The experience of female Veterans and health seeking behaviors

by

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Abstract

Most military branches began to allow females to serve equally alongside males in the 1940's. However, militarized masculinity poses a challenge for female service members as they negotiate military norms that continue as they transition to civilian life. Health services provided by the military are aimed to help with deal with life and work challenges. However, it is unclear female service members utilize these services as they are intended. The purpose of this study was to provide a better understanding of how health services were utilized by female Army Veterans based on their personal experiences during military service. The study focused on how these experiences have impacted the decision-making process to seek health services during and/or after service. A phenomenological heuristic qualitative study with 11 female Veterans (M =120 months; Service Range =36 months-328 months) with an overall average of 10 years of Active Army Service was conducted using a semi-structured interview guide. The study elicited participants' experience with health services offered by the military. Cross-thematic analysis found several themes that prevented participants from accessing health services during active duty: experiences of sexism, sexual harassment, unsupportive leadership, challenges of physical health, and limited access to social, family and health resources. The Vulnerability, Stress and Adaptation model was used to conceptualize the study and make meaning of the findings. Clinical and research implications are discussed.

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Chapter 1 - Introduction

Most military branches began to allow females to serve equally alongside males in the 1940's. However, it was not until the 9/11 Attacks that the Army really took note of gender disparities and wanted to integrate females into every combat arms occupation. This process created the Gender Integration Project, to give resources to leaders to support the ability to have professional and educational conversations about success and challenges in integrating women (U.S. Army Center of Military history, 2022). The growing presence of women in the U.S. armed forces, from approximately 2% in the 1970s to nearly 20% of current military recruits, has reshaped the Veteran population (Washington, et al, 2015).

Despite this growth in female service members, the current literature on Army Veterans does not reflect the changing military population. In fact, the most recent nationwide population-based assessment of women Veterans' needs, demographics, and experiences was conducted in 1985. Since that time, women's military roles have changed dramatically, and there has been increased attention to the health effects of military service on women (Washington, et al, 2015). Kimerling and associates (2015) noted the health priorities for women as being depression, pain management, chronic medical conditions, sleep hygiene, weight management, and posttraumatic stress disorder. Further, the disproportionate increase in suicide rates among female veterans, particularly those not currently using Veterans Healthcare Administration (VHA) care, have underscored the need to understand how to reach female veterans (Monteith, et al, 2021). Experiences of acute clinical concerns, such as thoughts of suicide, and mental health symptoms (e.g., depression, PTSD, substance use disorders), that are associated with increased risk for suicide have not been used to inform outreach and prevention efforts for female military personnel.

Despite the knowledge that needs are gender specific, the military continues to be masculinized. Upon most reviews, the current research focuses on the male demographic and their treatment after exiting the military. Militarized masculinity poses a challenge for female service members as they negotiate military norms that continue post-military. Veterans often struggle with their transition to civilian life and the negotiation of military and civilian gender norms (Bulmer & Eichler, 2017). Dismantling militarized masculinity is necessary to attend to the needs of our female military personnel. The purpose of the study is to explore needs of female service members, military services and support available to them, and what influenced their utilization of these services. This information will help identify ways to improve accessibility of military services and support for female military personnel.

Chapter 2 - Literature Review and Theoretical Framework

The soldierization of service members in the U.S. Army is the process of transforming an individual from a citizen to a Soldier, an identity they are expected to assume from thereon (Army Training and Doctrine Command [TRADOC], 2018). The U.S. military prides itself in creating the most physically and mentally fit soldiers in the world with "unmatched lethality." The Army's fitness requirements have historically only included standards for physical fitness that should portray a soldiery demeanor that needs to be maintained throughout a soldier's career (Department of the Army, 2019). Only in 2020 did the Army include mental and spiritual readiness as part of the Holistic Health and Fitness readiness doctrine (Department of the Army, 2020). The military mandates that physical fitness exercise is part of soldiers' daily regimen (for Active-duty soldiers), however, there is no mandate for mental or spiritual wellness despite its inclusion in the most recent readiness doctrine.

Soldiers are trained to respond at a moment's notice for combat, war deployment, and relocation. The ability to adapt and be prepared for unpredictability is a hallmark of their resilience (ASYMCA, 2022). Although training and deployment have been longstanding in military history, the effects on female body types have only recently garnered the attention of researchers. Stress impacts the human body in different for females in the military. A study comparing military and non-military population, found that the female reproductive system is directly impacted whereby, military personnel suffered more conditions of menstruation disorders (e.g., increased, or complete stop of menstruation during deployment) and infertility (e.g., need for fertility treatments or increased miscarriages) (Lawrence-Wood et al., 2016). And although muscoskeletal injuries are the most common injury amongst service members, females

account for almost 4% of stress fractures, whereas males only account for 0.8% (Rossi, Hauret & Jones, 2016). Some reasons for such injuries may be attributed to the female anatomy.

