing it off,” or “just dealing with it,” often suppressing their psychic pain and “just moving on.” During the claims-making process women described gender hostility and exclusion practices that were long-practiced and deeply imbedded within the military institution. In addition, findings suggest that women implemented strategies in order to manage their workplace since they could not alter or exit the military environment, even in instances when they had reported sexual assault but were required to work alongside their assailants. Gardner (1995) suggests that “the very existence of this reaction clearly demonstrates that women can critically and creatively mount strategies to deal with harassment” (p. 199). These women implemented strategies to manage the initial betrayal from the sexual harassment and sexual assault they experienced since it was not provided from the military institution. However, women also had to find ways to draw on themselves, since they were also betrayed by the military institution that they reasonably had assumed would protect them.

Throughout the interviews several strategies for betrayal management were identified. Women talked about “working twice as hard as the men” and taking on extra duties in order to avoid the betrayal they inherently described. Although these women incorporated Gruber’s (1989) first and second responses to harassment, avoidance and defusion, they were unable to move through the third and fourth responses, negotiation and confrontation, due to the military environment.

## Betrayal

Seven women experienced sexual harassment or sexual assault that occurred within the military by male servicemembers. During the study women provided accounts and experiences of problems that met the requirements for investigation (Ibarra and Kitsuse 1993:28). Exploration of these accounts and experiences pointed to the “theoretical advantages of studying claims-making by arguing that social constructionism provided the basis for developing a distinctively sociological approach that focused on the social processes through which social problems are constructed” (Ibarra and Kitsuse 1993:7). Overwhelmingly throughout the interviews, betrayal was conceptualized as the primary characteristic of MST and related experiences. Consequently, betrayal is the breaking of trust in the context of power within the military institution and is reflexive of conduct that produces greater impact subsequent to the initial betrayal.

Similar to the betrayal these women veterans explained in their interviews, Irving examines “the way rape cases illuminate that for black women the law is not a source of justice or protection, but contains, constitutes, and generates violence” (p. 68). What Irving (2007) suggests is also true for women servicemembers, regardless of race. During the interviews, in instances where sexual assault was reported the chain of command constrained women within processes that normalize and generate sexual violence by dismissing the allegations and returning these women to work with their assailants. As a result,

women were then outside the boundaries of protection from what I will refer to as “intramilitary violence.”

Additionally, Irving suggests that failure to make arrests assigns black women a dysfunctional particularity that in tandem confirms and extends the sexual value ascribed to women whose assaults are prosecuted (Irving, 2007). Women servicemembers depend on the military institution and its structural functionality for protection and justice; instead they discovered it consistently reinforced a military culture of sexual violence and clearly contributed to the oppression of women. One study found that, in 2007, only 8 percent of sexual assailants in the military were referred to courts martial, or military court, compared with 40 percent of similar offenders prosecuted in the civilian court system (Mulhall, 2009:7). It has been suggested that rape is the most blatant example of systematic misogyny and masculine dominance.

The Department of Defense’s (DOD) failure to uphold minimal standards of “intramilitary safety” perpetuates the betrayal of women servicemembers, and, as this betrayal goes unpunished, the failure to take legal action underscores (if not encourages) the ability to sexually abuse and harass women servicemembers (p. 71). Brownmiller (1976) suggests that it “is in the nature of any institution in which men are set apart from women and given the extra power of the gun that the accruing power may be used against all women, for a female victim of rape is not chosen because she is the representative of the enemy, but precisely because she is a woman, and therefore an enemy” (p. 62). Women have symbolically turned into the enemy of men in the military; it is actually a

bipolar division of gender that is stereotyped and traditional. Therefore, due to lack of action by the DOD, women were betrayed by the military institution and largely the United States government. These women had no alternative but to take on MST as a private trouble and incorporate management strategies in order to cope within the military environment.

### Conclusion

This thesis focused on the experiences of OEF/OIF women veterans currently enrolled in the VA health care system. The qualitative study design generated responses through in-depth interviews to identify the meanings of these experiences within the lives of women veterans. Participants were provided an opportunity to describe their unique experiences and reflect on what it meant to be a woman in the military, while actually being outside the military institution although part of the VA health care system.

