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From the Front Line to the Living Room: The Transition of Female Veterans Back Into Civilian Life

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From the Front Line to the Living Room: The Transition of Female Veterans Back Into Civilian Life

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Approval Page

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Abstract

From the Front Line to the Living Room: The Transition of Female Veterans Back Into Civilian Life. Bretia Arrington Gordon, 2018: Applied Dissertation, Nova Southeastern University, Abraham S. Fischler College of Education. Keywords: veterans, military personnel, military service, armed forces

The problem addressed in this study was female veterans faced unique challenges during military service and even more difficult experiences when transitioning into civilian life. Women long served in the military and reported similar as well as different experiences than men, especially in relation to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). For example, female veterans reported a higher percentage of sexual harassment and gender discrimination than did male veterans. Posttraumatic stress disorder (PTSD) and other mental health issues were also reported differently for female veterans than males. Women were found to be more likely to be diagnosed with a mental illness after returning from deployment.

This research was conducted using semi-structured interviews. The questions were broad in scope due to the sensitive nature of the problems faced by the participants. Questions focused upon recurring themes, such as PTSD, military sexual trauma, substance abuse, and impact on domestic relationships. The participants' experiences were analyzed for patterns and trends, and the information was used to encourage future research efforts in the improvement of services for female veterans. The purpose of this research was to collect information from OEF-OIF female veterans who experienced firsthand the challenges of being active duty and a civilian. The study also explored different aspects of issues not immediately identified or researched in depth in relation to this population. This research would help to inform change within the Department of Veteran Affairs (VA) system and other organizations supporting OEF-OIF female veterans and families.

Findings revealed participants shared similar experiences from their time in the military and during their deployment to serve in OEF and OIF. The accounts of their experiences presented themes of (a) PTSD and other mental health issues; (b) military sexual trauma; (c) discrimination based on gender, race, and rank; (d) different impacts of deployment; and (e) experiences with the VA health-care system. Findings provided a new understanding of the literature indicating the complex realm of what it is like for female veterans to (a) serve in combat, (b) transition back into their lives after deployment, (c) navigate the VA system, and (d) maintain their dignity and integrity while being discriminated against, and accepting and learning to live with PTSD, depression, and anxiety. Findings supported past literature, suggesting female veterans were more likely to need long-term services to assist them as they returned from combat and transition back into civilian life. They needed specific female-centered assistance from the VA to treat them for issues related to physical and mental health, counseling and quality medical services, and housing and employment assistance to deter potential homelessness. Findings also supported the call for the Department of Defense, U.S. Military, and the VA system to acknowledge the issues of discrimination based on rank, race, and gender and to hold those accountable who used it as a means to control and limit the potential of female members of the military.

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Chapter 1: Introduction

Female veterans who served during Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) were demographically different from the women involved in previous wars. These women were more likely to be younger and women of color, exposed to combat, been a target of sexual harassment and assault, and experienced mental health issues. These women were also more likely to come from backgrounds of low income, high stress, and poor social support, making it harder for them to overcome mental health issues and other stressors related to the military career (Mankowski, Haskell, Brandt, & Mattocks, 2015).

Combat deployments impacted the physical, psychological, and social well-being of the men and women who served. These individuals worked in tough environments with possible toxic exposures and few comforts (Disabled American Veterans, 2017; U.S. Department of Veterans Affairs, 2017). In this age of all-volunteer military service, smaller numbers of members carried the afflictions of requiring longer and more frequent deployments, involuntary enlistment extensions, lengthy deployment rotations, and reduced time at home in between deployments. The direct and indirect injuries, illnesses, and issues resulting from the global war on terrorism were likely to impact the health problems of veterans for years to come (Disabled American Veterans, 2017).

In recent years, the percentage of women in the U.S. military increased, and assigned roles and responsibilities evolved. Women participated in combat positions, resulting in a national concern (Afari et al., 2015). To better understand the scope of the debate, the researcher wished to learn about the history of females serving in the military, particularly since OEF, from October 2001 to December 2014, and OIF, from March 2003 to November 2011 (Tsai, Rosenhack, & Kane, 2014). Studies have been conducted

on the difficult issues associated with mental and emotional health, family dynamics and personal relationships, education and career, finances, and reproductive and physical health (Afari et al., 2015; Tsai et al., 2014). However, conflicting results regarding the manner in which the issues were addressed prompted a national debate, as well as the need to further the research already completed (Afari et al., 2015). For example, the inability of women veterans to access quality health care represented a major problem within the Veterans Administration (VA). The U.S. government took this problem seriously and began utilizing all resources, including more research, to improve the access of women veterans to health care (Koo & Maguen, 2014; U.S. Department of Veterans Affairs, 2017). This applied dissertation was designed to explore how female veterans confronted these complex issues during their transition back into civilian life.

Statement of the Problem

Many female veterans failed to successfully transition back into civilian life. Successful transition within this study was operationally defined as a female veteran who returned home after deployment and reassumed the social, family, workforce, emotional, and physical roles without being disrupted or held back due to social, economic, emotional, personal, and financial responsibilities. The issue of successful transition also involved female veterans who experienced some setbacks, such as lack of employment, divorce, or posttraumatic stress disorder (PTSD), and still managed to adapt, overcome, and thrive. Women long served in the military and reported similar as well as different experiences than men, especially in relation to the OEF-OIF wars (Demers, 2013; U.S. Department of Veterans Affairs, 2017). For example, female veterans reported a higher percentage of sexual harassment and gender discrimination than did male veterans. The issues of PTSD and mental health issues were also reported differently for female

veterans than males (Carlson, Stromwall, & Lietz, 2013; U.S. Department of Veterans Affairs, 2017). Women were found to be more likely to be diagnosed with a mental illness after returning from deployment (Belle & Bullock, 2014; Carlson et al., 2013; U.S. Department of Veterans Affairs, 2017).

There was insufficient access to care through the VA, as the organization was underprepared and unable to properly meet the increasing demands of female veterans returning from previous wars and service zones (Afari et al., 2015; Women Veterans Health Care, 2012). Veteran services were designed to care for male veterans. Moreover, as the VA was currently experiencing difficulties with properly serving the men, the problem became even greater as the organization attempted to address women's issues as well (Afari et al., 2015; Women Veterans Health Care, 2012).

Background and justification. In the past, veterans were mostly male. However, there were more women serving in the military at this time than in previous wars (i.e., World War II, Gulf War). These women served on the frontlines with the male soldiers, specifically in the recent Afghanistan and Iraq wars, were younger, and had different needs, which the U.S. Department of Veterans Affairs claimed to be working diligently to address (Afari et al., 2015; Women Veterans Health Care, 2012). Statistics indicated women represented nearly 15% active duty military and 17% of the National Guard and Reserve forces (Afari et al., 2015). Roles or responsibilities of military women also evolved over the years from administrative positions to those of gunners, police members, pilots, truck drivers, and fuel suppliers. These women also experienced more combat-related injuries (U.S. Department of Veterans Affairs, 2017; Women Veterans Health Care, 2012).

According to Women Veterans Health Care (2012), one in five women seeking

VA health care stated experiencing military sexual trauma, and one in five women veterans from the Iraq and Afghanistan wars were diagnosed with PTSD. As of 2014, 210,000 female veterans had served since 2001, and the numbers were steadily rising (Kesling, 2014). These data illustrated the growing problem in this country as the issue related to veterans, especially female veterans. The VA had undergone changes, but questions remained as to whether the situation would improve for the female veterans who returned home to resume their domestic responsibilities, jobs, and everyday lives (Kesling, 2014). Some experts indicated male veterans experienced the same issues as women, if not more (Afari et al., 2015). To sum it up, this research was designed to present the issues and challenges faced by females when returning from the battlefield after serving during the OEF and OIF wars. The research confirmed much work needed to be done to properly support this population of veterans (Afari et al., 2015; U.S. Department of Veterans Affairs, 2017).

Deficiencies in the evidence. As of 2012, the largest group of women in the military served in OEF, OIF, and Operation New Dawn. These individuals also became the fastest growing population of homeless veterans, a situation compounded by the inclusion of the children (Brannon, 2013; Briggs, 2012; Casura, 2017; Women Veterans Health Care, 2012). Kesling (2014) wrote that one in five women veterans reported experiencing military sexual trauma, including rape, yet 31% of VA clinics lacked adequate staff to provide treatment. The Pentagon and the VA acknowledged gaps in the system in terms of the disparity in the services offered to male and female veterans. Although these gaps represented only one facet of the inadequacy, the gaps were a very important component of the overall problem (Kesling, 2014).

Much research existed regarding female veterans on a variety of issues, such as

homelessness, PTSD, military sexual trauma, workforce issues, and transitioning (Afari et al., 2015; Belle & Bullock, 2014; Murray, 2013). However, less research existed on domestic relationships and academic or educational attainment following war. Women faced a unique set of issues simply by being women (Afari et al., 2015; Crompvoets, 2011; Fontana, Rosenheck, & Desai, 2010). To address this gap in the research, the current study focused on how these issues directly affected the ability of female veterans to transition back into civilian life and maintain self-sustainability.

Audience. This study may benefit female veterans, female soldiers, and families of military members or veterans, as well as agencies focused on providing services to veterans. It would also benefit researchers, educators, graduate students, consultants, and counselors.

Definition of Terms

For the purpose of this applied dissertation, the following terms are defined.

Civilian refers to a person who is not a member of the armed forces (Belle & Bullock, 2014; Murray, 2013).

Disability refers to a physical or mental handicap preventing a person from living a normal life or from gaining or holding a gainful job (Belle & Bullock, 2014; Murray, 2013).

Domestic refers to the home or family (Murray, 2013).

Female veterans refer to women who have served active duty since the Afghanistan war until present (Afari et al., 2015; U.S. Department of Veterans Affairs, 2017).

Mental health refers to psychological well-being and the ability to reasonably adjust to society and to the ordinary demands of life (Afari et al., 2015; Belle & Bullock,

2014; Brannon, 2013; Murray, 2013).

Military sexual trauma refers to rape, sexual assault, or sexual harassment occurring during military service (Kimerling et al., 2011; U.S. Department of Veterans Affairs, 2017).

Posttraumatic stress disorder (PTSD) refers to a disorder occurring after someone has been through a traumatic event, such as war, abuse, or assault. It can cause a person to feel afraid of the surroundings (National Center for PTSD, 2016; U.S. Department of Veterans Affairs, 2017).

Transition refers to change from one form or place to another (Murray, 2013).

Purpose of the Study

The purpose of this study was to solicit insights from repatriated female veterans about recurring obstacles preventing transition back into civilian life and to suggest corrective recommendations to the VA for consideration. The study sought to highlight the need to fund and support current and future research to promote best practices. Much research was conducted on the post-deployment of male veterans, but very little research addressed the issues of female veterans. This study served as a platform to (a) further the cause for the need of fair health-care access, (b) to raise awareness of the need for properly trained professionals and organizations, and (c) to increase awareness and bring more legislation addressing the unique needs of female veterans. This research focused on female veterans serving in the OEF-OIF wars and presented personal perspectives and experiences during the transition to civilian life. The researcher examined issues and challenges specifically affecting female veterans, such as mental health, family relationships, educational attainment, and homelessness. This research also examined how improvements could be made and provided some insight into possible best practices

for the VA system and other supportive services.

Chapter 2: Literature Review

Introduction

Chapter 2 focuses on the changing roles of men and women in the military, mental health issues and other types of trauma, family and personal relationships, and issues related to returning to the workforce or education and access to adequate health care. Women's experiences in the military, especially if these individuals served in war zones, could affect the ability to reintegrate into work, family, and social lives. Through the years, most research focused on male veterans (Brannon, 2013; Mattocks et al., 2012; Murray, 2013). The justification was the military has generally involved more male troops than female, and the types of roles played by the individuals in the military differed in levels of importance.

The effects of returning to civilian life after military service had recently become major issues concerning female veterans (Belle & Bullock, 2014; Mattocks et al., 2012; U.S. Department of Veterans Affairs, 2017). The studies conducted focused primarily on women's medical and mental health conditions after returning from deployment, but very few examined the personal experiences of these women and the ability or inability to cope with post-deployment, as well as the success or failure of these individuals in reintegrating into the communities, families, and careers (Brannon, 2013; Downing, 2012; Mattocks et al., 2012). In a study of women veterans, the Disabled American Veterans (2017) reported the following:

> Many women returned from wartime deployments stronger and without significant health problems, but many others suffered from unique post-war health care needs such as multi-organ systemic injuries associated with blast exposures, as well as other physical health concerns such as chronic musculoskeletal pain,

> headache, dizziness, trouble concentrating, respiratory conditions. Among the most prominent health care needs reported were a variety of mental health conditions, including PTSD, generalized anxiety disorders, depression, suicide, substance abuse and sleep disorders. Difficulty with readjustment, combined with poor health, contributed to functional impairments and difficulty in educational and occupational performance, and in family and social relationships. (p. 10)

This literature review included a discussion of these issues and provided some insight as to how the issues interrelated.

Theoretical Framework

Gender had a major influence on the roles men and women performed in the military (Casura, 2017; Fontana et al., 2010; Kleycamp, 2013). Women were often assigned to clerical, administrative, and nursing positions, as opposed to combat, which traditionally was the job of males. Since the Vietnam War, the Gulf War, and the previous conflicts in Iraq and Afghanistan, more women not only joined the military, but also served alongside men in combat zones (Casura, 2017; Fontana et al., 2010). The fight for equality and fairness in women's rights extended to the military. Women wanted to serve in the same capacities as men and feel able to perform at the same level as the male counterparts. However, resistance and discrimination continued to hinder the progress and opportunities of female veterans (Mattocks et al., 2012; U.S. Department of Veterans Affairs, 2017).

The plight of women's rights represented an issue around the world for hundreds of years (Buik, 2012; Carlson et al., 2013; Crompvoets, 2011). The issue delved even further into gender roles, civil rights, and equality. Through the years, the cause for women was championed by many individuals (Mattocks et al., 2012). Over the past 20

years, the U.S. Department of Defense made great strides and changes in policy pertaining to the roles of women in the military (Mattocks et al., 2012). These roles expanded to more combat-related jobs. Although women were still prohibited from direct combat, positions closer to combat zones exposed and put these individuals at risk for injury and death (Mattocks et al., 2012). The wars in Iraq and Afghanistan further distorted the line between combat and noncombat roles, as those wars were compared to guerilla fighting in urban war zones (Mattocks et al., 2012).

Mental Health Issues

The issue of PTSD. An increase in the numbers of female veterans who were in need of care and support occurred when repatriating since OEF and OIF; however, very little was known about specific mental health needs following deployment (Nunnink et al., 2010). The diagnosis of PTSD was the most common mental health issue facing veterans, both men and women (Nunnink et al., 2010; U.S. Department of Veterans Affairs, 2017). However, surveys showed this condition was most likely to occur in women (Nunnink et al., 2010; U.S. Department of Veterans Affairs, 2017). Traumatic brain injury largely affected female veterans and led to prolonged physical and psychological issues (Koblinsky, Schroeder, & Leslie, 2016; U.S. Department of Veterans Affairs, 2017).

During the OEF and OIF wars, women were working in similar capacities as the men, resulting in a higher risk to develop PTSD (U.S. Department of Veterans Affairs, 2017). A diagnosis of PTSD usually accompanied other mental health disorders, including substance abuse (Nunnink et al., 2010; U.S. Department of Veterans Affairs, 2017). Previous research showed 15% of veterans who returned from Iraq and 11% who returned from Afghanistan met the criteria for mental health issues such as PTSD and

depression (Mattocks et al., 2012; U.S. Department of Veterans Affairs, 2017). Furthermore, heightened psychological indicators, in conjunction with constant high levels of combat stress, were associated with a rise in suicide and suicidal ideation (Goldberg, 2011; Mansfield, Bender, Hourani, & Larson, 2011; U.S. Department of Veterans Affairs, 2017).