Biology has destined females to be different from males in at least three ways that make females more susceptible/vulnerable to injuries than males: (1) Females have smaller and narrower bones, with thinner bone cortices leading to lower bone mass (Evans et al., 2008). This feature inherently means that females have lower resistance than males to stress imposed by repetitive mechanical loading and are thus at greater risk of sustaining stress fractures. (2) Females use a higher percentage of their maximal oxygen consumption than males meaning that they would work at a higher relative intensity, resulting in earlier fatigue and lower tolerance time (Epstein et al., 2013). (3) Females walk with shorter stride length and greater stride frequency than men (Martin & Nelson, 1986). As carrying loads increase, females' stride length decreases, whereas men's stride length does not show significant change. Increased load means females will show a more pronounced linear increase in the time that both feet are on the ground (double support time) than do males (Martin & Nelson, 1986). Hence, females need to adjust and compensate, bringing the center of the load mass over the feet (base of support). Females tend to hyperextend their necks and bring their shoulders farther forward than do males, possibly to compensate for their inferior upper body strength (Ling et al., 2004). Adjustments like this can lead to physical health repercussions.

Another aspect that has been examined is the implications of multiple deployments for female service members who must make decisions around childbearing and childcare. On average, service members remain at a duty station for 2 to 4 years before transitioning to a new one. It is not uncommon that service members delay pregnancy or for single service members, make child custody arrangements prior to deployment. The latter is more likely to impact female

service members given that there are almost 3 times more single mothers than single fathers in the military (Schumar & Maloney, 2007). The Army's policy that prohibits single parents with custody of their children to enlist has significant consequences females who are more likely to have custody of their children (Department of the Army, 2016). Although this may be a gender-neutral regulation, it can still limit options for single mothers to pursue a military career.

Another disproportionate stress experienced by female service members is sexual harassment. The recent reports of a death by suicide and murder of a female service member after they reported sexual harassment by male military personnel has helped many other survivors to come forth with their stories. A survey of 383 female veterans about traumatic military exposure found that at least two thirds experienced sexual harassment and one third experienced sexual assault (Goldstein, et al., 2017). The study further noted that sexual harassment or assault were stronger indicators for PTSD and depression compared to combat trauma. Part of the masculinized culture of the military is the lack of proper advocacy for females. Despite countless records of such incidents over that last several decades, no proper repercussions or preventions to protect female service members have been established. For example, after a sexual assault incident in the mid-1990's, the military responded by requiring females to be accompanied by a fellow female (known as the battle buddy system) (Spence, 2015). The problem with this system was that female service members had to assume the responsibility to protect themselves which in turn limited freedom and privilege that was accorded to males who perpetrated the violence.

Having a strong support network may help mitigate stress. Social interaction has a strong positive correlation with mental health, whereas isolation and loneliness can increase the mortality risk (Ohrnberger, Fichera & Sutton, 2017). In fact, for females, social interactions

significantly increase oxytocin levels that has positive implications for mental health (Borland, et al, 2018). However, the constant transitions from one duty station to another make it difficult to create and maintain support networks. The stress encompassed lifestyle of the military is challenging to maintain without support systems. It has been noted that it can take more than 200 hours with another person to create close friendships/supports (Hall, 2019). The transient nature of military life can make this reality impossible. In order to fully understand how challenges unique to female service members may influence their help seeking behavior, the Vulnerability Stress Adaptation (VSA) model was utilized to conceptualize the study.

Vulnerability Stress Adaptation Model

Over the course of a lifetime, people will experience many events and interactions that can frame how they understand and respond to such things in the future. When thinking about the lifestyle of soldiers, it can undoubtedly be expected that one person will have an added layer of stress at some point in their military experience. Experiences can create responses which allow the person to adapt to that stressor. Using the (VSA) model can help researchers apply knowledge to understand what is applicable in learning about female veterans' experiences. The outcome is dependent on three influences: one's enduring strengths and vulnerabilities, or stable characteristics (e.g., personality traits, ethnicity, experiences in the family of origin); the stressful events and circumstances that are encountered (e.g., the transition to parenthood, job loss, neighborhood disadvantage); and the adaptive processes that are displayed (e.g., emotion experienced during interactions, behavioral skills, and associated cognitions). (Gonzaga, Campos, & Bradbury, 2007)

In looking at this model, it would be helpful to use it in understanding the experiences of female Veterans by breaking down these characteristics of how they respond to specific events in

comparison to male Veterans. The female Veteran can have an added layer of distinguishable traits and characteristics that will impact the decision-making process. It may also be helpful to see that they can have influences of other genders who play a role in this model. Studies from this model has shown that shared personality with partners or other close support systems can result in shared emotional experience and better outcomes (Gonzaga, et. al, 2007). From this information, we can see that if a female Veteran is feeling like she can associate better with her military colleagues, they could possibly obtain better emotional outcomes from their experience. But the criticism is understanding the gaps in gendered experiences thus creating fractures in the adaptation of stress as shown by VSA. It can be presumptive that whatever adaptive processes are utilized from stressful experiences will impact the Veterans overall symptom management. This model leads us to wonder if the Veteran is not being connected to resources or being supported after the stressful event based on their specific needs as a female.