Women veterans described accounts of sexual harassment or sexual assault during the interviews. Using qualitative methodology afforded the exploration of social processes through which social problems were constructed (Ibarra and Kitsuse 1993:7). The primary theoretical advantage of this study was the identification of the sense of betrayal as the “master hand” guiding MST; maintaining, sustaining, and perpetuating the ongoing cycle of sexual violence within the military institution. Using grounded theory techniques allowed for the ability to gather unique data that may reproduce categories which individuals use themselves in thinking, speaking, and acting about a specific social problem. This methodology aided in avoiding preconceived notions that researchers may

have by generating categories that members of society themselves use. Also, it allowed for the focus of an important characteristic of the word building of social problems.

### Limitations

Additionally, this thesis had limitations. This study was composed of a small sample of seven OEF/OIF women veteran participants; all were white women who utilize the same VA Medical Center. A more diverse sample population is warranted. Also, this study included OEF/OIF women veterans and excluded women veterans who served in the military during previous time periods. Recent studies suggest that as many as one-third of women veterans who served during previous time periods experienced sexual assault (Mulhall, 2009). In addition, only women veterans who use VA health care were eligible to participate in the study; therefore, this study excluded women veterans who use health care outside of the VA health care system. Five of the interviews were conducted at a VA Medical Center and three were conducted at a university. Study participants may have provided richer data had they been in a different environment during the interviews and not within the walls of the VA health care institution.

### Future Research

This thesis is a pilot study and one component of a much larger project. Initially the primary objective of this pilot study was to understand the military experiences of OEF/OIF women. In addition, the project originally intended to investigate what VA service providers' perceptions were regarding the health

care needs of women veterans who use VA health care and to help identify barriers to accessing health care services.

To address these topics, this project started with five specific aims: to explore the military experiences of women veterans who served during OEF/OIF; to explore the perceived impact military experiences have on the health, including the mental health, of women veterans; to describe women veterans' experiences utilizing VA services; to identify the health care needs of women veterans; and to explore VA service providers perceptions of women veterans health care needs.

However, during the interviews seven women veterans described accounts of sexual harassment and sexual assault, also known in the VA health care system as MST. There was a single participant who did not report MST; however, she had recently returned from a deployment in Iraq and reported suffering from severe PTSD. Therefore, due to her fragile state I did not probe during the interview. The prevalence and dialogue of MST both explicitly and implicitly throughout all but one of the interviews justified examining MST on its own and consequently the focus of this thesis. Additionally, studies indicate that there are serious health correlates of MST. Unfortunately, there is little research that explores health issues related to MST described by women veterans. Findings from the interviews suggest that the second component of this project explore the experiences of OEF/OIF women veterans and their related health. The next component of the larger project will be to examine their experiences while utilizing VA health care. The interviews with VA service providers will be