The issue of PTSD also directly influenced the onset of depression, which made the situation harder to overcome. Research also showed the concept of psychological resilience was weakened with the presence of PTSD (Mansfield et al., 2011; U.S. Department of Veterans Affairs, 2017). This concept could also be referred to as the ability to cope. When a veteran had PTSD and was unable to cope, coupled with the lack of access and support from others, this outcome could increase the probability of suicidal ideation and suicide (Kesling, 2014; Mansfield et al., 2011; U.S. Department of Veterans Affairs, 2017).

Research studies by the National Center for PTSD (2016) and Nunnink et al. (2010) indicated female veterans were underdiagnosed in VA facilities, which decreased the ability to access the needed care. For example, substance abuse represented an issue faced by women who tended not to seek treatment. These individuals often believed the situation was a result of another issue and, therefore, did not seek treatment for each specific problem (Nunnink et al., 2010). For instance, a person who struggles with drug addiction might have undergone a different treatment plan from someone who was an alcoholic. Because there was already a shortage within the VA system of qualified clinicians who could serve women, female veterans tended to go untreated or undertreated (National Center for PTSD, 2016; Nunnink et al., 2010).

According to research reported in the Women Veterans Study (Disabled

American Veterans, 2017), the VA needed to expand services to holistic female care to address the growing needs of female veterans. There was also a shortage of female-specific providers. This issue played a major role in the provision of adequate health care to female veterans. According to Fontana et al. (2010), female veterans reported a higher satisfaction with outpatient PTSD treatment care. A diagnosis of PTSD could have much to do with the capacity of any individual to test cultural customs of the military and to pursue help. Not doing so could bring about negative consequences for a person and might stifle the ability to recuperate from the traumatic event (Crompvoets, 2011; U.S. Department of Veterans Affairs, 2017).

Research showed PTSD to affect up to 20% of OEF-OIF female veterans, and 14% reported depression, anxiety, alcohol abuse, and other behavioral health illnesses (Belle & Bullock, 2014; Koblinsky et al., 2016). Hall, Elhai, Grubaugh, Tuerk, and Magruder (2012) examined gender differences in PTSD and found women were more likely than men to experience childhood sexual trauma or adult sexual assault. Men were found to report less sexual assault but more issues related to combat, war, and terrorism. Women were found to experience more severe PTSD symptoms than men (Hall et al., 2012). In research conducted by Dr. Ann Rasmusson, Boston University School of Medicine, female veterans were found to suffer more severe PTSD symptoms than male veterans. Other studies did not examine how the roles of men and women in the military explained the difference. For example, in a study examining 340 females and 252 male OEF-OIF veterans within 1 year of deployment, gender differences were not discussed in relation to the risk of PTSD symptoms, mental health functioning, or depression from combat exposure (Resnick, Mallampalli, & Carter, 2012). The authors believed further research should be conducted on examining these direct relationships for better data

(Resnick et al., 2012).

Exposure to combat zones and hazardous environment conditions, such as dust or wind storms, high temperatures, insects, rugged terrain, frigid cold temperatures, sleep deprivation, and heavy equipment or gear, played a major role in the emotional health of female veterans and the inability to function in personal relationships outside of the military. These circumstances played a major role in PTSD and depression (Jordan, 2011; U.S. Department of Veterans Affairs, 2017). While on duty, soldiers learned to adapt and overcome inhumane conditions physically, mentally and emotionally as necessary for survival. When these individuals reintegrated back home, soldiers may have had a difficult time separating prior experiences and traumas from loved ones (Jordan, 2011; U.S. Department of Veterans Affairs, 2017). These individuals could have dealt with survivor's guilt, rage, denial, anger, and other self-destructive behaviors, which can cause avoidance and withdrawal leading to a lack of intimacy. Soldiers returning home could be easily aroused by sounds, become easily irritable, have an overwhelming need for quiet and darkness, and become more prone to having nightmares or hallucinations (Jordan, 2011; U.S. Department of Veterans Affairs, 2017).

The issue of PTSD could contribute a significant role in the breakdown in family relationships, especially after combat exposure. Jordan (2011) indicated combat challenges included sniper fire, suicide bombers, undistinguishable insurgency, buddies blown to pieces, mortar attacks, and rocket-propelled grenades. Veterans who were in combat reported higher levels of dysfunction in personal relationships with spouses than those who were not in combat zones. Jordan explained how couple relationships could be highly influenced by their attachment bonds (i.e., insecure, anxious, avoidant, and disorganized).

Military sexual trauma. In 1993, the term *gender-based violence* was introduced in the declaration of violence against women (Mattocks et al., 2012). The term was described as any type of violent, gender-based act resulting in, or likely to result in, physical, sexual, or psychological harm or suffering to females to include threats, coercion, or arbitrary deficits of liberty (Mattocks et al., 2012). Gender-based violence was highly prominent, especially against women in the military. Military sexual trauma was a term used by the VA to refer to sexually related assault or repeated or threatening sexual harassment occurring while in the military (Mattocks et al., 2012; U.S. Department of Veterans Affairs, 2017).

Statistics showed 15.1% of female veterans of OEF and OIF and 0.7% of men reported military sexual trauma (Mattocks et al., 2012; U.S. Department of Veterans Affairs, 2017). According to a 2010 Department of Defense sexual victimization study, 4.4% of women and 0.9% of men indicated experiencing unwanted sexual contact (Williams & Bernstein, 2011). Sexual assaults occurring during military services had several long-term health consequences and were common in all female veteran units, including increased suicide risk, PTSD, major depression, alcohol or drug abuse, long-term sexual dysfunction, disrupted social networks, and employment problems. (Crompvoets, 2011; U.S. Department of Veterans Affairs, 2017). Another implication reflected in a study on patient satisfaction in the Veterans Health Administration indicated lower estimates of satisfaction with care among women veterans with a history of sexual violence while in the military than those without military experience. Furthermore, according to the Department of Defense study, approximately 22% of female veterans reported military sexual trauma (Williams & Bernstein, 2011).

Military sexual trauma was largely overshadowed due to an overwhelming

concern of combat exposure, death and injuries, and extended separation from family and friends. The assimilation of women into the military was met with resistance, and this reluctance resulted in an extreme avoidance of any problems women might have faced due to what some consider as women's insistence in being included in the male-dominated military (Kintzle et al., 2015; Koo & Maguen, 2014). Due to the sensitive nature of military sexual trauma, most sexual assault cases in the military were not reported for fear of retaliation and judgment by peers in the military and individuals in civilian life. As a result, victims might not have received medical attention, or the treatment was either delayed or inadequate (Kintzle et al., 2015; U.S. Department of Veterans Affairs, 2017).

The Department of Defense (2004) defined sexual assault as the suspected offenses of rape, nonconsensual sodomy, unwanted sexual contact, and attempts to commit these crimes. Female soldiers who were sexually assaulted by male comrades in a male-dominated environment were most likely to suffer from PTSD. The issue was even considered to be worse than if the assault came from a stranger (Williams & Bernstein, 2011). Other researchers, such as Benedict (2007) and Kintzle et al. (2015), compared the issue of PTSD to children abused by people who were close friends or even family members. Psychologically, these individuals experienced a sense of betrayal, helplessness, and shame and have often blamed themselves for the assault (Williams & Bernstein, 2011). The act of sexual trauma afflicted by military personal or fellow soldiers to female veterans was seen as an act of betrayal by those people expected to be protective (Gunter-Hunt, Feldman, Gendron, Bonney, & Unger, 2013).

Female victims of military sexual trauma reported more depression and alcohol abuse than those who were not victimized (U.S. Department of Veterans Affairs, 2017;

Williams & Bernstein, 2011). Military culture was found to decrease the chance a military sexual trauma incident would be reported. Due to hierarchy and the male-dominated nature of the military, victims of military sexual trauma were more likely to be blackballed and ridiculed by superiors and peers (Koo & Maguen, 2014; U.S. Department of Veterans Affairs, 2017). Reporting the assault caused more stress to the female veteran and only increased the likelihood of choosing not to report. Loyalty and honor were principles engrained in every veteran and were taken very seriously in the military. With female veterans being the minority, the pressure to keep quiet was highly encouraged, especially when it involves someone such as an officer (Jordan, 2011; Koo & Maguen, 2014; Piccoli, 2015).

Psychosis and Homelessness

Mental health issues were largely associated with increased rates of substance abuse, risky sexual behaviors, and mental health issues. Female veterans experiencing military sexual trauma were at greater risk for suffering from depression, alcohol and drug abuse, and anxiety disorders, which increased the need for preventive treatment (Gunter-Hunt et al., 2013; U.S. Department of Veterans Affairs, 2017). Statistics provided by Chapman and Wu (2014) showed the prevalence of binge drinking was higher in the Marine Corps than in the Air Force. In addition, 32% of women reported binge drinking, 8% reported heavy weekly drinking, and 7% reported alcohol-related problems. Female veterans were also found to engage in unsafe drinking and illicit drug use more than military men (Chapman & Wu, 2014; U.S. Department of Veterans Affairs, 2017).

Psychosis. Suicide, PTSD, military sexual trauma, and substance abuse were closely associated with suicide among veterans, especially female veterans. Drugs and

alcohol were often used to mask the pain soldiers and veterans experienced after combat (Belle & Bullock, 2014; Mansfield et al., 2011). The percentage of suicide among female veterans increased by 40% from 2000 to 2010 (Koblinsky et al., 2016). Some researchers have noted women were affected at a higher rate because of an emotional and nurturing nature (Belle & Bullock, 2014; U.S. Department of Veterans Affairs, 2017). Substance abuse altered neurological activity in a person's brain (Chapman & Wu, 2014) and could increase impulses and decrease mental ability or the ability to make sound decisions. Suicide was often the result of other mental issues, such as depression and PTSD (Chapman & Wu, 2014; Mansfield et al., 2011; U.S. Department of Veterans Affairs, 2017). Veterans suffering from depression or PTSD were also put at higher risk for self-isolation and ridicule. The need to belong and feel needed might have caused veterans to make decisions prematurely, which may, in turn, led to feelings of guilt, shame, and self-isolation. This feeling of hopelessness could lead to issues such as homelessness.

Homelessness. Psychological resilience referred to the ability to cope with traumatic situations and endure during difficult times (Leddy, Stefanovics, & Rosenheck, 2014). Lower resilience was reflected through people who committed suicide or had strong suicidal ideation (Casura, 2017; Leddy et al., 2014; Mansfield et al., 2011). Research showed men were more likely to commit suicide than women, regardless of mental issues or substance abuse (Chapman & Wu, 2014; Hargarten, Burnson, Campo, & Cook, 2013; Leddy et al., 2014). Female veterans were not only the fastest growing group of homeless veterans, but also more likely to be homeless than women who never served in the military (Koblinsky et al., 2016; Leddy et al., 2014). According to Hamilton, Poza, and Washington (2011), one in four homeless individuals was a veteran.

Research showed over one third of homeless female veterans dealt with mental

illness (Gunter-Hunt et al., 2013; Leddy et al., 2014; U.S. Department of Veterans Affairs, 2017). The number of homeless female veterans also increased, whereas the rates of civilian female homelessness decreased (Gunter-Hunt et al., 2013; Leddy et al., 2014). Childhood hardship, trauma, and drug and alcohol abuse during military service contributed greatly to homelessness among female veterans. Furthermore, female veterans had different needs than homeless male veterans. These veterans were more likely than male veterans to need specialty health care, mental health care, and treatment for physical and sexual trauma, housing provisions, and child-care assistance (Leddy et al., 2014; U.S. Department of Veterans Affairs, 2017; Washington et al., 2010).

In 2009, President Barack Obama and the Veterans Affairs Secretary, Eric Shinseki, announced a plan to end homelessness among U.S. veterans by 2014. As a result, the United States Interagency Council on Homelessness created Opening Doors: Federal Strategic Plan to Prevent and End Homelessness 2010. In 2014, the U.S. Department of Housing and Urban Development, the United States Interagency Council on Homelessness, and the VA announced veteran homelessness had declined by 33% since 2010 and by 11% between 2013 and 2014 (Woolsey & Naumann, 2015). Previously, there were approximately two million female veterans in the United States, who represented the fastest growing group of veterans without a home. The biggest problem reported by female veterans was feeling invisible in and out of the military (Disabled American Veterans, 2017). Piccoli (2015) identified the top five issues facing women veterans: invisibility, falling through the cracks, self-isolation, unemployment, and homelessness.

Family and Personal Relationships

Four to five million children in the United States had military-connected parents,

and two million had a parent who was a veteran (Lester & Flake, 2013). In a way, these children also served in the military because of parents. These children dealt with the issues associated with the deployment of parents and suffered when a relative suffered due to an injury or possible death. The military service of loved ones took a mental and emotional toll on families, especially when the service involved female veterans (Lester & Flake, 2013; U.S. Department of Veterans Affairs, 2017).

The result of deployment on men and women could differ because of women's responsibilities at home. Although the roles of women in the home changed through the years, these individuals were still expected to be primarily responsible for child rearing and other domestic duties. However, when women were deployed for military service, the absence at home created changes and new responsibilities for almost everyone involved (Mattocks et al., 2012). If the woman was married, the husband often became the sole person responsible for the care of the home and children. If the repatriated veteran was a single mother, one of the family members was likely to assume responsibility for the children (Mattocks et al., 2012). Women veterans were more likely to leave the military because of family concerns and responsibilities (Szelwach, Steinkogler, Badger, & Muttukumaru, 2011; U.S. Department of Veterans Affairs, 2017).

The deployment cycle model was described as a series of emotions and behaviors experienced by families and children when a family member was assigned to active duty away from home (Lester & Flake, 2013). There are five phases: pre-deployment, deployment, sustainment, redeployment, and post-deployment. In the pre-deployment stage, children were emotionally preparing themselves to be without their parent. This may be an emotional time filled with anxiety, anger, and withdrawal (Lester & Flake, 2013). During the deployment stage, children could become even more anxious and full

of anger and sadness. In the sustainment period, children accepted the deployment and were able to function without as much anger, and the parent might have returned. Upon the return of the parent, the child might become excited, experience a euphoric feeling, and begin to normalize and readjust to the parent being home (Lester & Flake, 2013). If redeployment and post-deployment occurred again, the child could withdraw and become angry (Lester & Flake, 2013).

The children and family of veterans began to adjust to their lives and their shifting roles while the parent was deployed. Once the parent returned, there could be an expectation the individual would assume the parental role in the family (Lester & Flake, 2013). The parent who was deployed might not be able to resume the parental role due to mental, emotional, or physical issues occurring while deployed (Holmes, Rauch, & Cozza, 2013; U.S. Department of Veterans Affairs, 2017). In the case of a female veteran returning home, the individual might not be able to reconnect with the husband and children emotionally because of military sexual trauma and PTSD (U.S. Department of Veterans Affairs, 2017). The female veteran could have recurring nightmares and develop a distrust of men. The family might not understand what was going on, causing the individuals to distance themselves and further isolate the female veteran (Lester & Flake, 2013).