Purpose of the Study

While we understand that the military system has evolved to allow females to join and actively serve, there are essential aspects that could be falling under the radar that directly impacts females. It is not known if female service members utilize services rendered to them by the military and what are any barriers that may exist to allow the access to services. The purpose of this study is to provide a better understanding of how health services are utilized by female service members during and after active service. The study will focus on how active service experienced by female Army Veterans influenced the decision-making process to seek health services during and/or after active service. The study aims to elicit the participants' experience with services offered by the military and factors that influenced their use of these services. The research questions that will guide the study are:

RQ1. What military experiences do female Army Veterans attribute to their decision to seek or not to seek treatment for health symptoms?

RQ2. What do female Army Veterans identify as factors that helped them cope or not cope with military-related stress?

Chapter 3 - Research Methods

A qualitative inquiry was utilized for the study. The aim of the study was to learn from the participants' lived experience. Qualitative research was chosen because it contributes to a body of knowledge that is conceptual and theoretical and is based on the meanings that life experiences hold for the interviewees (DiCicco-Bloom & Crabtree, 2006). The process allows the researcher to create a connection to the participants based on the experiences revealed through the participants' own words. The interview process allows the researcher to ask follow-up questions in direct response to answers that were provided to gain better clarification or allow for deeper exploration. This reflexive process was also undertaken by the researcher who has experienced the phenomenon being studied.

Self of the Researcher

As an Army Veteran, I served as a medic in the U.S. Army from 2005 to 2009**.** During my service, I was deployed to Iraq from 2007 to 2008, for 15 months. Upon returning from deployment, soldiers from my unit were met with a slip of paper with a handful of questions. If we marked "yes" on any of the questions, we were referred to a mental health professional. Otherwise, we were assumed to have no problems that needed attention.

It was not until after my return from deployment that I realized that I could use the help of a mental health professional when I alighted the plane in 2008. As a Veteran, I often discuss with fellow female Veterans our experiences with seeking treatment at the Veteran's Affairs (VA), and our conversations would ultimately focus on roadblocks and obstacles we experience. Even today, any medical appointments with the VA provokes such anxiety, and flashbacks of how I was continually dismissed and gaslighted about my symptoms. Such treatment has led me

to doubt my medical problems downplay health concerns for fear that I would be perceived as weak.

As a mental health provider, it is imperative that we understand the challenges of our clients and for female military personnel this would include the trials and tribulations of military life as seen from a female perspective. The dearth of literature on female military experience related to mental health services was the impetus for this study. Understanding female service members' lived experience will allow us to create mental health resources that are sensitive to their unique needs. Because of my personal and intricate connection with this topic, I chose to utilize heuristic inquiry for this study.

Heuristic Inquiry

Heuristic inquiry is unique because it does not exclude the researcher but instead includes the researcher's experience with that of the participants. This method is interested in discovering the essence and meaning of a phenomenon that the researcher has directly experienced (Moustakas, 1990). The researcher needs to be willing to enter a process of self-reflection and exploration of the topic being studied. This type of research is highly personal and allows the researcher to have their voices heard and story understood.

The non-linear approach of heuristic research that includes six phases: initial engagement, immersion, incubation, illumination, explication, and creative synthesis was applied in this study (Moustakas, 1990). The initial engagement phase involves discovering a passionate concern that the researcher finds compelling. This led me to my experience with the VA healthcare system that has significantly impacted my health, of which, I derived important meaning. The immersion phase consists of living and surrounding oneself around the research question. Each time I access the VA healthcare system, I am immersed in the system where I

relive my experience yet again. Incubation involves the process of withdrawing from intense, concentrated focus that allows the researcher to gain new perspectives or understanding. I have pondered on my experience with the Army and my healthcare experience for a long time. And during this time, I have had the opportunity to examine my experience from multiple angles. The next stage of illumination allows for new awareness to synthesize. It was this process of awakening to new discovery that led me to identify the focus for this study. Explication is the full examination of what has been awakened in consciousness. This phase provided the opportunity to assess the feasibility of the study and identify its method of inquiry. Knowing that I was connected to a sizeable group of female Army Veterans led me to believe that the study was indeed feasible.

Participants

Participants will include 11 female Army Veterans, recruited through social media and snowball sampling from the researcher's personal contact list. The researcher will send a message to her group of female Army Veterans and seek volunteers for the study. The inclusion criteria for the study: 1) Female Army Veteran. 2) Completed at least one enlistment term 3) Have access to the internet and Zoom 4) Ability to commit one 60-minute interview and one 30-minute follow up interview. At this time, transgender female Veterans will be excluded from the study as the Army only recognizes assigned gender at birth.

Data Collection

The researcher will conduct interviews with participants using a semi-structured interview guide (see Appendix 1). Although the questions are pre-determined, there is room for the researcher to ask follow-up questions based on the responses from the participants. This will

allow for flexibility in listening to the experiences and stories to give the researcher rich, in-depth data.