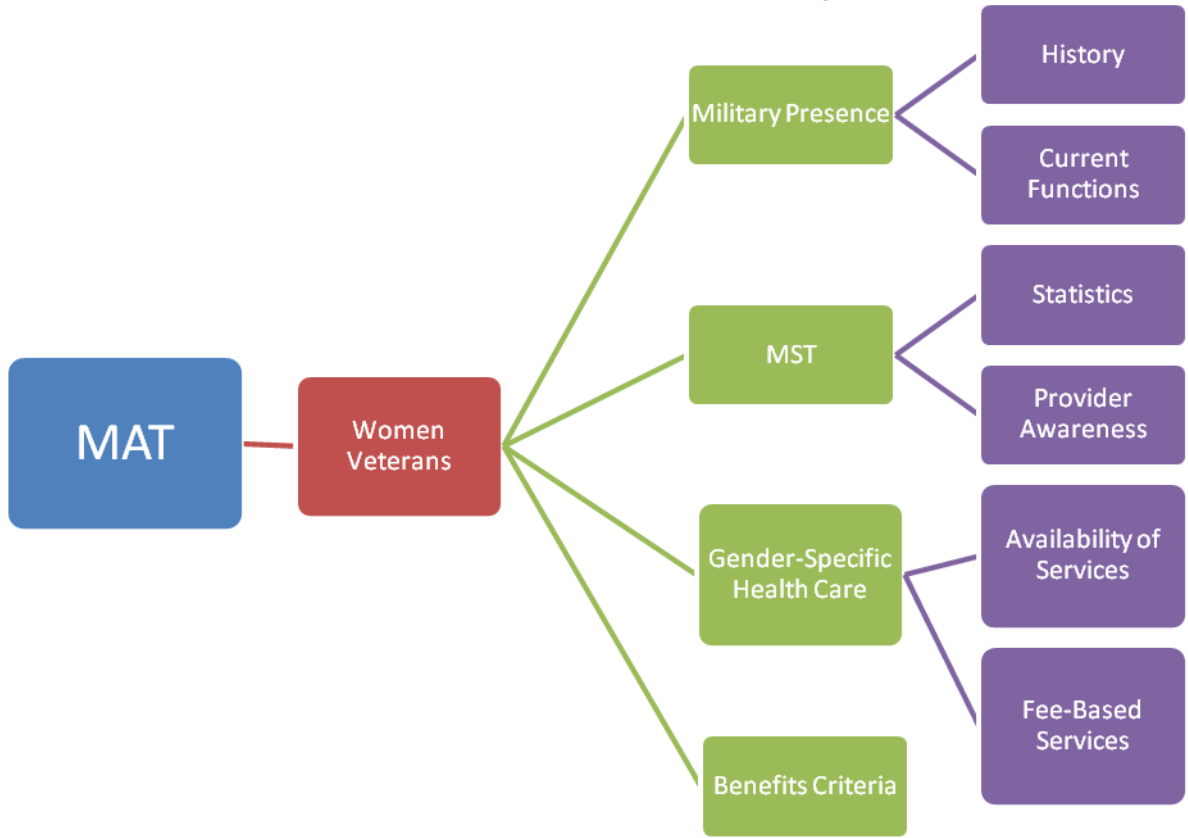
examined, and findings will be compared between VA service providers and OEF/OIF women veterans to determine the health care needs of the target population. Finally, recommendations for improving VA health care services will be provided in order to better meet the health care needs of the OEF/OIF women veteran population. All of these aims for future research will be informed by this pilot study that has examined one facet of the emerging social problem that is MST. With regard to putting these insights to practical use I developed a Mandatory Awareness Training model (MAT).

The first phase of the MAT program would be implemented throughout every VAMC by training department using one topic per quarter throughout the year. Feedback would be evaluated after each training session to determine specificity, attitudes, and ideas for future training needs. The MST element of MAT is comprised of two components. The first component includes educating providers about the VHA definition of MST, prevalence of MST, and VAMC MST tracking and MST specific health care policies. The second component of MAT includes educating VA service providers about how women veterans process, interpret, and communicate their experiences and the social problem of MST, insight that only this study provided. Therefore, MAT has been developed to be implemented in any agency to enhance the delivery of health care provided to women veterans.



APPENDICES

Mandatory Awareness Training



VAMC  
Model -1a

## BACKGROUND INFORMATION QUESTIONNAIRE

Your answers to the following questions will help us better understand your background and military history.

1. **Subject #** \_\_\_\_\_

2. **Age** \_\_\_\_\_

3. **What was your most recent service branch in the military?**

- Air Force
- Army
- Coast Guard
- Marine Corps
- Navy
- Other \_\_\_\_\_

4. **What was your most recent component in the military?**

- Active Duty
- National Guard
- Reserves
- Civilian Government Employee

5. **Have you ever been deployed?**

- Yes
- No

6. **How many times have you been deployed?**

- 1
- 2
- 3
- Other \_\_\_\_\_

7. **Where were you deployed?**

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**8. Since my return from deployment my health status has:**

- has stayed the same always
- worse than what is was prior to deployment
- has improved since return from deployment