Homecoming theory. The homecoming theory was a term created after World War II (Ahern et al., 2015), which served as way to understand the challenges experienced by veterans while transitioning back into home lives. The theory indicated how the home experiences changed for the service members and family members or friends (Ahern et al., 2015). Responsibilities changed, thus altering the dynamics of the relationships. Once the veterans returned home, there was an expectation of things

returning to previously experienced situations. However, those relationships must be reestablished (Ahern et al., 2015).

Mattocks et al. (2012) suggested 40% of active duty women were mothers, and divorce rates for female service members were on the rise. Divorce placed additional stress on the veterans who needed to find other child-care arrangements while deployed (Mattocks et al., 2012). Research by the U.S. Department of Defense also showed divorce rates for veterans, especially during the Iraq and Afghanistan conflicts, were higher than for the general population (Jordan, 2011). Divorce also affected dual military couples, meaning both spouses have served in the military. The military service of two married individuals can be even more stressful than the difficulties faced by an average veteran with a civilian spouse (Jordan, 2011).

Jordan (2011) discussed many aspects of how combat could impact the relationships of veterans from the conditions and environmental stressors in Iraq and Afghanistan to the combat skills taught to soldiers to survive during deployment. The civilian spouse might not be able to relate to any of these issues because the information was restricted to military members. Veterans were also told not to discuss military missions and experiences during those times because the information was confidential, and silence represented the honorable thing to do (Jordan, 2011). Many veterans, male or female, preferred not to discuss experiences in the military, especially in war zones.

Reintegration. The use of battle mind skills was necessary for the survival of veterans in combat. Battle mind skills involved an individual's ability to control how the brain processes fear, trauma, and the unknown. The skill had to be unlearned (Jordan, 2011). Fight or flight was a similar concept involving a person's response to stressful situations (Jordan, 2011). The individual either fled from danger or electively faced the

threat. Battle mind skills did not give a person an option. Fleeing was not possible (Jordan, 2011). The individuals needed to be mentally, emotionally, and physically prepared to react in an instant. This skill benefited service members in combat but could damage relationships with families, especially spouses (Jordan, 2011).

After having utilized battle mind skills while in combat, a female veteran returning home from deployment may be riddled with mental and emotional issues as a result of difficult transitions (National Center for PTSD, 2016; U.S. Department of Veterans Affairs, 2017). Female veterans suffered from PTSD just as frequently as male veterans. When a female returned from war, more pressure may have been placed on the individual to return more quickly to previous roles in the family (Jordan, 2011). Family members could assume the female veteran's role in combat was not as bad as the role of a male service member or might not understand the female veteran's experience in combat. The female veteran may question personal need, leading to family breakdowns in communication and coping ability (Jordan, 2011; Luchsinger, 2016). There may also be hesitation about seeking help from mental help professionals. The same issues could occur in friendships because of an inability to relate to one another. The reintegration progress required time on everyone's part (Jordan, 2011; Luchsinger, 2016).

The emotional impact of war affected all veterans in some way. However, OEF and OIF especially had detrimental impacts upon the reintegration of female veterans due to the number of deployments. Veterans could often be deployed three or more times for at least a year at a time (Jordan, 2011). For veterans, redeployments could have a detrimental impact on the ability to stay connected to spouses (Jordan, 2011). Children suffer as well (Jordan, 2011). A spouse had a choice but the child did not. Jordan (2011) examined the relationship between the mental health issues of 250,000 army wives and

the deployment of the husbands (Jordan, 2011). Findings indicated both the veterans and the wives suffered from types of recurring mental issues: stress, sleeping problems, anxiety and depression. Spouses were reluctant to obtain help for mental and emotional issues because of not wanting the military spouse to be punished or affected negatively (Jordan, 2011; Murray, 2013).

Jordan (2011) connected the reintegration of veterans with how the couples interacted with each other emotionally. For example, when combat veterans had secure attachment to spouses, the ability to cope with combat-related issues was greater because secure connections with significant others typically served as a powerful remedy to traumatic experiences, such as war (Jordan, 2011; Murray, 2013). The avoidant attachment only enabled those who wanted to be more independent or less attached to the spouse. This attachment also served to enable fear or being too close or intimate with someone (Jordan, 2011; Luchsinger, 2016).

Research conducted in 2014 indicated 30% of the OEF-OIF veterans were diagnosed with PTSD within the VA system (Fischer et al., 2015). In addition, familial systems and social support declined due to a lack of understanding of the veteran's mental health issues (Fischer et al., 2015). Veterans were found less likely to receive or complete treatment for PTSD without family support (U.S. Department of Veterans Affairs, 2017). The research indicated families might also benefit greatly from counseling to understand the nature of PTSD, the effects on a person, and how to help a loved one cope (Fischer et al., 2015; U.S. Department of Veterans Affairs, 2017). Since 2008, the VA mandated all VA medical centers to offer couples and family therapy, family education, or family psychoeducation services for veterans with PTSD (Fischer et al., 2015 U.S. Department of Veterans Affairs, 2017).

Female veterans were also more likely than male veterans to experience intimate partner violence due to mental health issues related to PTSD and depression (Iverson et al., 2015; U.S. Department of Veterans Affairs, 2017). In fact, because 33% of women who entered the military had a history of sexual abuse, and 35% experienced childhood or emotional abuse, these individuals were more likely to develop PTSD while serving in the military (U.S. Department of Veterans Affairs, 2017). All of these issues played a major role in the ability of female veterans to function within the family units upon returning home (Burkhart & Hogan, 2015).

Workforce and Education

In 1944, the U.S. Government began providing military veterans with financial assistance for higher education with the GI Bill of Rights. One of the main reasons individuals joined the military, specifically during the Global War on Terrorism, involved the educational benefits (Naphan & Elliott, 2015). In 2009, the GI Bill improved the educational benefits for veterans and dependents. A reported 45% of veterans of the Global War on Terror had used these benefits as of 2011. These veterans were 30 years old and under, as compared to veterans from other wars (Naphan & Elliott, 2015). Furthermore, even though larger numbers of veterans were pursuing educational goals, attaining a college degree was not as easy of a feat.

Transitioning to college could be challenging for any student, even without a military background, due to the independent nature of a college campus (American Council on Education, 2010; Bennet, 2014; Murray, 2013). Self-motivation was also needed to succeed. Unlike home or the military, there was no one to ensure the students stayed on task. The students needed to make the necessary decisions to remain in good standing and handle personal academic obligations. However, this transition could be

difficult for student veterans for similar as well as different reasons. In the military, authority figures delegated what service members did (Naphan & Elliott, 2015). The military men and women worked mostly on teams with the same goal in mind. Being college students required independence. Even if a group assignment was given, the student still must make independent decisions. In the military, each soldier was a brother's keeper, but, in civilian life, individuals were not required to think in the same way (DiRamio, Jarvis, Iverson, Seher, & Anderson, 2017; Murray, 2013).

In college, students who did not complete their assignments might fail, but there was room for error and understanding with professors (Murray, 2013). Veterans experienced difficulty when trying to cut off the military mentality while reintegrating. For some, this outcome can lead to anxiety, depression, isolation, and other mental health and social issues. In addition, judgment and curiosity might come from nonstudent veterans, professors, and so forth. These individuals might be treated as the enemy by some and viewed as a spectacle by others (Naphan & Elliott, 2015). Civilians might not understand the sensitive nature of asking certain questions to veterans, especially nonstudent veterans. These things might lead to some student veterans discontinuing a college education or enrolling in nontraditional, veteran-friendly colleges and could also lead to unemployment due to the stress of college and the workforce (Kato, Jinkerson, Holland, & Soper, 2016; Murray, 2013).

Historically, female veterans were more likely to be unemployed than veteran males as well as nonveteran females and males (Szelwach et al., 2011). Again, this situation represents an example of traditional gender discrimination and shows women in the military experience the same level of difficulty as civilians. The objectives of female veterans were very similar to those of other nonveteran women who worked, seeking

employment offering fair pay, promotional opportunities, reasonable benefits, and flexibility to balance work and home life (Szelwach et al., 2011). However, some female veterans lacked the work experience, education, and skills necessary to acquire stable jobs (Szelwach et al., 2011).

Research (Murray, 2013; Szelwach et al., 2011) showed veterans with higher levels of education had more positive opportunities to attain employment outside the military. The more difficulty experienced to attain a job offering stability, the more difficulty experienced in the transition to civilian life (Szelwach et al., 2011). For the veterans who wanted to further their education, the post-9/11 GI Bill gave veterans the opportunity to receive benefits for any approved program offered by a college or university in the United States granting an associate's degree or higher (Szelwach et al., 2011). Szelwach et al. (2011) found most women veterans since 2006 had more college experience than women who had not served in the military. One of the better benefits for veterans was the opportunity to take advantage of the GI Bill to attain higher education (Szelwach et al., 2011). However, female veterans faced many complex issues, hindering the ability or willingness to use this benefit. Some of those included mental health and physical disabilities developed while deployed, familial responsibilities, and the need to fit back into the supportive role if married. These individuals might have been afraid to embark on college life because of fear of being misunderstood or not being able to keep up (Szelwach et al., 2011).

Veterans frequently reported problems associated with academic loads, socialization with peers, and limited access to services in colleges (Ostovary & Dapprich, 2011). Veterans in general were trained to think and behave in a certain way while in the military. It could be difficult to reenter civilian life and turn the behavior off to fit in the

mode of civilian life, let alone student life (Jones, 2013; Murray, 2013). Being students in a college setting with the complexities of the environment and the constant distractions, veterans may find it intimidating and overly difficult to fit in with peers and to fulfill academic responsibilities (Jones, 2013; Murray, 2013).

Military sexual trauma could also affect the attitudes of female veterans in the classroom due to being less likely to connect with peers, coworkers, classmates, and professors due to mental issues, social anxiety, physical disabilities, and fear of feeling inferior (Gunter-Hunt et al., 2013; U.S. Department of Veterans Affairs, 2017). Statistics showed 20% of OEF-OIF veterans reported mental health problems, and the percentage increased for student veterans (Kato et al., 2016; Murray, 2013). Thirty-five percent suffered from severe anxiety, and 24% reported severe depression, and these statistics were reported to be 10% to 18% higher than those for nonstudent veterans (Kato et al., 2016). The stress of transitioning to academia as a student could be difficult for veterans to handle mentally. There was the pressure of meeting deadlines, learning new nonmilitary-related information, being nontraditional in a traditional environment, and not fitting in socially with peers. These things could increase the chance of mental health issues within the student veteran population (Kato et al., 2016; Murray, 2013).

Because of the increasing number of student veterans entering college, universities around the country began creating programs and services specifically for veterans (DiRamio et al., 2017). A 2012 study conducted by the American Council on Education surveyed approximately 40% of institutions of higher learning that had either planned or created a Veteran's center on the campuses (DiRamio et al., 2017). Other research found many student veterans who attended colleges with those veteran-specific services did not utilize them. When trying to understand the lack of help-seeking

behavior in student veterans, issues related to fear or judgment could be the leading cause. Many veterans experienced distrust when it came to personal military records. These individuals tended to feel any kind of help specifically targeting the veteran status represented a breach of confidentiality as related to mental health issues. Even regarding education, the attitude of not seeking help continued (DiRamio et al., 2017).

Access to Health Care and Support Services

The VA operates the largest integrated health-care system in the United States, and the organization continues to grow because of the increasing need to serve veterans (Kudler, Straits-Troster, & Brancu, 2011; U.S. Department of Veterans Affairs, 2017). One of the major issues with the VA system regarding veterans, especially women, involves the lack of access to quality health care. The reason for this problem is clearly multifaceted, but the situation exists mainly because of the strong presence of male veterans in the past (Kudler et al., 2011). Women make up 8% of all veterans and more than 11% of veterans from OEF and OIF (Kudler et al., 2011). Access does not refer simply to the ability to see a clinician, but also involves the ability to receive quality care. One of the most serious issues with the VA system involves the lack of qualified and trained professionals who know and understand the special issues faced by women veterans (Crompvoets, 2011; Hoge et al., 2004).

Whether it was gynecologists who could perform pap smears and treat sexual issues or social workers who could assist women with social support, the VA lacks the ability to effectively treat the needs of female veterans (U.S. Department of Veterans Affairs, 2017). Research made it clear there is a deficiency in services based on gender in the VA (Crompvoets, 2011; Murray, 2013). Given the increasing number of women in the military who are accessing VA care, recognizing the distinctive stressors experienced

by female veterans is vital to best arrange for their care (Koo & Maguen, 2013). Crompvoets (2011) connected access to services with structural and cultural barriers. According to the research, issues regarding female veterans' access to health services contributed to a lack of knowledge about eligibility and availability. Crompvoets also found previous research indicating ethnic or racial minorities had a more difficult time accessing services because the perceptions of needs were unique and kept these individuals from seeking and receiving the needed services after deployment.

Because of the complexity of military sexual trauma and its association with one's military experience, female veterans could be reluctant to go to the VA for care (Gunter-Hunt et al., 2013). Statistics indicated around 17% of female veterans used the VA's services, and more than half of these women had some type of service-connected disability (Koo & Maguen, 2013). In 2009, female veterans using the VA for health care increased by 83% from 159,630 in 2000 to 292,921, whereas male veteran care increased only 50%. The percentage for female veterans was expected to triple from 2010 to 2040 (Koo & Maguen, 2013). Kudler et al. (2011) discussed how living in rural areas affected veterans' access to health care. The authors found veterans who lived in rural areas dealt with an additional barrier to access. Different concerns affected veterans who lived in rural areas, such as poor conditions of roads, lack of public transportation, cultural difficulties, and lack of interest (Kudler et al., 2011).

To deal with the increasing demand of female veterans who needed access to health care, the Veterans Health Administration created programs to help link the individuals more efficiently to care (U.S. Department of Veterans Affairs, 2017). The goal of the program was to reduce the risk of veterans of becoming homeless, reduce felonious recidivism, expedite recovery, and improve overall health by addressing

personal needs (Finlay et al., 2015). The first step to receiving VA care for military sexual trauma was the veteran need to report the incident or screen positive to questions describing the act of military sexual trauma (Koo & Maguen, 2013). According to Koo and Maguen (2013), examples of the questions were as follows: Did you receive unwanted sexual attention, such as touching, cornering? Did someone ever use force or threats of force or punishment to have sexual contact with you? Further research has shown many veterans do not enter treatment ready to deal with military sexual trauma, especially female veterans who have experienced sexual assault and those who know the person who assaulted them (Koo & Maguen, 2013).

Combat veterans represented the highest priority patients for treatment, benefits and services, and, therefore, were of most concern to the VA system (Fontana et al., 2010). However, due to the role changes of female veterans in combat, the VA had to make adjustments the organization was not prepared for since the Iraq and Afghanistan wars. In other words, the need for health-care services, specifically for female veterans, was increasing and would be for years to come (Fontana et al., 2010), as the needs of female veterans in past wars changed. The services male veterans usually receive are demanded by female veterans at a higher rate nowadays (Fontana et al., 2010). The roles female veterans played in World War II and the Vietnam War changed. These individuals are no longer in nursing and clerical roles but are exposed to more violent and stressful conditions, which puts the female veterans at greater risk for danger physically, emotionally, and mentally (Crompvoets, 2011; Fontana et al., 2010).

Female veterans needed to feel comfortable with the providers in the VA system (U.S. Department of Veterans Affairs, 2017). Women who felt the provider was previously associated with the military might not be comfortable with disclosing

information and then receiving the necessary care and support (Koo & Maguen, 2013). This problem is especially critical for female veterans who experienced military sexual trauma and substance abuse. The female veteran could fear she would be reported or identified, which could have ramifications regarding the military career (Koo & Maguen, 2013). According to a national survey conducted about veterans receiving VA care, female veterans were mostly satisfied with the VA; however, depending on personal demographics and circumstances, the satisfaction may change (Koo & Maguen, 2013; U.S. Department of Veterans Affairs, 2017).