Participants that meet the criteria for the study will sign an informed consent form and a demographic questionnaire that will be sent to them via email. Interviews will be conducted via Zoom. It is estimated that each participant will be interviewed for about an hour. Upon completion of the first interview, each participant will be compensated with a $50 Visa gift card. If necessary, a second interview of a shorter length will be scheduled. A second interview may be necessary if after completing interviewing the first participant, the researcher discovers new information from subsequent participants and develops new follow-up questions and wants to provide the first participant an opportunity to respond to these questions. The interviews will be recorded, and Zoom's automatic transcription function will be utilized to access the transcription of the interviews that will be used for data analysis. The researcher was awarded the 2022 Arts, Humanities & Social Sciences Small Grant from Kansas State University to cover compensation expenses for participants.

Data Analysis

Cross-thematic analysis will be used to identify unifying themes that cut across all participants. Data will be coded by the researcher and two co-analysts (both are current Couple and Family Therapy graduate students). A co-analyst who is not connected to the U.S. military was chosen in order to provide a neutral and unbiased viewpoint. The second co-analyst has been selected based on her limited knowledge of the military as a spouse only.

The analysis will begin with each analyst independently coding the data from the same transcript. Codes created will be based on key phrases or descriptions from the participants.

Interview questions were used for main coding purposes as they were already generalized areas for participant responses and sub coding themes were then utilized from the responses.

In-vivo statements connected to the codes will be identified for possible inclusion in the findings. The codes will then be organized and assessed for similarities and larger themes that encompass the codes will be developed. After the first transcript is analyzed, the second transcript will be coded using the same method above. Last, triangulation of themes across transcripts will be conducted to synthesize and solidify the main themes and sub-themes that capture participants' stories.

Chapter 4 - Findings

This study explored the experiences of female Army Veterans that contributed to their utilization and non-utilization of healthcare offered by the Veteran Health Administration (VHA). All the themes that emerged from the interviews with 11 participants illuminated the issues that served as barriers to the well-being of our female Veterans. Three main themes and numerous sub-themes emerged from the data: *sexism* (sub-themes: sexual assault and harassment, gynecological health, double standards, gendered assumptions, and limited opportunities), *healthcare* (sub-themes: poor medical care, challenges with mental health providers, invisibility at the VHA, and healthcare options), and *lack of support systems* (sub-themes: family support, and friends and colleagues). The themes and sub-themes that are described below are interconnected and not mutually exclusive.

Sexism

All participants described the Army environment as sexist. The pervasiveness of sexism tainted their experience in the Army. They shared how being a female service member contributed to their experience of discrimination especially when their unique needs as women were dismissed. These experiences were common occurrences and they contributed to participants' weariness of utilizing VHA services. Sub-themes included *sexual assault and harassment, gynecological health, double standards, gendered assumptions, and limited opportunities.*

Sexual assault and harassment

Complaints about sexual harassment by leadership were a major theme that emerged from the data. Participants said that they did not only experience sexual harassment, but their complaints were not taken seriously. Numerous stories were shared by participants. Participant

#3 stated, *"I've been sexually harassed probably every week of my 10-year career, you know, if you add it [all her experiences of harassment] all up."* Participant #17 had her breasts and buttocks grabbed without permission while Participant #11 was forced to perform a sexual act as an ultimatum to pass a mandatory course. Neither participant reported the incidents.

Comments about female anatomy were another form of harassment that participants endured. Participant #10 shared that she was outraged when told that bending over to tuck her laces back into the boot was unladylike. The fear of being sexually harassed/assaulted was a constant worry for many participants. Participant #2 shared that she needed escorts to her tent every night while deployed because several traveling all-male units were sleeping in temporary tents near hers which made her feel unsafe. Participant #12 felt unsafe as one of the few females in a large deployment area. In order to protect herself she had to take on a persona that was not hers, *"So you have three choices. You can be the whore, the lesbian, or the bitch. I chose to be the bitch because that's the only defense mechanism."* Participant #17 also disclosed her distaste for unsolicited comments being made about her body from males she worked with.

Participants shared many reasons for not reporting sexual harassment. Participant #19 discussed how a friend of hers was assaulted and the friend was too scared to tell someone because the perpetrator was married to another soldier in the unit. When Participant #10 spoke up about being sexually harassed by another soldier, the female soldier in her unit told her, *"I can't believe you said anything. Why don't you just deal with it?"* When reports of sexual harassment were made, no action was taken. According to Participant #10,

> *I think because I'm female, but if I'd been a White male, it would have been different… nothing came of it [her report of sexual harassment]. I guess what I learned is, you can*

put the complaint in and all it does is brand you as a troublemaker, and nothing comes of it.

Several participants felt that rank and power contributed to their unwillingness to report discrimination or harassment. It was a consensus among all participants who experienced harassment, felt that the seniority of the perpetrator trumped any complaint filed. Participant #11 said,

I worked for a general and his chief of staff and he called us his heroine. He would fondle us and think nothing of it. And we went to report him, and they said, 'He's got 30 years in, you've got three years in, who do you think they are gonna believe?