**9. What services from the VA system do you or have you used:**

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**10. Are you a service-connected disabled veteran?**

- Yes
- No

**11. Are you retired from the Armed Forces?**

- Yes
- No

**12. What is the highest level of education you have completed?**

- high school or GED
- some college
- 2-year degree or vocational or technical school
- 4 year college degree
- graduate degree

**13. If employed, what is your current occupation or job?**

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**14. What is your racial/ethnic background?**

American Indian or Alaskan Native

Asian or Pacific Islander

Black or African American

Hispanic

White

Other \_\_\_\_\_

**15. Are you currently:**

single, widowed

single, never married but in a relationship

single, never married and not in relationship

single, divorce

married

married, separated

**16. Do you have children?**

Yes

No

**17. How many children do you have?**

\_\_\_\_\_

Thank you!

## WOMEN VETERAN INTERVIEW GUIDE

### **First, let's talk about your experiences in the military as a woman.**

1. Can you describe your experiences as a woman in the military?
  - a. What led you to join the military
  - b. Can you describe the most positive experience of being a woman in the military?
  - c. Can you describe the most negative experience of being a woman in the military?

### **Now, I would like to ask you some questions about leaving the service and becoming a veteran.**

2. Can you describe your discharge experiences and what that was like for you?
  - a. Can you describe what led you to end your military service?
  - b. What does it mean to be a women veteran?
  - c. What was it like for you to return your civilian life?
  - d. Can you describe any health problems you had at that time?
  - e. How, if at all, did your experiences in the military affect your health?
    - i. Mental health, physical health
    - ii. Adjustment to civilian life

### **Now, I have some questions about your experiences receiving care through the VA health system.**

3. Overall, can you describe your experience using the VA health system?
  - a. What made you decide to use the VA for your (some of your) health care?
  - b. Describe your experiences with the intake coordinator? PCP? Mental health provider if any?
  - c. What sorts of services did you seek/use?
  - d. Can you describe a typical appointment with your main provider?
  - e. Can you describe your most positive experience, if any, using the VA?; how about your most negative experience, if any?
4. Can you describe what you like about using the VA for your care? How is it different from using non-VA services? How is it similar?
5. Can you describe some of the problems, if any, you have encountered using the VA?

**Now, I want to ask you some questions concerning women center services such as OB/GYN care, prenatal care, fertility care, etc. (note, they may have already addressed this)**

6. What are your experiences using these services with the VA?

**These next set of questions deals with some sensitive health care needs that may be difficult for you to discuss. Remember that we do not have to discuss everything and that you can choose to skip some questions. Some researchers have found that women in the military are more likely to experience PTSD and/or MST.**

7. Can you describe to me your health needs, if any, surrounding these issues?
8. Have they been met? Can you describe any barriers to receiving these services?

**Finally, I have some questions about your opinions regarding how the VA might improve health care services for women veterans.**

9. Would you recommend using the VA for health services to other women veterans?
10. If you were responsible for improving the system of care for female veterans, what would you do to help them find out about services available to them?
11. Once they knew about services, what kinds of changes would you implement to improve their experiences using VA health services?

**Final Question: Is there anything else that you would like to discuss or share that you feel is important that you may have left out?**

Closing Statement: Thank you so much for your help. We'll put together a report summarizing what you have told us and what we learn from other people that we are interviewing. We are hoping to share this information with people who run women veteran programs and with policy makers who are trying to make sure they get the services they need. Thank you for your valuable input. We appreciate your time.

## VA SERVICE PROVIDER INTERVIEW GUIDE

**Opening Statement:** *My name is \_\_\_\_\_ from the VA HSR&D and the Sociology Department. We are interested in how to provide the best possible system of care for Women veterans. We are mostly concerned with better understanding the service needs for the OEF/OIF Women veteran population using VA health care and other related needed services, as well as why many veterans may not be utilizing needed services.*

*We invite you to participate in this discussion because you have special understanding of the service needs and experiences of OEF/OIF Women veterans. We value your perspective and opinions and ask that you help us better understand this population to possibly provide information that could improve the system of care for this population.*

*The information that you share with us today will add to information we have acquired from interviews. We will use your comments and suggestions along with information from other sources to better understand service needs and to share this information with those that can improve the services provided.*

- 1. You were invited to participate in this discussion because of your unique experiences working with OEF/OIF women veterans. What are some of the special needs or characteristics of the woman veteran population?**
  - a. What services do they need the most? Which do they access most often?
  