Two programs utilized by the VA system to address the needs of access to health care for veterans were the Veterans Justice Outreach program and the Healthcare Reentry Veterans program. These programs were designed for veteran inmates reentering society and veterans who had legal issues in the court systems and jails (Finlay et al., 2015). Clearly, these programs did not focus on female veterans but may have assisted the individuals. However, many female veterans did not have access to this program and ran the risk of getting overlooked in the VA health-care system. The shortcoming of such a program might not address health-care issues directly but simply assist veterans with access to care instead of increasing the quality of care (Finlay et al., 2015).

Recent studies showed female veterans were either not using the VA for health care or were dissatisfied with the quality of services and care offered. In response to those issues, the VA presented new initiatives to improve the quality of care (Koblinsky et al., 2016). The Veterans' Access, Choice, and Accountability Act of 2014 and the Affordable Care Act were designed to help with the expansion of access to health care outside of the VA system for veterans, especially female veterans. The National Council for Behavioral Health also projected 40% of OEF-OIF veterans would seek mental health services

within the communities (Koblinksy et al., 2016).

A national research study conducted in 2009 focused on female veterans' access to health care. The study, involving interviews of 3,611 female veterans, found female veterans had specific barriers to access, such as low income, lack of insurance, and lack of knowledge of VA services for women specifically (Washington et al., 2010). The populations of OEF-OIF female veterans were found to utilize the VA more due to the increase of combat exposure and number of women in the military at the time. In comparison to other military eras (i.e., Vietnam and World War II), these individuals represented 44% versus 14% (Washington et al., 2010).

Some other OEF- and OIF-specific barriers to health care were found within the VA health-care system: reintegration matters, gender sensitivity from health-care staff, and the coordination of obstetrical and mental health care (Washington et al., 2010; U.S. Department of Veterans Affairs, 2017). Another barrier to health-care access involved the age of the OEF-OIF female veterans. Female veterans prior to the OEF-OEF combats were older in age, which made them eligible for programs such as Medicare (Washington et al., 2010). The younger female veterans were not only entering in larger numbers, but were also staying in for longer periods of time, resulting in greater risk for mental health issues and physical disabilities and increasing the need for quality gender-specific health-care services (Washington et al., 2010).

Summary

The literature review included a discussion of research indicating female veterans faced a unique set of challenges while making the transition from active military duty to civilian life. These individuals are challenged by (a) the transition from serving as a soldier to being a mother or wife; (b) the lack of access to proper health care; (c) the

sexual, mental, and psychological trauma suffered during the deployment experience; (d) the lack of postsecondary education or the inability to transition into college life; (e) the guilt or remorse experienced from being unable to return to domestic responsibilities and children; and (f) the economic challenges due to financial hardship or lack of work experience (Szelwach et al., 2011). The ability of women veterans to cope was largely based on a supportive and understanding environment providing the space needed to debrief and readjust. These women also need to be nurtured and tended to in a different way than male veterans. The ability to receive quality health care from qualified professionals is important, as well as the ability to be comfortable when seeking those services (Crompvoets, 2011).

Although the amount of previous research increased concerning this population, there was still more to be learned. More research was needed to investigate how services for female veterans progressed since 9/11. The need for this research was important and would be for years to come because veterans were still undergoing treatment and making the transition from the Iraq and Afghanistan wars. The impacts from these wars were still being measured, and the outcomes were not completely known. However, further research on the issues addressed in the current study was designed to contribute to improving the quality of life of female veterans for years to come.

Research Questions

The following research questions were developed to guide this study:

1. What is the experience of female veterans transitioning back into civilian life?

2. What are the challenges these female veterans faced during their transition? How can these individuals overcome those challenges?

3. How can the Department of Veterans Affairs improve its services to female

veterans?

Chapter 3: Methodology

Aim of the Study

The purpose of this study was to collect data and information on how female veterans who served in the OEF and OIF wars viewed and assessed their transition back into civilian life. The goal of this research was to gain further insight into female veterans' perspectives regarding the transition, the challenges faced during the transition, how some overcame those challenges, what kind of assistance was provided by the Department of Veterans Affairs, and the usefulness of the assistance in facilitating the reintegration into civilian life, including health care. To gather in-depth data in the veterans' own words, a qualitative approach was used.

Qualitative Research Approach

The qualitative research methodology is the most appropriate type of research used to obtain information for exploring and understanding a central phenomenon. This type of research design gave the participants opportunities to express personal views in the form of words, so the information could be interpreted and analyzed for meaning (Creswell, 2015). Phenomenological research involves an attempt to understand the perspectives, perceptions, and experiences of another person and allows the researcher to gather firsthand information regarding a lived experience of the participant (Creswell, 2015). For example, the researcher examined the everyday life of a participant. As a result, the shared experiences based on the researcher's insight and experience provided a descriptive point of view of the phenomenon. This research was conducted from an exploratory approach, allowing the participants to express themselves in an open fashion. The participants were recruited from a cross-sectional approach.

This research was conducted through the use of semistructured interviews (see Appendix A). The interview questions were broad in scope due to the sensitive nature of the issues experienced by the participants in the study. The information received was relevant because it involved the experiences of the participants. The questions also highlighted pertinent themes (e.g., military sexual trauma, substance abuse, domestic relationships). The experiences of the participants were interpreted, and the information was used to encourage future research efforts in the improvement of services for female veterans in general (Creswell, 2015). The purpose of this research was to collect conclusive information from female veterans who experienced firsthand the challenges of being active duty and a civilian. The researcher also explored different aspects of issues previously unidentified or researched in depth in relation to this population. The goal of the research was to propel change within the VA system and other organizations supporting female veterans and the families.

Participants

Description of sample. When conducting exploratory research, researchers choose participants who reflect the population being studied, known as purposeful sampling (Creswell, 2013). In this case, female veterans who served in the OEF and OIF combats during the Afghanistan War were recruited through social media, word of mouth, and from the local law enforcement agencies. The participants were screened using a demographic form asking about military service (see Appendix B). Current military status and discharge status were not requested and did not disqualify the individuals from being able to participate. Nine participants were interviewed, and Skype was used for some veterans who were unable to meet in person as a result of living out of town. The intention was to gather relevant information to be used in the research relating

to personal experiences and perceptions or views in the war. The participants were asked a series of interview questions but were not coerced to do so as result of being uncomfortable or deciding not to participate.

Informed consent. While conducting research with human subjects, it was important the individuals consented or gave permission for use in research. The consent form disclosed what the research was about and gave individuals an opportunity to decide on participating or not, as well as let the individuals know the benefits and risks for participation. Ethical practices needed to be implemented in the research to ensure the process was reliable and fair. In this research, the researcher and the participants were protected from the recruitment stage to the participant stage.

The researcher had to recruit participants before the study began. In doing so, permissions were gained prior to the study. While recruiting, the researcher had to let the participants know the details of the study and what needed to be done. The researcher could not force anyone to participate at any time during recruitment and after. While recruiting, the researcher provided a brief description of the study and the criteria as well as contact information. Once the individual contacted the researcher about the nature of the research, the study was explained in detail. If the individuals wanted to participate, the researcher asked about signing the informed consent form at the time of the interview. Once the letter of participation and demographic survey were received by the researcher via email or in person, the participant received a confirmation email. A unique identifier was assigned to each participant to protect anonymity. When the participant came in for the interview, the researcher went over the informed consent form and had the participant sign it.

Data-Collection Tools

The researcher collected responses to in-depth interviews with the intent being the information received would be enough to support the hypotheses of the research and to assist with future research. Firsthand information from the participants was more powerful than secondhand perceptions. The interview data provided the opportunity to gain personal and accessible information not always possible from observation. The interviews were conducted one on one, in a group or via Skype or Facetime, semistructured, and audio recorded for transcription. An interview protocol (see Appendix C) was used to ensure the process and interview was conducted correctly and, in a way, protected the integrity of the research (Creswell, 2013, 2015). The research was conducted in an office closed and private from disruption. The protocol was a checklist used by the researcher to ensure everything was being done accordingly and in order.

Procedures

To begin the research, the researcher gained permission from the Institutional Review Board at Nova Southeastern University to implement the research study. The researcher obtained the access to the participants through word of mouth and flyers placed in public places and on social media. The flyers were used as a recruiting tool for the study. Contact information for the researcher was on the flyer so interested persons could contact her. Once contact was made, the researcher explained the study to the interested person. The individuals were also asked if they were female veterans who participated in OEF or OIF. Once confirmation was received, the individuals were asked about being interested in participating in the research. If the individuals were, the researcher sent an email with a letter of participation invitation and the demographic survey. If the individuals were not interested in participating, the researcher thanked the

individuals and asked about spreading the word of the research. The interviews took place within a month after confirmation. The location of the interview was in the clubhouse at the Grand Reserve at Pike Road apartments. The clubhouse was remote and private and used only when reserved. The doors were locked, and there were no signs to indicate what was taking place.

An interview protocol with the outline of the interview questions and important information was utilized during the interview. A digital voice recorder was used to record the interviews via Skype, Facetime or in person. The researcher let the participant know when the interview began and it was being recorded. The researcher also let the participant know 12 semi-structured questions were going to be asked. The interviews lasted no longer than 1.5 hours. During the closing of the interview, the researcher assured the participant the interviews and recordings were confidential and responses would be transcribed and compiled into themes. The participants received a copy of the interview via email upon request at the end of the study. The interview responses were transcribed and saved and placed in a secure file for 3 years after the completion of the study. It would then be shredded.

Data Analysis

The researcher transcribed the data from the interviews by carefully listening to the recordings by using earphones. The information was converted from audio to text on a computer in a summary style and not word for word. The interviews were listened to by the researcher three times. The data from the interviews were analyzed and organized into topics and themes. To ensure reliability and accuracy, the researcher read the data to make sure the information was the same as the audio. The researcher was also looking for any nonthematic information and analyzing it for future considerations. The researcher

employed a coding method to make sure all themes were precisely depicted and analyzed for the research. The researcher also used a hands-on approach to assist with the analyzing efforts and accuracy (Creswell, 2015). The data were analyzed by placing the information into categories, such as PTSD, military sexual trauma, personal relationships, Veterans Affairs issues, and so forth. The categories were reflective of the sections in the proposal. The researcher listened for recurring themes and information. A chart was made to organize the frequency of recurring themes per participant. The themes were totaled and listed in order of the most frequent (see Appendix D).

Ethical Considerations

Participants received a code for identification purposes, which protected the information as anonymous. Emails were used to share documents about the study and to confirm participation. Those were the only emails used in this research. All further communication took place either face to face or by telephone. The four core ethical principles were applied in this research: beneficence, justice, respect for persons, and respect for communities (Creswell, 2013). Finally, the data from the research were stored in a secured access file on the computer requiring a pin code for entry.

Trustworthiness

The credibility and trustworthiness of this study were demonstrated using member checks (Johnson, 2011). The strength of the research was based on the interview responses from the participants. The researcher discussed some of the information provided to ensure validity and reliability. She also verified participant responses and reviewed the interpretation of those responses. This gave the participants an opportunity to ensure correctness and make any changes if necessary. The use of member checks also increased trust between researcher and participant.

Potential Research Bias

The researcher had a personal interest in the plight and issues concerning female veterans. Her grandmother was a nurse in the Army in World War II at a time when African American women were joining the military to advance themselves and serve the United States. Several other members of the family as well as personal friends served in World War II, Vietnam, and the Afghanistan War. The researcher witnessed the effects of PTSD, substance abuse, and mental health issues among female veterans and how the issues interrelated and influenced personal relationships. The researcher felt there was a shortage of information specific to female veterans and believed this research would be best if focused on the issues faced by women who have served in the military.

Because of the possibility of potential research bias, the researcher used several methods to ensure personal perspective did not sift through the study. First, the researcher did not receive a personal account from her grandmother of the experience as a female veteran so the perspective would not be immersed into the study. Second, the researcher based the study only on the data and information received from the participants. Finally, the researcher never spoke in detail with any female veterans about personal experiences to the point bias could even exist or interrupt the progress of the study, and the researcher was not a veteran.

Limitations

Some limitations and restrictions may potentially affect the outcomes of the study. There was a chance the participants may not open up about certain experiences, such as military sexual trauma. Due to the sensitive nature of this issue, the researcher took precautions when approaching this topic. Other potential limitations to this study involved the number of participants, time constraints, potential issues with PTSD, and

flashbacks. The information received may also be inadequate and lack depth.

Chapter 4: Results

This research explored the personal experiences of female veterans who served in combat during the Operating Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) wars and were repatriating. These findings are based on in-depth interviews with nine female veterans from different branches of the military and from around the United States. The confidentiality of all of the research participants was protected, and extensive information about them was not reported in the discussions. All participants were identified by initials of the specific branches of the military and a number. In the following section, a description of the study site and a brief demographic description are included.

The Participants

The researcher interviewed nine female veterans who served in either OEF or OIF combats. All of the participants in this study served in the military between 5 and 20-plus years. Six participants served in the Army, two served in the Air Force, and one served in the Navy. Several joined the Reserves later in the military careers. One participant identified as Caucasian and eight identified as African American. The transcripts for the nine interviews can be found in Appendix E.

AR1. AR1 obtained associate's, bachelor's, and master's degrees in nursing. This participant served 1 year in OIF working with computers and radios. AR1 was currently enlisted in the Air Force Reserve and National Guard as a nurse and had been in the military for 15-plus years. This participant was married to an Army veteran and had two children.

AR2. AR2 served 30 years in the Army Nurse Corps. This participant served as the chief nurse during and after deployment. AR2 held a master's degree and was currently working toward her doctorate. This participant was married with one adult son.

AR3. AR3 served close to 10 years in the military. This participant worked as a light wheel vehicle mechanic. AR3 was a divorcee with one child.

AR4. AR4 served over 13 years in the Army prior to medical retirement. This participant was responsible for refueling aircraft and ground vehicles. AR4 was currently working toward her bachelor's degree. This participant was married to an Army veteran, and the couple had five children.

AR5. AR5 worked as a platoon leader when deployed. This participant had some college experience, was not married, and did not have any children.

AR6. AR6 served in the military for over 20 years. While deployed, this participant worked as an automated logistics specialist. AR6 was still in the military and worked as an MOS instructor. This participant did not have children and was not married during deployment but was currently married to a Veteran and had one child.

USN1. USN1 worked as a pipefitter the first 12 years and a Navy counselor for the remaining years. This participant had one daughter who was 9 years old when deployed for the first time.

AF1. AF1 had never been deployed prior to OIF. This participant worked as an instructor of the Reserved Officers Training Corps for a major university and a budget officer. AF1 was a single parent to a daughter with special needs.

AF2. AF2 worked as a chaplain's assistant. This participant was deployed in OEF for 3 months. At the time of deployment, AF2 was single with no children. This participant was now married to a veteran, and the couple had one daughter.

Participant Experiences

Women were in the forefront of the U.S. military more so over the past decade than ever before (Rohall, Ender, & Matthews, 2006). Women were no longer limited to roles considered to be less dangerous and were provided more frontline opportunities (Rohall et al., 2006). Although all women in the military were not in areas placing the individuals in more danger, there were more presently than in past wars (Rohall et al., 2006). The participants in the study came from different backgrounds and different positions in the military, but all shared a commonality in personal experiences as women working in a male-dominated field. USN1 shared her experience:

> My first 12 years in the Navy, I worked as a pipefitter, so I worked mostly with men. I was usually the only African American woman or woman period. The second half of my career I worked as a Career Counselor. It was hard to advance in the 1990s and early 2000s so it was discouraging but I never gave up. Once I became an E5 in the Navy, I was placed into leadership positions. I had to deal with a lot of angry men working hard for me. The Navy was good for me and good to me and I am happy I was able to join and live the experience.