Participant #11 shared that she was forced into choosing one of two different sexual acts or she would fail the course she was in. She described it as, "*I had to. I didn't say anything to anybody. Who's gonna? I've already tried to report a full bird colonel...I just buckled up and did what I had to do.*" The Army has made attempts to teach about harassment, but according to participants, any instruction has gotten lost in translation. Participant #10's comments inferred the normalization of sexual misconduct. She said "*I thought it was inappropriate, but almost like an old guy would do with his secretary or something. So, yeah that's that one time in terms of touching I wouldn't call assault, but it made me feel uncomfortable."*

Participants discussed how the Army poaches soldiers at young ages and takes advantage of naïve minds. For example, Participant #19 talked about a leader always wanting to see "*nice*" pictures of her all dressed up. She said, "*looking back now, he [the leader] was a total sleazeball, like that was inappropriate. But again, I didn't know any better. I didn't know I had the option [to tell the leader no]*." Participant #3 shared that a young female without life experience must watch out for

People with ill intent are in the ranks every day. You have to be aware. You're the only person that's gonna have your own back at the end of the day. Whether it's your literal body or your career, it's all on you.

Gynecological health

Participants inferred that the Army crossed boundaries when they dictate fertility treatments and fail to consider the unique needs of the female body in training. For instance, Participant #19 shared that she was forced to switch the type of birth control she was on because the Army did not think her current one would have been effective while on deployment. She felt that this required change robbed her of the autonomy to make decisions for herself. Participant #10 shared that despite having had a gynecological-related procedure that required rest, she was sent back to duty the same day where she almost passed out. She stated, *"female body parts are not taken into consideration for recovery."* Participant #12 described having ovarian cysts during her deployment and having to "fly out" to another city for treatment. She remarked "*We didn't have any [female doctors]. There was no time unless you were fucking dying. Nobody cares about you bleeding from your vagina."*

Being pregnant and childbirth emerged as negative experiences for four of the 11 participants. Participant #11 was medically discharged from service due to complications from a cesarean section. Participant #9 shared that the inferior quality of medical care during childbirth almost ceased her life and that of her child. She explained how her providers missed blood incompatibility that could have killed her and/or her child. She said, *"the Army doctors don't care. The baby care was horrible."*

Two participants shared their experience of being shamed when it was discovered that they were carrying a child. Participant #9 who found out she was pregnant while being deployed

said she was shamed for it and had her deployment terminated. She further shared that she did not have access to proper medical treatment while she waited for her passage back to the U.S. Another participant shared that she found out about her pregnancy shortly after redeployment to the U.S. and overheard negative comments speculating on the timing of her conception. The same participant shared how she had to constantly utilize the regulations on pregnancy to prevent having to partake in duties that were contraindicated during pregnancy. She insinuated that the leadership dismissed her needs as a pregnant service member. Participant #9 expressed her sense of isolation from her unit when she was sent to complete physical training with other pregnant service members from outside her unit. Being part of the "*pregnancy PT (Physical Training)*" led her to feel like she was "*copping out.*" There appeared to be a lack of sensitivity to the needs of pregnant service members. This insensitivity continued post-pregnancy.

Discussions with participants revealed how male service members were clueless about birth recovery. Male colleagues were candid about their beliefs that it was unfair that females received six weeks (about one and a half months) of maternity leave while males only received two weeks of paternity leave. This disregard for rest and recuperation appeared to weigh heavily on participants. The pressure to return to duty truncated the maternity leave for Participant #6 who felt forced to return to duty sooner than she was ready. Upon returning to duty, participants found that there was no accommodation for new mothers. Participant #9 shared, *"You're [female] not getting extra breaks to go for breast milk. [Her unit] tells me to just figure it out [space to pump]. So here I am, breast pumping in the parking lot at work in the heat. And I am thinking this is pretty freaking whack."*

Double standards

The participants described instances of double standards across genders that they viewed as apparent within the Army. Participant #10 shared her frustration with gendered work expectations. She said, "*You start to get more and more disgusted by how we just have these really dated gendered norms that if it's a social function, give it to the female.*" Such statements inferred that organizing social functions was deemed a woman's job. This participant further noted how wives were allowed to visit their husbands at the offices, but it was considered 'improper' for her husband to visit her office for lunch. Participant #3 shared how being assertive was gendered. It was acceptable for men to be assertive but not women. She said, "*All men said I was assertive, which is true. I am assertive, but the problem with that is when people see that word when it comes to a woman, it's an alternative word for being a bitch."*

The impact of double standards was further shared by Participant #12. She tearfully described the impact of being bullied and treated harshly compared to the males in her unit,

> *They were just so cruel. There were days that I would sit in my car and cry for like an hour before I went into the building. I have zero self-worth. I thought about doing it [die by suicide] with pills. I definitely had a lot of suicidal ideations, and it will show such a shitty time in my life.*

Double standards were not reserved for male leaders but perpetuated by female leaders too. Participant #19 described female leaders as being harsher on female soldiers for dress code violations than male leaders. For instance, a female drill sergeant harassed Participant #19 for having hair falling out of her bun after male drill sergeants had inspected the line and not called out the participant. She further shared how her female leader did not stick up for her and the other soldiers,

She never stood up for us and that was just so hurtful, knowing she is a female and has been in our position. She just stood by and let it happen [being yelled at by male leaders], and…take their word for it.