- 2. Please describe your experiences of working with OEF/OIF women veterans. How do you see yourself fitting into the system of veteran care?**
  - a. What type of services do you provide or refer people to?
  - b. What other service providers do you work with to connect women veterans with?
  
- 3. How well do you feel the needs of this population are met?**
  - a. Which medical or support services are being provided?
  - b. Which medical or support services are not being provided but needed?
  - c. Which medical or support services are being provided but not adequately
  - d. Which medical or support services are being provided, but are provided in such way that they are inaccessible to people in this population?

**4. What unique characteristics of this population facilitate the delivery of services to them?** I.e. What strengths or skills do they have for self advocacy? Are there particular locations they are comfortable being served or methods of outreach that they are likely to respond to?

**5. What are the unique needs or characteristics of this population that make it difficult to deliver services to them?** i.e. Are there certain issues that need to be addressed prior to receiving needed services (e.g. mental health issues, financial, substance abuse, etc.)? Are female veterans difficult or easy to enroll in services, if so, why?

**6. Do you think that military experiences of OEF/OIF women veterans have an impact on their health?** i.e. If so, what experiences? How do you think they impact their health?

**7. Have women veterans described some of their experiences while utilizing VA services, especially health care?** If so, what were they?

**8. What are the biggest barriers for women veterans to receiving needed services and utilizing long-term services available to them within the VA system?**

a. What is the biggest barrier that prevents them from receiving care and services?

b. What is the biggest barrier that prevents them from remaining in care or utilizing services?

**9. What motivators do you think would help the women veteran population to utilize needed services, if any?**

**10. If you were responsible for improving the VA system of care for women veterans, what would you do to help them find out about services available to them?**

**Final Question:** Is there anything else that you would like to discuss or share that you feel is important that may have been left out?

**Closing Statement:** Thank you so much for your help. We'll put together a report summarizing what you have told us and what we learn from other people that we are interviewing. We are hoping to share this information with people who run women veteran programs and with policy makers who are trying to make sure women veterans get the VA services they need. Thank you for your valuable input. We appreciate your time.



**WOMEN VETERAN RESEARCH STUDY**

- **Are you an OEF/ OIF female veteran?**
- **Are you currently using VA services or have you in the past?**  
**(i. e. VA Medical Care, the Vet-Center, VA Disability, or Chapter 31/Voc-Rehab)?**

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If you are a female veteran who answered yes, I would like to offer you an opportunity to share your experiences. I am a researcher and OEF/OIF female veteran interested in hearing what *you* have to say. I want to learn more about what services you need from the VA system, what your experiences have been using VA services, and recommendations you might have to improve VA services.

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**Participating in this study is simple!**

**\*Eligibility:**

- must be a FEMALE veteran
- must be using veteran services or have used VA health care, counseling, or other related services in the past
- must be willing to donate 1 hour of your time for a private interview

**Convenient and Confidential!**

Day, Time, and location will be arranged. If interested, Email: Sarah Aktepy at [saktepy@iupui.edu](mailto:saktepy@iupui.edu) or Call: (317) 988-3568.

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# CURRICULUM VITAE

SARAH LOUISE AKTEPY

## EDUCATION

- February 2010      Master of Arts  
Indiana University Purdue University-Indianapolis, IN  
Major: Sociology, Concentration: Medical Sociology
- December 2007      Bachelor of Science  
Old Dominion University, Norfolk, VA  
Major: Sociology, Emphasis: Social Welfare  
Minor: Human Service
- December 2004      Practical Nursing Diploma  
Medical Careers Institute, Virginia Beach, VA