AF1 added the following:

> I had a hard time because I was somewhere I wasn't wanted. It was what it was. I worked 12- to 16-hour days. It was a humbling experience and I was trying to make sense out of it. I worked as a Budget Officer at the time.

AR3 worked as a light wheel mechanic and a detainee guard. AR2 was in the Army Nurse Corps for 30 years and was promoted through the ranks to Chief Nurse after her deployment. AR4 was a Petroleum Supply Specialist who was responsible for refueling aircraft, ground vehicles, and maintenance equipment. AR6 provided insight on how she

felt while deployed by stating, “It was difficult. I was exposed to the elements and to the environment. There were mortar attacks and a heightened sense of fear. OIF was worse because the bombs and attacks occurred close to where I was located.” AF2’s experience as a Chaplain Assistant in the Air Force afforded a different experience:

> Being in the Air Force, we serve as more of a supportive role. I did not experience any live fire on my deployment. I was blessed for it. I was a chaplain assistant. I prepared the chapel for worship. We also performed field visitations to our troops, counseled anxious troops, visited injured troops in the hospital and were bodyguards for the chaplains. Chaplains are not allowed to carry weapons.

Deployment. The participants in this study were asked about personal experiences being deployed in OEF or OIF. Among the participants, one was not boots on the ground but on a Navy ship. Even though USN1 did not have the same experiences as the other participants, this participant was impacted the same:

> Yes, I was deployed on Navy Ships never boots on the ground. The first time I was deployed was right after 9/11 so I was excited and scared. I was excited to go get the bad guys but scared I may not make it home.

AF1 added the following:

> Yes, I have been deployed to Iraq for 1 year. When I found out I had a range of emotions. I was surprised because I had been in the Air Force for 18 years and had never been deployed. I was teaching ROTC at the time and was a single parent. I just told myself I would make the most out of it since Iraq wasn’t as bad as Afghanistan.

AR1 stated, “Yes I was deployed in OIF. When I found out, I thought it was a joke and I was upset.” AR5 stated, “Yes, I have been deployed. I didn’t feel any type of way; I

knew it was a possibility joining." AR3 made the following statement:

> For my first deployment, it was fear, sadness and uncertainty. I was deployed only a short 6 months after reporting to my permanent duty station. The second deployment was a little different. I was more prepared, however still nervous and sad.

AR2 stated, "Yes, I was surprised because, in years past, I was told, due to my rank of colonel, the military did not want to pay. I did not think of ever being deployed." Two participants were not as descriptive about personal feelings after being deployed. The individuals both shared feelings of nervousness and fear but nothing more. There was a sense of emotional detachment from the deployment experience. It is possible the participants suppressed the experience as a way to be protected from the feelings experienced while being in and around combat.

Family and personal relationships. During the interviews, participants were more comfortable to discuss personal experiences regarding families and relationships, as half of the participants were not married or parents during the deployment. However, four participants who were married or parents shared similar challenges of managing relationships and parenting while trying to survive in a high-stress environment. AF2 was single with no children during deployment. However, this participant described how the mother was nervous and told AF2, "You will come back the way you came." AR6 was also unmarried with no children and stated, "It was heartbreaking when I found out I was being deployed. My family and I were sad and crying." AR4 also stated the family was very afraid. AR1 stated the following:

> No, I was not married at the time and I didn't have any kids. When my family found out I was being deployed, they didn't believe it. They don't really show

> emotion but they were coping in their own way.

There were many additional challenges faced by the participants who were married or parents. For instance, AF1 made the following statement regarding personal experience as a single mother:

> I was a single parent. I had one daughter who had special needs. Luckily, I had a great relationship with her father and my mom took care of her while I was deployed. My mom was worried for me when I was deployed. She uprooted from California and moved to South Carolina to care for my daughter. She did not know anyone there and she left her life and all of her friends.

USN1 added, "Yes, I had one daughter who was 9 years old. My family was worried I wouldn't come back. It was the first time in 10 years of being active duty I deployed." AR2 offered the following statement:

> My husband was very supportive, my elderly mother was scared for me plus my dad passed to years prior to my deployment. My son who lives with my mother was very proud and promised he would take care of his grandmother. My brother and his family were proud but somewhat worried.

Unlike the other participants, AR3 had a more difficult family dynamic to work through while deployed:

> My husband left during my first deployment because he was resentful. I was blissfully unaware he would not return and my son was too young to know what was happening. It was only after my second deployment when I would have enough time in the country to file for my divorce. A custody battle took place over our child, and I was awarded partial custody due to my multiple deployments. This made me regret and hate being in the Army.

Education. Eight of the nine participants attended college while in the military or after exiting the military. Research showed some veterans were affected by the military experience while working toward a college education (Murray, 2013). The interview question focused on personal experience as student veterans. AR1 attended college right after high school but soon after was deployed and had to postpone the education. During the military career, AR1 received three degrees and currently worked as a nurse in the Air Force Reserve and Nurse Practitioner in private practice. AR1 stated, "I never had a problem with being a student veteran." AR6 stated, "Yes, I attended college while in the military. I felt different as a student veteran because of TDY and not being able to finish in a timely manner." USN1 added the following:

> Yes, I attended college while active duty and after. My experience with going to college was okay. I used my time never the Navy's time because I never wanted anyone to say anything negative or say I was in the Navy to attend school. Once I received degrees some people were not happy for me and made remarks about it, so I would never talk about my degrees to people who did not already know.

AF1 offered the following comment:

> I attended college while I was in the military and when I was out. I did great while still in the military. I was encouraged to go to school and further my education. My jobs allowed me to attend school based on my work schedule. I joined the military mainly to further my education. I continued my education after the military in an online learning environment.

AR4 stated, "Yes I attended college while I was serving in the military and I am currently enrolled in college. As a student veteran, school gets a little overwhelming to me. I must try really hard to focus on my assignments." AF2 added the following comment:

> I attended college after. The college experience was great. I went under MGIB with a stipend. I could completely focus on my studies without having to work. I was more mature when I went to college at a later age, 27.

AR5 did not attend college, and AR3 said the experience as a student veteran was no different than before joining the military.

Identification of Posttraumatic Stress Disorder and Other Mental Health Issues

The issue of PTSD was not gender or race specific but affected many veterans regardless of age, gender, class, rank, or branch of the military (U.S. Department of Veterans Affairs, 2017). The participants in the study were very open with personal experiences with PTSD. AR6 stated, "I have been diagnosed with PTSD. I am less trustworthy of people and it has changed me." AR3 added the following comment:

> When I was first evaluated for PTSD, it was still a fairly fluid diagnosis. It was also widely over diagnosed. I have been on several different medications, and tried a multitude of different treatments and exercises. It is difficult to deal with and try to assimilate to the "normal" life when those around you don't understand what you are going through.

AR5 stated, "PTSD was the reason I left the military. I could do the job fine. I just didn't feel like forcing myself to pretend it." AF1 discussed the experience with PTSD:

> I was diagnosed with PTSD while in Iraq. It affects my sleeping and alertness. It is not as extreme as some and I am a younger woman. Therapy is not geared towards female veterans. A lot of the groups at the VA are for older men. There is also a fear because of stigma in the workplace.

AR4 stated, "My experience with PTSD and other mental health issues has been a daily struggle. I was medically retired from the Army due to them." USN1 added the

following:

> I do not have PTSD but I am diagnosed with anxiety and major depression disorder. I knew about the anxiety and I am not sure where or how it started. I did not know about the major depression disorder until I went to the VA.

Two participants were not diagnosed with any mental health issues but were affected by the military experience. AF2 stated, "I did have a lot of nightmares, hypersensitivity and a lot of apathy when I returned." AR2 made the following comment about the experience:

> I really cannot say I experienced PTSD. I was only scared when we were told a bomber tried to get on our base to drive his vehicle between the mess hall and our Post Exchange store (I was in the store at the time). I then came to the realization I could have actually been killed!

AR1 mentioned thinking about being affected by the bombs and other things going on, but this participant had not been diagnosed with any mental health issues.

Sexual Trauma

The most challenging part of the interview was asking the participants questions about military sexual trauma. It was obvious the participants were very aware of what it was and how it affected many friends as well as themselves while in the military. There was also a sense some of the participants may have possibly had personal experiences but were more comfortable speaking about others. AR2 became an advocate for veterans who had experienced sexual harassment and molestation and made the following comment:

> I think of female soldiers being molested and harassed by their male counterparts. During my deployment, I was the Coordinator for the Sexual Harassment/Assault Response and Prevention Program (SHARP). Of course, all cases remained strictly confidential but what I found was most of the enlisted females were

> sexually assaulted by noncommissioned soldiers as well as officers. Sometimes their commanders were afraid to press charges for fear of retaliation and stripping of ranks.

AF2 added the following:

> It is a real concern. When you are confined to an area for a long period, sometimes the worst comes out of people. Many people who outrank a fellow troop will take advantage of their position. Yes, I know plenty of people who have experienced this.

AR4 made the following comment:

> When I think of military sexual trauma it breaks my heart. The reason being is because we all took the same oath and lived by the same Warrior Ethos. I just can't understand how someone could violate their battle buddy. Yes, I do know a couple of people who have experienced military sexual trauma.

AF1 stated the following:

> Military sexual trauma happens but is not reported. I never experienced it physically. Lower ranking officers would be hesitant to report if it did happen. I have spoken to my students about it. The military can do a better job with an open door policy. It is male dominated. As far as the healing process goes there needs to be services when they are out of the military. The stigma associated with it keeps people from saying anything. I know someone who has experienced it and didn't want to report it.

USN1 stated, "I know several women who have had military sexual trauma." AR6 added the following comment:

> Military sexual trauma is underreported. The chain of command frowns upon it. I

> do know someone who has experienced this and I have seen it happen. There were five guys and one girl. No one would believe her. She was only 19 years old. They deployed her along with the guys to the same place. She was there for 6 months and she had separation anxiety and a breakdown. The chain of command failed her. They eventually sent her home.

The main theme identified with this question was military sexual trauma was very common across all branches of the military, and the issue goes unaddressed and unpunished (Burkhart & Hogan, 2015). Individuals were not only victimized based on gender, but rank, race, and authority also played a major role in how sexual trauma was handled throughout the military.

Insights of Gender, Race, and Rank

The question was asked about participant experiences as females in the military. All but one participant mentioned being a female was not the only component of inequality, but it also influenced rank and authority. AF2 was not treated differently because of gender due to the position as a chaplain assistant. This environment was different than some other areas of the military. USN1 stated, "I sure do! On many occasions, I feel like I was overlooked for certain jobs or qualifications. I was disrespected by men in higher paygrades. AR4 added the following comment:

> I felt as if I was treated differently because of my gender. My experience in the military was one of always having to prove myself worthy of recognition. I had to work three times as hard as my male counterparts to make sure I was ahead of them.

AR3 shared her experience:

> Being a female in a primarily male-dominated MOS was difficult to "prove"

> myself. There were several times I was flat out told by my superior they would not promote me until they absolutely had to. And when asked why, their response was always because I was a girl. Overall, my experience was no different from males. Although it may have caused some setbacks and challenges, it also allowed me some opportunities males found it difficult to get.

AR1 made the following comment:

> I was the only female in my section and the men constantly tried to ignore me. If I said anything they would intentionally act like they did not hear me. It is a lot of racism and it is very male minded. The lower ranking officers created problems. If my superior officer told me it was ok to do something the lower ranking officers above me would tell me to do the opposite. I felt like it was because I was a female.

AR2 added the following:

> I sometimes felt it with some of my White counterparts and commanders. For most of my 30 years in the military I would say they were positive ones. I will say still today there is much prejudice in the military.

AR6 stated, "Yes I was treated differently. There were times I did not get certain assignments because I was a "female". AF1 made the following comment about rank and race: "I feel like I was treated differently for being a woman in certain situations, especially rank and race. They did treat me differently." AR5 stated, "I feel like I had a double whammy. Being a female is hard but being a black female was even harder. I had more hurdles."

Difficulties Related to Health Care in the Veterans Affairs System

The VA system was scrutinized for long wait times, inadequate medical services, lack of support services for veterans, and lack of qualified medical staff specializing in women's health (Disabled American Veterans, 2017). One of the goals of this research was to obtain firsthand accounts from female veterans who used the VA for health care. Most of the participants had similar experiences and feelings about the VA system. AF1 made the following comment:

> I do go to the VA for medical services. It is ok, but appointment times would be months out. I take it for what it is and look at them like military doctors. All my doctors are females. I had more options since I was retired. I go on base for more specialized care, but I mainly use private doctors.

AR2 added, "Yes, after deployment, I registered with my VA and used Women's Health services, labs, x-ray, pharmacy and dermatology departments with good experience." About accessing health care, this participant added the following:

> Working with some veteran's associations I have been told some of the VA facilities were difficult to access medical care. However, we are looking into assisting female veterans in social services and homelessness. The Division of Veterans Services in New York City has been an advocate of these issues.

AR1 had this to say about the experience at the VA and accessing health care:

> Yes, I have used the VA for services and I do not like them. They weren't good and would have me waiting forever for appointments. I went when I got back from being deployed. I have not had a problem accessing health care.

AR6 offered the following comment:

> Yes, I have used the VA for health care and the quality is not what a veteran

> should receive. I go to a private provider. It is very difficult accessing health care as a female veteran. In the VA, there is a lot of rescheduling from doctors and appointments would be 6 months out. When I would return, the doctor would change to someone I am not familiar with.

AR3 shared the experience as follows:

> Yes. Other than the one time I was seen in the emergency room, I have not had a good experience. In less than 3 years I have had no less than a handful of different primary care physicians. I have been disrespected by staff and physicians alike. Being a female has made no difference in my opinion to a male accessing health care at the VA.

AR4 added the following comment:

> Yes, I have used the VA for services. My experience with the VA is like fighting with hell! Some of the people who work within the system are very insensitive to all veterans' needs.

AF2 made the following comment about the VA and health care for female veterans:

> I used the VA for counseling for depression and transitioning. I used the rehabilitation center to assist with MGIB and civilian employment. I have been to the VA for diagnosing and treating my skin cancer. I was pleased with all the services. I was treated with dignity and respect. I was seen by competent and caring professionals. I know my story is the exception, but it is true! The VA has a women's clinic where your provider is your primary care and OB/GYN services. I normally can have an appointment in 2 weeks for non-urgent matters. I feel comfortable since it is an all-women's clinic.

USN1 stated, "Yes, I use the VA for everything. The VA here in the State of Hawaii is

very accommodating and professional." This participant made the following comment about health-care access: "I have had a good experience with the VA here." AR5 mentioned not using the VA at this time.

Transitioning to Life After Military Service

Several of the participants were still in the military but in different branches and capacities. However, it was found the participants still experienced some challenges with careers outside of the military and now being married with children. Four of the participants did not report any issues with the transition. The participants anticipated it and were prepared for the lifestyle change mentally and financially. The participants who had the most difficult time transitioning were mostly the Army veterans and one Air Force veteran. AF1 made the following comment about transitioning:

> I was ready for the transition back into being a civilian. I had planned for it beforehand. I was financially prepared before I got out. I do miss the camaraderie. Civilians are more laid back. Overtime was not an option.