Gendered assumptions

There appeared to be assumptions about the women's abilities and the effect women had on men. These assumptions were hurtful to participants. For instance, Participant #19 shared how she was tasked to lead her platoon on a running course to ensure they kept a slow pace. When she proudly shared that she was a good runner, she was put back in formation because she was running too fast. Participant #10 shared that when she was stateside and her husband was deployed in severe combat conditions, her leader assumed that she would be a burden to her male coworkers. She said, "*I was told to not be such a downer. If I needed to talk to anyone, make it the women in the department."* Participant #2 described a few incidents of being deployed and how that impacted male viewpoints since she was a medic. Her leadership made comments towards her saying "*I cannot have a female on my mission."* This participant also mentioned being blamed for things like their communication radios were not working (although she reiterated that had nothing to do with her role as the medic) or she said, "*I was basically told that it's not well liked to have a female on the boat, you know jinxing the mission."*

To combat assumptions that females were weak, participants felt the need to prove their worth or not appear weak which entailed over-exerting themselves physically that led to injuries. Participant #2 described how she would put all her "*battle rattle*" (referring to her rucksack and protective gear) and *"if I fall, I will never be able to get back up because it weighed more than I did. My husband's like 'I can help you' and I'm like I won't be seen being helped*." Not asking

for help to break the assumptions of being weak or dependent was also shared by Participant #12 who said,

> *I was already getting bullied at work and they [leadership] want [me] to go and get help. You know, going and getting help meant that you were trying to get out of shit. So, I got up and both my ankles gave out. But I ended up deploying and after many patrols had to have my boot cut to get my ankle out of it. That was dumbest fucking thing I have ever done in my life, because now I have permanent damage that will never go away and four surgeries on same ankle.*

Limited opportunities

Being a dual Army couple was seen as a disadvantage for participants when it came to being deployed. Because of the difficult or dangerous missions required in the Army, service members needed to establish a care plan that provided guardianship for their child(ren) in case of demise while on duty. Service members who cannot or are unwilling to sign off guardianship of their child(ren) to a family member can resign using the Family Care Plan Chapter. There were two participants who were up for deployment with their husbands. These couples chose not to burden their families which meant that one of them had to use the Family Care Plan Chapter. In both cases, it was the female service member who used the plan and sacrificed the opportunity of deployment. Another female discussed her position in psychological operations and how that impacted her decision in wanting a family. She mentioned how females were recycled out of the program, but males whose spouse's gave birth, were given compassionate recycles (go back to a different spot in program and continue as planned). This participant said she discussed this with her male counterparts on how it was a massive decision to either sacrifice her career she wanted

or have a family because of her age. She said the males responded with "*sucks to suck*" or "*that's what you get for being a woman*." This limits opportunities to be successful in this career.

Healthcare

Participants were vocal about the inferior quality of healthcare that they received while active duty and as a Veteran. Their disappointment spanned across both medical and mental healthcare. They concluded that providers were poorly trained but because of the lack of options and the cost of private healthcare, they had little choice but to utilize the Army's healthcare system. Sub-themes that emerged from the data included *poor medical care, challenges with mental health providers, invisibility at the VHA, and healthcare options*.

Poor medical care

All participants shared numerous health issues that were linked to their Army service. It was common for participants to incur injuries, but these led to chronic health issues that most participants were still dealing with as veterans. The overall inferior quality of healthcare and sexist attitudes of providers appeared to be a major deterrent for participants to seek healthcare for themselves. Participants' stories revolved around two main health areas: pain management and weight management.

Pain management. All participants described having at least one physical condition linked to their Army service. Of the 11 participants, eight (75%) experienced fractures, joint surgery, and/or early-onset arthritis. These injuries significantly altered participants' health from pre- to post-service. The main health complaint was the lack of proper pain management that participants attributed to their gender. Participant #10 believed that it was because she was

a female, they [healthcare professionals] don't [her] take pain seriously. Once I had a filling done and the dentist told me to raise my hand if it hurt...when I finally did, he told me to suck it up because it was only a minor filling.

In addition to the attitude of healthcare professionals, participants cited the long wait for an appointment as a barrier to seeking healthcare. For Participant #3, the wait prevented her from receiving much-needed care for pain management. Participant #3, who needed injectable pain medication to manage neck pain, shared that the long wait for an appointment affected her ability to receive timely medication. This delay meant having to endure the pain that led to increased anxiety levels.