## PROFESSIONAL EXPERIENCE

- 07/08-12/09      Research Associate  
Roudebush VA Medical Center  
Indianapolis, IN
- 04/08-12/09      Research Assistant  
IU Family Medicine & Bowen Research Center  
Indianapolis, IN
- 07/04-05/05      Licensed Practical Nurse  
Sentara Norfolk General Hospital  
Norfolk, VA
- 02/00-11/03      Program Specialist  
United States Navy  
Norfolk, VA



## AWARDS AND GRANTS

- 2008 Educational Enhancement Grant. IUPUI. \$400.  
Awarded to fund Master's thesis.
- 2008 Travel Expense Grant. Graduate School. IUPUI. \$800.  
Awarded to fund travel for paper presentation at the 2009  
Pacific Sociological Association (PSA) Conference.
- 2008 Thesis Expense Grant. Department of Sociology. IUPUI. \$500.
- 2007 Virginian Pilot Scholarship. Old Dominion University. \$500.
- 2006-2007 Alumni Enrichment Grant. Old Dominion University. \$1500.

## TECHNICAL REPORTS

- 2008 "Needs Assessment for the HIV/AIDS Population in Central  
Indiana." For the Health and Hospital Corporation of Marion  
County. Zollinger TW, Kochhar K, Aktepy SL.

## PROFESSIONAL PRESENTATIONS

*Disability and Stress-Associated Health Conditions Among Women Veterans Returning from Iraq and Afghanistan.* Paper presentation at the annual Society for the Study of Social Problems (SSSP) conference. San Francisco, CA, August 7-9, 2009.

*Health, Illness, and Healing: The Female Veteran Experience.* Paper presentation at the annual Society for the Study of Social Problems (SSSP) conference. San Francisco, CA, August 7-9, 2009.

*Factors Influencing First Practice Location of those Completing Residency/Fellowship.* Poster presented at the annual Academy Health Conference. Chicago, IL, June 28-30, 2009.

*A Qualitative Study about the Experiences of Women Veterans.* Poster accepted to the annual Academy Health Conference. Chicago, IL, June 28-30, 2009.

*Women, War, and Stress-Related Health Conditions: What the VA Plans to Do.* Paper presentation at the annual Pacific Sociological Association (PSA) Conference. San Diego, CA, April 8-11, 2009.

*Health, Illness, and Healing: The Female Veteran Experience.* Paper accepted to the annual Pacific Sociological Association (PSA) Conference. San Diego, CA, April 8-11, 2009.

## PROFESSIONAL AFFILIATIONS AND CERTIFICATIONS

2004-2010	License for Practical Nursing-LPN (Virginia: Multi-State Privilege)
2007-2010	Healing Touch Practitioner Certification-HTPA (Level 1, 2 & 3)
2008-2010	Society for Women in Sociology (SWS)
2009-2010	Society for the Study of Social Problems (SSSP)
2009-2010	Pacific Sociological Association (PSA)
2008-2009	IU Center of Excellence in Women's Health
2008-2009	Sociology Graduate Student Organization
2007	Women in Leadership Certificate (Old Dominion University)

## HONORS

2007-2009	Golden Key International Honor Societies
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## TEACHING EXPERIENCE

### Primary Instructor at IUPUI

2009 (Fall)  
R100-Introduction to Sociology

### Guest Lectures at IUPUI

2009 (Fall)  
R321-Gender and Health, Topic: *Post-Traumatic Stress Disorder Secondary to Military Sexual Trauma*

2009(Fall)  
R240-Deviance & Social Control: *Military Sexual Trauma*

2008-2009 (Fall/Spring)  
R321-Gender and Health, Topic: *Post-Traumatic Stress Disorder Secondary to Military Sexual Trauma*

2008-2009 (Fall/Spring)  
R314-Families and Society, Topic: *The Impact of Military Sexual Trauma and Post-Traumatic Stress Disorder on Families*

2008-2009 (Fall/Spring)  
R420-Sociology of Disability, Topic: *Military Sexual Trauma, Combat Trauma, and Living with Post-Traumatic Stress Disorder*

2008 (Fall)  
R100-Introduction to Sociology, Topic: *Gender*