AR6 added, "I had the mindset as a soldier and I viewed civilians from a military perspective which was a challenge and still is." AR3 stated the following:

> Horrible. This is not the Army's fault, or the lack of transitioning training. Going from a life where there are rules and regulations for everything, an unwavering work schedule, and friends who are more like family than other family and friends who have essentially lived their life in absence of you. They do not understand what you have been through, how you could have done certain things, why you act or talk different than you did. It's like trying to mix oil and water. Although possible, it is very difficult, and despite years can remain separated.

AR4 stated the following:

> My overall experience transitioning from being a soldier to be a civilian has been a total change of lifestyle. It is scary, unnerving, and unfamiliar. I had to get used to not having a set schedule each day and not being directly responsible for others' lives. I still to this day deal with the stressors of adapting even though it is going on 4 years since I last wore a uniform.

AR2 made the following comment:

> I had a civilian position prior to deployment and was fortunately guaranteed my position upon returning so I was secure there. However, it was a little difficult getting back into the everyday nuisances of my civilian job.

AR5 stated, "Transitioning hasn't been hard at all. I was a civilian before the Army and this is how I view it." AR1 said, "It was weird transitioning back into civilian life. The hardest thing I can remember was being jet lagged."

AF2 had this to share:

> Transitioning was smooth for me since I did full-time school. It gave me time to explore and have less stress from one work environment to another. When I graduated from school, I was a stay at home mom for 2 years before starting my new career as a RN. My first few civilian jobs were challenging because the work family I had in the military was not there. The standards were lower, and people were not as accountable. I got through it though. I had to find my new place in life.

USN1 made the following comment:

> My transition was great! Before I retired I was a realtor in San Antonio and enjoying my new career choice until my husband dropped the bomb we had to move to Hawaii. I did not want to move anymore and I damn sure did not want to

> go back to Hawaii. I went on terminal leave early November and separated January 2015, then we left for Hawaii April 2015. Once we got to Hawaii of course I had no friends and no job, so I hated every minute of it, but I was happy to be done with the Navy.

Further Considerations

At the end of the interview, the researcher asked each participant if there was any other information to be shared about personal experience or thoughts about the study. AR6 made the following comment about the VA: "Female veterans who deal with PTSD or with physical injuries are not treated as seriously as the male veterans and it needs to change." AFI made the following comment about female veteran disclosure: "When women get out of the military many of them don't identify themselves as Veterans. Female vets should be more comfortable with identification." AR1 had this to say about women's health: "Women's health is very important as a female veteran. They really need to do more for female veterans. This is one reason I chose to become a Nurse Practitioner with a focus in women's health." AF2 added the following comment about her experience:

> I feel more sexual injustice happens in other branches outside of the Air Force from my experience. I had a strong career but wanted more freedom to go to school and to choose where I would live. However, I did enjoy my state-side experiences. I honorably separated from the military because deployment life was not for me.

AR4 had this to say about the feeling of sisterhood:

> The female veterans I have met have been wonderful! We help each other get through the hard days. We support each other. And most importantly we

> understand each other. I have ongoing life bonds with some of my fellow female veterans and some that I can call a sister.

AR2 concluded the interview with the following comment:

> Just to say I would do it all over again and join. I am very serious about my duties as an Army nurse and would serve my country if called upon to do so. I also want to thank you for what your research covered from the front line to the living room.

Summary

Female veterans transitioning to civilian life face a myriad of challenges and adjustments (DeStefano, 2015). These women are expected to return to everyday life in the same condition as before, spiritually, physically, emotionally, and economically. Although female veterans may not have all experienced PTSD, sexual trauma, or discrimination, the women did share similar experiences of being in stressful and dangerous environments for an extended period of time. The idea of possibly not returning home can be stressful and weigh heavily on a person's spirit and mind (DiRamio et al., 2017). The participants represented three different branches of the military (e.g., Army, Navy and Air Force), yet all shared the same sentiments about the fear of life during deployment and the ability to adjust following deployment.

Transitioning from the military to civilian life is not a simple task (DeStefano, 2015), and veterans who have experienced it understand the complexity of reuniting with families, accessing quality health care, and pursuing higher education. Repatriating veterans are at high risk for mental health problems, physical injuries, reduced life satisfaction, potential unemployment or delayed employment, and potential problems readjusting to family life. If these issues remain unaddressed, the results will not only affect the quality of life of female veterans, but will also manifest into larger issues

affecting society.

Chapter 5: Discussion

Introduction

This research explored the transition of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) female veterans back into civilian life. It also examined the challenges faced by these individuals during the transition and their experience with receiving quality health care from the Veterans Administration health-care system. An exploratory method was used to conduct open-ended interviews with nine female veterans who served in OEF or OIF. Together, the participants' experiences spoke of the significant external situations and conditions influencing personal views and perspectives of serving in combat and having to return home and navigate the challenges of living in a civilian environment. In the previous chapter, firsthand accounts of personal experiences were provided, emphasizing themes materializing from the data. The emergent themes were comparable to the literature, implying the VA system and the Department of Defense had not effectively addressed the issues faced by female veterans (Disabled American Veterans, 2017; Finlay et al., 2015). In this chapter, the researcher reflects on the outcomes from the study; addresses the research questions; and presents the inferences, limitations, and final insight from this study.

Research Question 1

The first research question posed asked about the most common experiences faced by female veterans transitioning back into civilian life, which, in turn, might lead to personal failure. Important issues discussed in the interviews involved deployment and the impact of gender and race on military service.

Deployment. According to Vogt et al. (2017), 2.4 million veterans left the

military since the Afghanistan and Iraq wars began, and another one million were expected to leave within the next 6 years. Women were provided more opportunities to serve in roles, placing the individuals in more danger than ever before (Rohall et al., 2006). The men are not the only individuals carrying out duties on the frontline. Woodhead, Wessely, Jones, Fear, and Hatch (2012) explained women still served in supportive roles, even though females were increasingly more exposed to combat. The participants in the study worked in different roles while in OEF or OIF (i.e., nurse, radio operator, chaplain assistant, logistics specialist). There was one colonel and several other leaders in the fields to include the Army, Navy, and Air Force. These participants were not only working with other soldiers, but were also in charge of units. This served as an example of the current roles in which women were serving compared to decades ago. The military's purpose and mission had not changed, but the traditional roles of female veterans had.

The participants mentioned different issues experienced while being deployed. Some had mixed emotions after finding out about being sent to combat zones. Others were petrified to be heading to war. Some participants reported knowing what was being signed up for and were as prepared as possible for the danger ahead. Many of the participants discussed families' reactions. One participant said the family members did not react very much, showing a lack of emotion, but the family was concerned. Another participant went through a range of emotions, having a daughter with special needs. Even though this participant had a good relationship with the child's father, the elderly mother moved from another state to care for the participant's daughter. One participant's spouse was unsupportive and grew resentful due to the multiple deployments, and the couple eventually divorced. Vogt et al. (2017) stated female veterans from the Afghanistan and

Iraq wars are more likely than men to be unemployed and to divorce.

Impact of gender and race on military experience. Discrimination represented a problem not only in society, but also in the military. Rohall et al. (2006) stated, "The percentage of women, while increasing and serving in greater military positions and occupations than ever before, continues to be underrepresented in the services compared to the percentage of women in the larger society" (p. 59). More women were enlisting in the military but remained underrepresented and dealt with the same issues in regular society. The participants were asked several questions about how gender impacted their military experience. All of the participants acknowledged being a female affected by the way they were treated by fellow service members. One participant spoke about an experience with being reprimanded unfairly by a mid-level ranking officer while the commander may have approved the experience. This participant also mentioned how difficult it was earning respect from lower ranking soldiers due to gender and race. Another participant talked about being constantly being passed up for a promotion from being "a girl."

In regard to race, most of the participants experienced discrimination and unfair treatment because of race. For example, AR5 stated, "I feel like I had a double whammy. Being a female is hard but being a Black female was even harder. I had more hurdles." These situations put these women in stressful situations while trying to survive in a mostly male-driven combat environment. Skopp, Reger, Mishkind, Raskind, and Gahm (2011) explained women may be more likely to blame themselves or to view the world as untrustworthy following trauma, leading to increased PTSD susceptibility.

In terms of how gender and race impacted the ability to transition, the level of trauma related to being treated unfairly had to be examined. According to Eichler (2017),

female soldiers were exposed to gender-based violence and harassment in the military at much higher rates than male soldiers. Gender harassment, sexual harassment, and racial discrimination were all forms of bullying. When an individual was in a situation involving these experiences, there was a higher probability of being affected mentally, emotionally, and, in some cases, physically (Skopp et al., 2011). These traumatic experiences impacted the way these women behaved, perceived, felt, and interacted in personal life. The ability to transition was also challenging and difficult for the families, friends, and coworkers. Military gender harassment did not receive much attention or support from military personnel or leaders who were male. Regardless of the reason, these types of negative experiences likely contributed to stress during deployment and upon the return to civilian life (Street, Gradus, Giasson, Vogt, & Resick, 2013).

Research Question 2

The second research question posed asked participants about the challenges faced during transition and about overcoming those challenges. Important issues discussed in the interviews involved mental health and military sexual trauma, as well as the impact of military service on family and personal relationships.

Mental health and military sexual trauma. Numerous psychological stressors were linked with deployment in combat zones, including expectancy of combat,-related psychological distress, sexual violence, and being away from family and friends (Spelman, Hunt, Seal, & Burgo-Black, 2012; U.S. Department of Veterans Affairs, 2017). The participants spoke about personal experiences with PTSD, depression, and military sexual trauma. Some of the participants were diagnosed with PTSD and others with depression and anxiety. A couple of participants did not have PTSD or depression. However, all of the participants dealt with some type of mental or emotional stress from

being deployed to learning how to readjust to being in a civilian environment. One participant spoke about being medically discharged from the military due to PTSD. This participant also discussed an experience trying several different medications and treatments to help with her diagnosis. Another participant stated, “I could not pretend anymore.” The severity of mental issues faced by female veterans upon returning home was much greater than either the Department of Defense or VA had reported (Baker, 2014; Casura, 2017; Chapman & Wu, 2014; Murray, 2013).

Spelman et al. (2012) explained data supporting higher rates of depression for women veterans compared to male counterparts. Women also more commonly reported military sexual trauma and were at increased risk of eating disorders and weight loss (Chapman & Wu, 2014; Spelman et al., 2012). All of the participants acknowledged knowing other female veterans who had experienced military sexual trauma and explained it was very common in the military, especially during deployment. Some participants expressed angst about the prevalence of military sexual trauma and how it was handled in the military. There was an existing subculture continually ignored by leadership at all levels because those individuals were often participants (Spelman et al., 2012). Female veterans were often victimized by male peers and those in leadership positions (Spelman et al., 2012). The brotherhood between male soldiers takes precedence over the misconduct and immoral behavior taking place (Spelman et al. 2012). Some of the reasons many female veterans do not report military sexual trauma or sexual harassment include feelings of being retaliated against or blackballed, being assaulted more severely, or knowing no one will do anything about the situation (Spelman et al. 2012; U.S. Department of Veterans Affairs, 2017).

As it pertains to deployment, the ability to mentally and emotionally adjust to

civilian life was impacted by the experiences of female soldiers while away (Belle & Bullock, 2014). There may be things in the environment triggering the PTSD or depression (Belle & Bullock, 2014; Burkhart & Hogan, 2015). There may also be some difficulty with interpersonal relationships due to trust issues and the feeling of being violated by someone who was supposed to protect soldiers (Spelman et al., 2012). One participant did mention struggling with the inability to trust other people because of PTSD. Another participant talked about failure to understand how a battle buddy could sexually assault another soldier because the behavior goes against the oath taken. Another participant had no idea about depression or anxiety until after diagnosis. The researcher believes some of the participants who were not diagnosed with PTSD may also struggle with some aspects of the disorder, and there may be a certain level of denial present.

One participant mentioned some female veterans may not want to be diagnosed or treated due to the stigma and fear of being discriminated even more (Spelman et al., 2012). Maguen, Ren, Bosch, Marmar, and Seal (2010) discussed how female minorities made a disproportionate number of military veterans. The authors also mentioned different factors possibly preventing a female veteran from seeking treatment for mental health issues, such as employment, family obligations, and school. Spelman et al. (2012) explained the VA and Department of Defense guidelines recommended an interdisciplinary approach involving integrated teams of primary care, mental health, and social work providers, which could normalize and destigmatize mental health treatment.

Impact of military service on family and personal relationships. Former president Barack Obama defined the military family as active-duty service members, members of the National Guard and Reserve, and veterans, as well as members of the immediate and extended families of those who died in service to the United States

(Clever & Segal, 2013). Families played a major role in the strength and effectiveness of individuals in the military (Fischer et al., 2015). When a veteran had a strong and supportive family unit, the expectation was the individual would be a better soldier and uphold the values of the military (Fischer et al., 2015). When a veteran was deployed, in a sense, the family was deployed as well. Family members were constantly worried about the loved one and often experienced financial and emotional problems (Clever & Segal, 2013; Schmidt, Simmonds, & Sulfaro, 2013).

Skopp et al. (2011) explained intimate relationships also may facilitate development of competent coping skills to be garnered during times of separation and prolonged stress, serving as social capital. Deployed individuals were concerned not only about the families, but also personal survival. Female veterans were unique as a result of often being the primary caretakers of the children and families (Schmidt et al., 2013; Skopp et al., 2011). When these individuals were away for a prolonged period, the absence sends the families into survival mode as well. If these individuals were single parents, the families must take care of the children. If these individuals were married, the spouses were left behind to fill in the gap and take on the responsibilities of caring for children and completing household chores (Clever & Segal, 2013; Skopp et al., 2011).

The participants were asked about families and children during deployment. Some were not married and did not have children upon deployment. A few were married with children or were single parents. Most of the participants who were married or parents during deployment had supportive family units. However, one participant experienced marital problems during deployment. This individual talked about how the ex-husband became resentful about the military wife being away so much. The couple's son was a baby at the time, so the baby was unaware of what was going on. However, eventually,

the ex-husband left and filed for a divorce and full custody. This participant agreed to the divorce and, because of military deployments and background, was awarded only partial custody. The experience influenced this participant's disdain for the Army.

The ironic part of this research was many studies referred to race as a determinant of marital outcomes among female veterans (Belle & Bullock, 2014; Brannon, 2013; Kleycamp, 2013). According to Clever and Segal (2013), African American men and women and White men on active duty were less likely than civilian counterparts to divorce, but White women in the military were more likely to divorce than civilian counterparts. Even though the sample size in this study was relatively small, the one participant who identified as White Non-Hispanic divorced due to being active duty, whereas the other participants who experienced supportive spouses were African American. Vogt et al. (2017) indicated female Afghanistan and Iraq War veterans were more likely than men to be unemployed and to experience a divorce.

Research Question 3

The third research question posed asked how the Department of Veterans Affairs could improve services to female veterans. The important issue discussed in the interviews involved experiences with the VA system. Although a growing amount of literature focused on the rapidly increasing prevalence of mental health disorders among OEF and OIF veterans (Belle & Bullock, 2104; Murray, 2013), relatively little was known about gender differences among these new generations of veterans, especially among veterans seeking VA health care (Maguen at al., 2010). Few studies examined the differences in health outcomes for female OEF and OIF veterans (Buik, 2012; Hoge et al., 2004). With the increase in numbers of females joining the military and returning from war zones, more research needed to be conducted on how the VA addresses this

population of veterans.