Weight management. Seven out of 11 participants discussed weight-related challenges linked to their service in the Army. These participants were noted to utilize the term 'fat' to describe their weight. One of the major impacts of weight conditions was linked to self-esteem. Participant #3 shared that her low self-esteem *"stems from you know being called fat by my peers and my, you know, bosses."* She shared that being called 'fat' led to crash dieting and unhealthy eating patterns. Although the Army prides itself on being fit and ready for battle, some participants said that they struggled with the mindset. Participant #3 disclosed, *"I was in really good shape before the Army. [Then] I joined the Army, and everything just went to hell, and I haven't been able to recover [from] it…I joined the Army, got fat and out of shape*." Another participant was frustrated that her leadership was allowed to question her weight because her "*uniform looked too tight*" and he suggested she buy larger uniforms. Needing to "*look the part*" of a soldier appeared to negatively impact participants' self-esteem. Weight issues were cited as the antecedent of a plethora of other issues such as joint pain, diabetes, asthma, and fatigue.

Challenges with mental health providers

All the participants disclosed having been diagnosed with mental health illness such as posttraumatic stress disorder (PTSD), anxiety, and depression. Despite needing mental health treatment to manage symptoms of their illnesses, participants were not seeking the treatment they needed. The main reason cited was prior negative experiences with mental health professionals that led to participants' distrust and disillusionment of mental health services rendered by the Army. It appeared that even the mental health symptoms that would be considered severe were not treated with urgency. Participant #9 bravely admitted, "*I thought about drowning my kid, I knew I wouldn't, but they [mental health providers] did nothing about it. I begged to go inpatient for six months and they did nothing*." She described her child as difficult to handle because the child would use her trauma against her. Some participants cited the constant change in providers that negatively impacted their treatment as a reason for their disillusionment with services. Participant #2 said that her provider would change every few months and she would be retraumatized each time she had to retell her story to her new provider.

Difficulty in managing anxiety was a common issue that was shared by participants. Participant #3 labeled her anxiety "*crippling*," denoting a level of severity that prevented normal functioning. Participant #11 shared that her abilities to manage her anxiety symptoms had worsened to the point that she felt compelled to sign custody of her child over to her ex-partner. This same participant also admitted having a significant history of suicidal ideation. Participant #2 felt efforts to seek out mental health services were met with a nonchalant attitude. She stated,

> *I walked into the VA (Veteran s Affairs) with suicidal thoughts. She [mental health provider] asked me if I had suicidal thoughts and I said yes. She looked at me then just kept asking me questions. I didn't get an appointment until a month later.*

The reluctance to seek treatment for mental health was also related to how providers would prescribe psychotropic liberally and as the first option. In one instance, the side effects of the medication were worse than the illness itself. According to Participant #10, her provider even remarked "*of course first action is to dope you up.*" Participant #3 shared a time when she was advised by her provider to take an anxiety medication that would also help with pain and sleep, but instead she gained 50 pounds and not all the other benefits noted by the provider. She shared that "*it took like a year to wean off of it [the prescribed medication] ...like I went to the hospital twice because I was having withdrawals like what heroin addicts go through. So, I was like I'm never doing medication again.*" Another participant was pressured into taking medication for symptom management for mental health reasons.

The need for mental health services was not only needed for mental health illnesses but personal struggles such as sense of self, especially post-deployment. Changes in their units or transitioning out of the Army was a major milestone for several participants for whom joining the Army was to a part of something bigger or belonging to a group. The Army gave them a role that gave them a purpose in life. When their skills were not fully utilized post-deployment, many participants lost hope as they struggled with their identity. Participant #3 shared,

> *I really struggled for the first six months when I got back because I wasn't doing anything, I wasn't using my mind. I wasn't contributing, I just felt like I was existing... [after being] put to work in a corner. I would rather poke my fucking eyes out."*

The double standards noted in an earlier theme also emerged in stories about post-deployment. Participant #3 whose husband was also a service member saw the differences in how he was treated compared to her post-deployment. She said, *"I just like nosedived, and he got to do all these cool things, and I am like what am I doing with my life*." Participants' struggle

with their sense of self was made more difficult when they reflected on how much was asked of them by the Army. For example, Participant #3 shared, "*the Army will take every ounce of effort and will...[that] you're willing to give up.*" She further shared that she had to fight to "retain my identity" as a soldier and for her that meant standing up to leadership and refusing to be overworked in positions that did not utilize her skill set.

Questioning one's sense of self was a common theme when participants shared life changes after transitioning out of the Army. Many struggled to have an identity outside of the Army. Participant #12 disclosed her distress over retirement/exit briefs when leaving the Army. She upsettingly stated,

> *They [Army installation workers] tell you there is a 75% chance you will commit suicide within the first 12 months and to prepare for that. They're telling people that there's a likelihood that you will off [kill] yourself because you don't know how to reintegrate into regular society. Transition is like a shitshow.*