This study focused largely on the VA's ability to properly care for female veterans who served in OEF and OIF. According to Baker (2014), approximately 2.5 million service men and women served in OEF and OIF. Of the 2.5 million, 61% were eligible for VA health services (Baker, 2014). The statistic applied more pressure to a flawed health-care system and illustrated the need to ensure U.S. veterans were taken care of upon returning home. Women veterans faced a unique situation because more were either currently serving or had served in the military since the Global War on Terrorism began. These veterans would return with a host of issues needing to be addressed by the VA health-care system. The VA served as a go-to health-care system for veterans. The services were designed specifically to meet the needs of veterans. However, the VA was also structured and organized to benefit male veterans more so than female veterans. Although changes were implemented since the beginning of the Global War on Terrorism and related wars (e.g., OEF, OIF), there is still more work to be done (Baker, 2014; Belle & Bullock, 2014).

Women's health encompasses every physical, emotional, and mental need a woman could have. There is a need for adequate obstetric and gynecological services, as well as providers and counselors trained in military sexual trauma and other mental health and physical needs uniquely affecting women. One of the participants mentioned how appointments would be changed to a different doctor without her knowledge, and this participant did not feel comfortable because of the personal nature of female issues. Another participant who was currently a women's health provider discussed the need for better women's health services in the VA system. This participant also mentioned this was one of the reasons for becoming a nurse practitioner with a focus on the health of

women. This participant also talked about how long the wait times would be and how the next appointment would be months away. As a result, participants began to see private practice providers who could help them more efficiently. A few participants had positive experiences at the VA health facilities. These participants acknowledged the service was not perfect, but it met personal expectations and the individuals would continue to use the VA when necessary.

Another issue affecting female veterans' access to health care involved a lack of employment or financial stability (Casura, 2017; Spelman et al. 2012). Most of the participants used their GI Bill (Bennet, 2014; Murray, 2013; Spelman et al. 2012) to pursue higher education. These individuals enrolled into the military as a result of wanting to do something else related to a career. One participant talked about how important it was for female veterans to have a financial plan prior to leaving the military. This participant said it was more difficult to transition when there was a lack of financial stability. Access to quality health care could be negatively impacted when a female veteran did not have the financial means to seek care outside of the VA health-care system (Casura, 2017; Spelman et al. 2012). Most of the participants were working in different career fields providing the option and ability to seek treatment elsewhere. According to Spelman et al. (2012), because many veterans were seeking care outside the VA system, all providers must have a familiarity with the health challenges faced by this patient population.

Conclusions

The researcher explored the thoughts, feelings, perceptions, and experiences of female veterans who served in OEF and OIF. The study illustrates these women do face the same issues as male veterans but in a unique way. What works for the men will not

work for the women. The system cannot be a one-size-fits-all approach. A discriminatory culture exists on every level in the military regarding gender, race, and rank (Carlson et al., 2013; Chapman & Wu, 2014). This negative culture not only affects the way female veterans are treated, but it also influences the policies, procedures, and infrastructure within the VA health-care system (DeStefano, 2015).

Within the past several years, much debate and legislation took place to enforce change for all veterans (DiRamio et al., 2017). When these veterans returned home from being deployed, all wounds were not visible. These individuals returned with scars only qualified medical providers and social service professionals could address. However, if these providers were not trained on how to treat this population, then the system had failed and the federal government and the Department of Defense must also assume some of the responsibility. According to Spelman et al. (2012), the service and sacrifices of these veterans and families required an effective community-wide system of care to offer support upon recovering and rejoining the communities.

In the exploration of the participants' detailed accounts, the researcher tried to understand the overall experience of what it was like being a woman in a male-dominated field and surviving war while trying to readjust to living a normal life. Despite the sensitivity of the research, the pros outweighed the cons. This study brought a voice to women who wanted to express themselves and be heard. These individuals wanted to use this research as a platform to share personal experiences and possibly help other female veterans. Despite the lack of cultural diversity, the participants were all different yet similar. Personal experiences were parallel despite the differences. In the end, the participants were all women who faced the same challenges and adversities regardless of branch of military or rank. President Barack Obama (2015) stated the following:

> So long as I'm Commander-in-Chief, we will sustain the strongest military the world has ever known. When you take off the uniform, we will serve you as well as you've served us, because no one who fights for this country should have to fight for a job, or a roof over their head, or the care they need when they come home. (p. 1)

Limitations

Several limitations exist in the areas of inquiry and diversity of the participants. Regarding inquiry, the findings in the study are representative of the women's overall experience as females in the military instead of just the transition to civilian life. Deployment during OEF or OIF served as the focal part of the study. However, the interviews consisted of several questions regarding health-care access, PTSD, military sexual trauma, and education. The researcher felt, to better understand the issues surrounding females in the military as related to transitioning and the VA system, there needed to be a clearer picture of all the issues influencing the ability of the individuals to successfully transition, emotionally, mentally and physically.

Most of the data collected from the interviews were detailed and painted a clear picture of the participants' personal experiences. However, some participants were not as descriptive or forthcoming but spoke in general terms with small amounts of detail. Some participants wanted to tell personal stories and were aware of issues affecting female veterans as a whole, whereas other participants did not experience many personal issues while serving in the military during OEF-OIF or during the transition. On average, the interviews lasted 30 minutes to 1 hour, as the length depended on the openness of the participants. The researcher found a few participants really understood the bigger picture and wanted to help other female veterans. These individuals saw this research as being a

platform to tell a personal story.

Most of the participants were African American, and one identified as White non-Hispanic. These individuals were selected on a first-come, first-serve basis. Race did not influence the decision of participation. Advertisements and word of mouth went out to any female veteran who served in OEF or OIF. The findings indicate the experiences were no different based on race; however, if there was more racial diversity among the participants, the findings may have been different or would provide more insight into the experiences of a broader spectrum of female veterans. The findings also indicated the African American participants mentioned racial discrimination, whereas the White non-Hispanic participant did not. This does not mean the White non-Hispanic participant did not experience any discrimination based on race, but maybe it was not as much of an issue personally as it was for the other participants. This is a limitation because, had the sample population been more diverse, there would have been more experiences and insights to explore and document.

Implications and Future Research

These findings indicated implications for the U.S. military and the VA system for improved services and treatment of female veterans, as well as accountability of those who violate or treat these individuals unfairly based on gender, rank, or race. The U.S. military's policies and procedures must change, and an appropriate system must be developed for reporting and holding accountable individuals who violate other veterans. The participants mentioned the fear of authority and retaliation as a reason military sexual trauma was not reported as it should be. The victims are victimized not only by the perpetrator, but also by the good-old-boy culture protecting individuals in higher positions. Race is also a major factor in how these issues are handled. Some females are

not just assaulted because of gender but also because of race. Although racial issues are a historical part of the United States as well as the U.S. military, there needs to be an overhaul of how the system handles racially motivated issues.

Another implication of the findings involves the abuse of power. Some participants indicated military sexual trauma was not a result of any wrongdoing on the part of the female. Some saw it as more of an issue of taking advantage of someone of lower rank who happened to be female. Because of the hierarchies in the military and the emphasis on serving and doing what is required, there is a possibility of lower ranking service members who feel pressured into doing things to contribute to victimization (i.e., sexual, mental). Again, policies and procedures and the structure should be modified to alleviate the potential of issues like this from happening in the future. The system needs to be reevaluated so female veterans are not afraid to report for fear of retribution and retaliation. The system should encourage those who are victims of sexual trauma or harassment to report these incidents because the military holds a higher standard of conduct and professionalism for its members.

The VA system is also another entity catering to male veterans. Traditionally, the military has been male dominated, which has influenced the way the system has been created and structured. Great strides have been made in improving the way female veterans are treated over the past decade. However, there is much more to be done. Female veterans are still complaining about inadequate female-centered health care, long appointment and wait times, inconsistent medical providers, and limited women's health services. It is recommended the staff be trained in women's health and unique situations mostly affecting female veterans. There needs to be gender-specific mental health services, counselors, and support services to help these individuals with the transition

after deployment. The services can assist with family issues, reconnecting with children and spouses, employment and career counseling, and educational planning. This can help curb the issue of homelessness among female veterans, potential drug addiction, broken families, lack of education, unemployment, and mental health breakdowns.

The implications for future research include more recent studies to add to the existing body of literature. According to Baker (2014), the numbers reported by the Department of Defense and the Veterans Health Administration, in some of their studies on OEF-OIF veterans being diagnosed and treated for PTSD and other mental health issues, may be higher than the numbers acknowledged. The author explained, because there is no reporting from non-Veterans Health Administration providers, the numbers may be inaccurate and present a larger problem than realized among veterans. Another area needing to be explored more is the impact of war on military families. Previous research has shown children who have had parents deployed several times are more likely to experience behavioral and emotional issues. Younger children may experience behavioral problems, and teens may feel overwhelmed due to the mounting pressure of having to take on more responsibilities in the home (Clever & Segal, 2013). Skopp et al. (2011) explained common home-front worries may include missing important events, financial concerns, and anxiety about partner fidelity, family health issues, and child behavior problems.

Future studies can provide a platform to push the agenda and address the growing concerns of female veterans and their families. More qualitative research can be done to bring firsthand information to the forefront. A study could be conducted on the postmilitary experience of male and female veterans after transitioning into civilian life. The purpose would be to compare the issues faced by these individuals after moving

forward with life in the civilian world. This study focused on the experiences of female veterans in OEF and OIF and the challenges faced by these individuals during the transition. It did not focus as much on the issues of daily life after getting out of the military. Although some of the issues raised in this research are relevant, there may be some fundamental differences in how the research is approached, and this type of investigation would give a more in depth account of the before, during, and after of military life.

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Appendix A

Interview Script

Interview Script

Research Topic: From the Front Line to the Living Room: The Transition of Female Veterans Back Into Civilian Life

Time of Interview:

Date:

Location:

Interviewer:

Interviewee:

Interviewer's Script: The purpose of the study is to solicit insights from repatriated female veterans as to recurring obstacles to transition to civilian life, to advance corrective recommendations to the current practices of the VA system for consideration or implementation, and to highlight the need to fund and support current and future research to posit best practices. You will participate in a 1-hour interview consisting of 12 questions. You will answer each question with as much detail as possible, but you can choose not to disclose information you are not comfortable with due to the sensitive nature of this research. You will be assigned a unique identifier to be identified by throughout the study. In addition, all data will be properly secured in my laptop under specified files and locked with an access pin. All data will be kept for 36 months after the completion date, and I will shred and properly dispose.

1. Have you ever been deployed? How did you feel when you found out you were being deployed?
2. Were you married? Did you have children at the time?
3. Describe what it was like when your family and children found out you were being deployed?
4. Describe your experience and position in the military.

5. When you think of military sexual trauma, what are your thoughts? Do you know of anyone who has experienced this?

6. Do you feel you were treated differently because of your gender? What was your experience like as a female in the military?

7. Did you attend college while in the military or after? If so, how was your experience as a student veteran?

8. What is your experience with post-traumatic stress disorder or other mental health issues related to your military experience?

9. Tell me about your overall experience transitioning from being a soldier to being a civilian? What was it like?

10. Have you ever used the VA for any services? If so, what would you say your experience was like?

11. How has it been accessing healthcare and other services as a female veteran?

12. Is there anything else you would like to share about your experience as a female veteran?

Thank you for your cooperation and participation in this interview. Please be assured your responses and your involvement in this study are confidential.

Appendix B

Demographic Survey

Demographic Survey

Title of the study: From the Front Line to the Living Room: The Transition of Female Veterans Back Into Civilian Life

The purpose of this questionnaire is to allow the researcher to gain information to determine the qualifying participants. The questionnaire is divided into three sections consisting of personal, educational, and professional development data.

1. What is your age range?
   A. 21-26 years old
   B. 27-32 years old
   C. 33-38 years old
   D. 39-44 years old
   E. 45+

2. What is your ethnicity?
   A. African American
   B. White
   C. White Non-Hispanic
   D. Hispanic
   E. Asian
   F. Multiracial

Military Data

3. Are you currently in the military?
   A. Yes
   B. No

4. What branch of the military did you serve?
   A. Army
   B. Air Force
   C. Marine Corps
   D. U.S. Navy
   E. Army Reserves
   F. Air Force Reserve
   G. National Guard
   H. Coast Guard

5. How many total years of military experience do you have?
   A. 0-3 years
   B. 3-5 years

C. 5-10 years
D. 10-15 years
E. 15-20 years
F. 20+ years

6. What was your job in the military?

_____

_____

Thank you for your time and cooperation.

Appendix C

Interview Protocol

Interview Protocol

1. **Informed Consent –** Read to participant and have them sign before starting interview.

2. **Audio Recorder –** Let the participant know the interview is about to begin and the audio recorder will be turned on.

3. **Interview –** While recorder is on reiterate the confidentiality policy and state the unique identifier prior to beginning the interview. Use the interview script and begin the interview.

4. **Close the interview –** At the end of the interview, reiterate the information they provided will be transcribed and used in the results of the research without their identities.
    a. Remind them the information will be stored in a secure file for 36 months after the completion of the study and shredded.
    b. Ask if they would like a copy of their interview.

Appendix D

Themes

Themes

Issues Mentioned Most Frequently

Issue	AR1	AR2	AR3	AR4	AR5	AR6	USN1	AF1	AF2
Gender/Race/Rank	X	X	X	X	X	-	X	X	-
PTSD/Mental Health	-	-	X	X	X	X	X	X	X
Military Sexual Trauma	-	KS	KS	KS	-	KS	KS	KS	KS
Family Issues	-	-	X	-	-	-	-	-	-
Veteran Affairs	X	X	X	X	-	X	X	X	X
Education	X	X	X	X	-	X	X	X	-

Issue	No. participants	%
Veterans Affairs	8	89
Gender/Race/Rank	7	78
PTSD	7	78
Sexual trauma	7*	78
Education	7	78
Personal relationships	6	67

Note. PTSD = Posttraumatic stress disorder.
*Knew someone who experienced it.

Appendix E

Interview Transcripts

Interview Transcripts

Interview Results for AR1:

1. Yes I was deployed in Operation Iraqi Freedom. When I found out, I thought it was a joke and I was upset.

2. No, I was not married at the time and I didn't have any kids.

3. When my family found out that I was being deployed, they didn't believe it. They really don't show emotion but they were coping in their own way.

4. I was over the communication section. It was a weird experience and it is very hard to describe.

5. Yes I am aware that military sexual trauma does happen and people don't talk about it. No, I don't know anyone personally that experienced it.

6. Yep I was the only female in my section and the men constantly tried to ignore me. If I said anything they would intentionally act like they did not hear me. It is a lot of racism and is very male minded. The lower ranking officers created problems. If my superior officer told me it was ok to do something the lower ranking officers above me would tell me to do the opposite. I felt like it was because I was a female.

7. I went to college right after high school but soon after deployed and had to postpone my education. I was a non-traditional student. I never had a problem with being a Student Veteran. I went on to complete 3 college degrees in Nursing. I recently received my Master's in Nursing.

8. I wasn't affected with PTSD or other mental issues. I thought that I would because of the bombs and other things going on around me but I didn't.

9. It was weird transitioning back to civilian life. The hardest thing that I can remember was being jet lagged.

10. Yes I have used the VA for services and I do not like them. They weren't good and would have me waiting forever for appointments. I went when I got back from being deployed.

11. I have not had a problem accessing healthcare.

12. Women's health is very important as a female veteran. They really need to do more for female veterans. This is one reason that I chose to become a Nurse Practitioner with a focus in Women's Health.

Interview Results for AR2:

1. Yes, I was surprised because, in years past, I was told that due to my rank of Colonel, the military did not want to pay. I did not think of ever being deployed.

2. Yes, I am married with one adult son.

3. My husband was very supportive, my elderly mother was scared for me plus my dad passed two years prior to my deployment. My son who lives with my mother was very proud and promised he would take care of his grandmother. My brother and his family were proud but somewhat worried.

4. I was in the Army Nurse Corp for 30 years and grew up the ranks of leadership. Prior to and after deployment I was the Chief Nurse of the 8th Medical Brigade, Ft. Wadsworth, Staten Island, NY.

5. I think of female soldiers being molested and harassed by their male counterparts. During my deployment, I was the Coordinator for the Sexual Harassment/Assault Response and Prevention Program (SHARP). Of course, all cases remained strictly confidential but what I found was most of the enlisted females were sexually assaulted by non-commissioned soldiers as well as officers. Sometimes their Commanders were afraid to press charges for fear of retaliation and stripping of ranks.

6. I sometimes felt it with some of my white counterparts and commanders. For most of my thirty years in the military I would say they were positive ones. I will say that still today there is much prejudice in the military.

7. Both. I attended my Master's and two postmasters certificates while in the military, since returning from deployment I am in the DHA Program at Walden University as a student veteran receiving Post 9/11 benefits.

8. I really cannot say I experienced PTSD. I was only scared when we were told a bomber tried to get on our base to drive his vehicle between the mess hall and our Post Exchange store (I was in the store at that time). I then came to the realization I could have actually been killed!!

9. I had a civilian position prior to deployment and was fortunately guaranteed my position upon returning so I was secure there. However, it was a little difficult getting back into the everyday nuisances of my civilian job.

10. Yes, after deployment, I registered with my VA and used Women's Health services, labs, x-ray, pharmacy and dermatology departments with good experience.

11. Working with some veterans associations I have been told that some of the VA facilities were difficult to access medical care. However, we are looking into assisting female veterans in social services, homelessness, etc. The Division of Veterans Services in NYC has been an advocate of these issues.

12. Just to say that I would do it all over again and join. I am very serious of my duties as an Army Nurse and would serve my country if called upon to do so. I also want to thank you for what your research covered from the front line to the living room.

Interview Results for AR3:

1. Yes. For my first deployment, it was fear, sadness and uncertainty. I was deployed only a short 6 months after reporting to my permanent duty station. The second deployment was a little different. I was more prepared, however still nervous and sad.

2. Yes, however when my husband left during my first deployment, I was blissfully unaware that he would not return and my son was too young to know what was happening. It was only after my second deployment when I would have enough time in the country to file for my divorce. A custody battle took place over our child, and I was awarded partial custody due to my multiple deployments. This made me regret and hate being in the Army.

3. For my first deployment, my son was too young to understand why I was leaving. My husband (at the time) was resentful. My parents were nervous and scared.

4. By MOS I was a light wheel vehicle mechanic; but that was simply a title. I became a detainee guard, Better Opportunities for Single Soldiers representative, a R&U personnel, and a Sponsorship Cell NCOIC. Each position had its own experiences and challenges.

5. I think this was an unaddressed issue however in the past several years, it has become widely addressed. Yes I know several.

6. Absolutely! Being a female in a primarily male-dominated MOS was difficult to "prove" myself. There were several times I was flat out told that as my superior they would not promote me until they absolutely had to. And when asked why, their response was always because I was a "girl". Overall my experience was no different from males. Although it may have caused some setbacks and challenges, it also allowed me some opportunities males found it difficult to get.

7. Yes. Both on active duty and after. No different as when I attended before joining.

8. When I was first evaluated for PTSD, it was still a fairly fluid diagnosis. It was also widely over diagnosed. I have been on several different medications, and tried a multitude of different treatments and exercises. It is difficult to deal with and try to assimilate to the "normal" life when those around you don't understand what you are going through.

9. Horrible. This is not the Army's fault, or the lack of transitioning training. Going from a life where there are rules and regulations for everything, an unwavering work schedule, and friends who are more like family than other family and friends that have essentially lived their life in absence of you. They do not understand what you have been through, how you could have done certain things, why you act or talk different than you did. It's like trying to mix oil and water. Although possible, it is very difficult, and despite years can remain separated.

10. Yes. Other than the one time I was seen in the ER, I have not had a good experience. In less than three years I have had no less than a handful of different primary care physicians. I have been disrespected by staff and physicians alike.

11. Being a female has made no difference in my opinion to a male accessing healthcare.

12. Not that pertains to being a female veteran.

Interview Results for AR4:

1. Yes I have been deployed. I felt very nervous.

2. No. I was not on my first deployment.

3. My family was very afraid for me.

4. I served a total of 13 years and 8 months in the Army. Part of it was in the Reserves and the rest on Active Duty. My experience in the military was very life changing. I was a 92F (Petroleum Supply Specialist). My primary job was to refuel aircraft, ground vehicles and maintenance equipment. I also was responsible for the accountability, storage, issuing, and receiving of all petroleum products.

5. When I think of military sexual trauma it breaks my heart. The reason being is because we all took the same oath and lived by the same Warrior Ethos. I just can't understand how someone could violate their battle buddy. Yes, I do know a couple of people who have experienced military sexual trauma.

6. Of course. I felt as if I was treated differently because of my gender. My experience in the military was one of always having to prove myself worthy of recognition. I had to work 3 times as hard as my male counterparts to make sure I was ahead of them.

7. Yes. I attended college while I was serving in the military and I am currently enrolled in college. As a student veteran, school gets a little overwhelming to me. I must try really hard to focus on my assignments.

8. My experience with PTSD and other mental health issues has been a daily struggle. I was medically retired from the Army due to them.

9. My overall experience transitioning from being a soldier to be a civilian has been a total lifestyle change. It is scary, unnerving, and unfamiliar. I had to get used to not having a set schedule each day and not being directly responsible for others' lives. I still to this day deal with the stressors of adapting even through it is going on 4 years since I last wore a uniform.

10. Yes, I have used the VA for services. My experience with the VA is like fighting with hell!!! Some of the people who work within the system are very insensitive to all Veteran's needs.

11. It has been well since I still receive medical benefits from the Dept. of Defense. That is my choice of healthcare over the VA.

12. The female veterans that I have met have been wonderful! We help each other get through the hard days. We support each other. And most importantly we

understand each other. I have ongoing life bonds with some of my fellow female veterans and some that I can call a sister.

Interview Results for AR5:

1. Yes, I have been deployed. I didn't feel any type of way, I knew it was a possibility joining.

2. No to both

3. My parents were upset, but they knew this (the Army) was something I wanted to do.

4. At that time I was a 2LT, and an evacuation platoon leader with 32 medics.

5. Military sexual trauma to me is assault that occurs to a person while serving in the military.

6. I feel like I had a double whammy. Being a female is hard but being a black female was even harder. I had more hurdles.

7. No I did not. I was in the ROTC prior to college.

8. PTSD was the reason I left the military. I could do the job fine. I just didn't like forcing myself to pretend it.

9. Transitioning hasn't been hard at all. I was a civilian before the Army and that's how I view it.

10. Not currently at this time.

11. It hasn't been an issue at this current time.

12. Not at this time.

Interview Results for AR6:

1. Yes, I have been deployed. I felt devastated.

2. No to both

3. It was heartbreaking when I found out that I was being deployed. My family and I were sad and crying.

4. It was difficult. I was exposed to the elements and to the environment. There were mortar attacks and a heightened sense of fear. OIF was worse because the bombs and attacks occurred close to where I was located.

5. MST is underreported. The chain of command frowns upon it. I do know someone who has experienced this and I have seen it happen. There were 5 guys and 1 girl. No one would believe her. She was only 19 years old. They deployed her along with the guys to the same place. She was there for 6 months and she had separation anxiety and a breakdown. The chain of command failed her. They eventually sent her home.

6. Yes I was treated differently. There were times that certain assignments I did not get because I was a female.

7. No I did not at first. I did eventually begin college and it was a challenge because I would have to start and stop (TDY) when I got deployed and not being able to finish in a timely manner. I finished after returning home and going into the Reserve.

8. I have been diagnosed with PTSD. I am less trustworthy of people and it has changed me.

9. Transitioning has been a challenge because I had the mindset as a soldier and I viewed civilians from a military perspective which was a challenge and still is.

10. Yes, I have used the VA for health care and the quality is not what a veteran should receive. I go to a private provider. It is very difficult accessing health care as a female veteran. In the VA, there is a lot of rescheduling from doctors and appointments would be 6 months out. When I would return, the doctor would change to someone I am not familiar with.

11. It has been difficult. I go to the VA for certain services but I prefer my private provider. There are some situations that are female in nature that I would prefer to talk with a female provider about but I have to see who they have available. There needs to be more female-centered care.

12. Female veterans who deal with PTSD or with physical injuries are not treated as seriously as the male veterans and it needs to change.

Interview Results for AF1:

1. Yes I have been deployed to Iraq for one year. When I found out I had a range of emotions. I was surprised because I had been in the Air Force for 18 yrs and had never been deployed. I was teaching ROTC at the time and was a single parent. I just told myself that I would make the most out of it since Iraq wasn't as bad as Afghanistan.

2. I was a single parent. I had one daughter who had special needs. Luckily, I had a great relationship with her father and my mom took care of her while I was deployed.

3. My mom was worried for me when I was deployed. She uprooted from California and moved to South Carolina to care for my daughter. She didn't know anyone there and she left her life and all of her friends.

4. I was an Air Force ROTC instructor at the University of South Carolina. I was preparing for the future reserve officer training on the Freshman and Junior level. As far as my experience during deployment, I can't complain. I had a hard time because I was somewhere that I wasn't wanted. It was what it was. I worked 12-16 hour days. It was a humbling experience and I was trying to make sense out of it. I was a Budget Officer at the time.

5. Military Sexual Trauma happens but is not reported. I never experienced it physically. Lower ranking officers would be hesitant to report if it did happen. I have spoken to my students about it. The military can do a better job with an open door policy. It is male dominated. As far as the healing process there needs to be services when they are out of the military. The stigma associated with it keeps people from saying anything. I know someone who has experienced it and didn't want to report it.

6. I feel like I was treated differently for being a woman in certain situations, especially rank and race. They did treat me differently.

7. I attended college while I was in the military and when I was out. I did great while still in the military. I was encouraged to go to school and further my education. My jobs allowed me to attend school based on my work schedule. I joined the military mainly to further my education. I continued my education after the military in an online learning environment.

8. I was diagnosed with PTSD while in Iraq. It affects my sleeping and alertness. It is not as extreme as some and I am a younger woman. Therapy is not geared

towards female veterans. A lot of the groups at the VA are for older men. There is also a fear because of stigma in the workplace.

9. I was ready for the transition back into being a civilian. I had planned for it beforehand. I was financially prepared before I got out. I do miss the camaraderie. Civilians are more laid back. Overtime was not an option.

10. I do go to the VA for medical services. It is ok, but appointment times would be months out. I take it for what it is and look at them like military doctors.

11. All of my doctors are females. I had more options since I was retired. I go on base for more specialized care but I mainly use private doctors. The appointment times at the VA are long.

12. When women get out of the military many of them don't identify themselves as Veterans. Female vets should be more comfortable with identification.

Interview Results for AF2:

1. Yes, I was deployed to Kuwait for 3 months in 2003 serving in the Air Force for OEF. I was nervous about the working conditions, the long flight and how long I would have to be there.

2. I was single with no children.

3. My mom was nervous. I could tell she was trying to be strong for me. She stated, "You will come back the way you came", Whole (mentally) and in once piece.

4. I was not as bad as anticipated. Being in the Air Force, we serve as more of a supportive role. I did not experience any live fire on my deployment. I was blessed for it. I was a chaplain assistant. I prepared the chapel for worship. We also performed field visitations to our troops, counseled anxious troops, visited injured troops in the hospital and were body guards for the chaplains. Chaplains are not allowed to carry weapons.

5. It is a real concern. When you are confined to an area for a long period, sometimes the worst comes out of people. Many people who outrank a fellow troop will take advantage for their position. Yes, I know plenty of people that have experienced this.

6. I don't feel like I was treated differently. I feel that was because of my job (chaplain assistant) people were more friendly.

7. I attended college after. The college experience was great. I went under the MGIB with a stipend. I could completely focus on my studies without having to work. I was more mature when I went to college at a later age 27.

8. I did have a lot of nightmares, hypersensitivity and a lot of apathy when I returned.

9. Transitioning was smooth for me since I did full-time school. It gave me time to explore and have less stress from one work environment to another. When I graduated from school, I was a stay at home mom for 2 years before starting my new career as a RN. My first few civilian jobs were challenging because the work family that I had in the military was not there. The standards were lower, and people were not as accountable. I got through it though. I had to find my new place in life.

10. I used the VA for counseling for depression and transitioning. I used the rehabilitation center to assist with MGIB and civilian employment. I have been to the VA for diagnosing and treating my skin cancer. I was pleased with all the services. I was treated with dignity and respect. I was seen by competent and caring professionals. I know my story is the exception, but it is true!

11. The VA has a women's clinic where your provider is your primary care and OB/GYN services. I normally can have an appointment in 2 weeks for non-urgent matters. I feel comfortable since it is an all-women's clinic.

12. I feel that more sexual injustice happens in other branches outside of the Air Force from my experience. I had a strong career but wanted more freedom to go to school and to choose where I would live. However, I did enjoy my state-side experiences. I honorably separated from the military because deployment life was not for me.

Interview Results for USN1:

1. Yes, I was deployed on Navy ships never boots on the ground. The first time I was deployed was right after 9/11 so I was excited and scared. I was excited to go get the bad guys but scared that I may not make it home.

2. Yes, I had one daughter who was 9 years old.

3. My family was worried that I wouldn't come back. That was the first time in 10 years of being active duty I deployed.

4. My first 12 years in the Navy I was a pipefitter, so I worked mostly with men. I was usually the only African American woman or woman period. The second half of my career I worked as a Career Counselor. It was hard to advance in the 1990's and early 2000's so that was discouraging but I never gave up. Once I became an E5 in the Navy, I was placed into leadership positions. I had to deal with a lot of angry men working hard for me. The Navy was good for me as well as good to me and I am happy that I was able to join and live the experience.

5. Think of unwanted touching and or rape. I know several women who have had military sexual trauma.

6. I sure do! On many occasions. I feel like I was overlooked for certain jobs or qualifications. I was disrespected by men in higher paygrades.

7. Yes, I attended college while active duty and after. My experience with going to college was okay. I used my time never the Navy's time because I never wanted anyone to say anything negative or I was in the Navy to attend school. Once I received degrees some people were not happy for me and made remarks about it, so I would never talk about my degrees to people who did not already know.

8. I do not have PTSD but I am diagnosed with anxiety and major depression disorder. I knew about the anxiety and I am not sure where or how it started. I did not know about the major depression disorder until I went to the VA.

9. My transition was great! Before I retired I was a realtor in San Antonio and enjoying my new career choice until my husband dropped the bomb we had to move to Hawaii. I did not want to move anymore and I damn sure did not want to go back to Hawaii. I went on terminal leave early Nov and separated January 2015, then we left for Hawaii April 2015. Once we got to Hawaii of course I had no friends and no job, so I hated every minute of it, but I was happy to be done with the Navy.

10. Yes, I use the VA for everything. The VA here in Hawaii is very accommodating and professional.

11. I have had a good experience with the VA here.

12. Nothing more to add. I hope I was able to help you.