Participants said multiple times that the Army appeared to believe that breaking soldiers down helped with creating stronger minds. But Participant #19 felt that the Army may change soldiers but in a way that takes away a person's authenticity. She said, "*the military breaks you down to build you back up, but NOT in a way that you feel like yourself anymore*." Participants further shared that the idea of not being told what their role was anymore made it difficult for them to understand what their role was anymore. It was like the Army had indoctrinated a sense of dependency so much so that participants felt lost when they transitioned out of the Army. Many of the participants felt like they did not understand themselves and questioned their sanity. Participant #9 felt that she had no "*real transferrable skills*" when she exited the Army. As Participant #12 was transitioning out of Army alongside an Air Force service member, she was

asked why she chose to serve in the Army "*because they [Air Force] never smelled [burnt] flesh and they question 'What the fuck are we doing here?'. You still question your insanity and is this what I look for [being traumatized]?"*

Participant #14 questioned her not knowing herself "*Am I just crazy? Am I just being dramatic?*" There appeared to be confusion in having lost a deeply meaningful identity and not having a clear process to rediscover themselves as they transitioned out of the Army. Participant #9 summed it up,

> *You're trying to figure out what kind of person you're supposed to be after [transitioning out of the Army]; you think it's going to be easy to make decisions on your own, but you don't know what the hell you are doing.*

Not a single participant spoke of seeking help from the Army as they grappled with identity issues. Their disillusionment with the system led them to struggle alone in silence.

Invisibility at the VHA

When visiting the VHA, participants felt invisible. They were often assumed to be spouses or employees over being a Veteran that for participants, perpetuated the gendered and masculinized mindset of the Army. Despite having had females service members for some time, participants felt invisible when they visited the VHA. So not only were participants getting poor medical care from their providers, but they were also disregarded and made to feel like frauds at the VHA. To garner attention and receive a proper reception from the staff, participants noted that it was necessary for them to 'dress the part' and even so that did not always work. Participant #10 stated, "*So I wear something that says like 'military women' or 'not every GI is a Joe' and 'retired U.S. Army and woman Veteran', and I'll still get questioned*" about her identity.

Participant #9 echoed a similar sentiment and said, "*I've got to explain that female Veterans exist. That's the one thing I had a person say, 'You can't be a Veteran, you're a girl.' I'm like well here's my ID.*" The disappointment of having to prove one's identity after putting one's life on the line was summed up by participant #? who said, "*It's absolutely ridiculous that you have to treat yourself out like a pony on parade and hope that they [VHA staff] will actually notice what you're wearing to not denigrate [yourself].*"

Healthcare options

One of the biggest hurdles for participants was knowing what healthcare resources and options were available to them as Veterans. They expressed concerns over not being well-informed and updated on healthcare resources, the roles within the healthcare system, and how and where to seek the help they needed. This was especially poignant given the lack of providers. Participant #3 shared, "*There's just not enough mental health counselors that people are waiting months to be seen and I'm like the problem is that in those months bad things happen."* Participant #18 said that she was not denied services, but the long waits were disheartening. She said, "T*here were different times when I tried to book something, and they had nothing available. So, I was like, forget it, I'm not gonna wait months for an appointment*." Another participant said that her request for a referral to another physician and one that was more qualified [to handle complex health conditions], was denied. The participant also conveyed that service members were indoctrinated to be dependent on the Army such that they felt lost when guidance was not available. Many participants shared that it was a daunting task to start the search process that they gave up even trying. Participant #3 said, "*I don't even know what's out there. I know it's such a lame excuse...but at the end of the day, I'm tired. I don't wanna look it up like unless it's*

handed to me." Participant #12 also reiterated the same notion and said, *"We didn't know our benefits and we didn't know we could go get help, like nobody tells you any of that"*.

Ironically, when participants do utilize VHA services, they have been harassed by family members who accuse them of taking advantage of the government system. Participant #19 shared that she was repeatedly harassed by family members who accused her and her spouse as being "*government moochers*" because they were getting money from the government for disabilities incurred while in active duty. This participant also noted that although they had negative experiences with VHA, they had too many medical conditions to be able to afford private or alternative healthcare. Participant #19 explained, "*Just because it's [VHA] free healthcare, does not mean it's good healthcare."* The dependency on Army healthcare benefits appeared to limit participants' other options. Participant #2 said that she chose to continue her term with the Army so she could access healthcare over retiring and seeking Social Security disability benefits for injuries occurred during active duty. This meant sacrificing her health over financial stability. The need for accessible quality healthcare was a theme that resounded across most of the participants and the lack of options due to the cost of healthcare in general meant tolerating what the VHA had to offer.

Lack of Support Systems

Participants had poor support systems which included family and friends/colleagues. The lack of understanding of family members and the lack of available female service members of the same rank made it a challenge to form solid social networks. The two sub-themes that emerged from the data were *family support, and friends and colleagues.*

Family support

Family members, even those who were Veterans themselves, were not as supportive as they could be because of their lack of knowing the female's experience in the Army and generational gaps in war experience. Participant #3 became tearful when explaining her need to withhold from her father how horrible she had been treated in the Army because of her gender. She further explained that she withheld to protect his idea that the Army was a glamorized career and if he knew of her hardship, he would have wanted her to quit.

Fear of being made to feel responsible for any hardship experienced in the Army was another deterrent for participants to share with family members. Participant #19 felt that discussing some of the trauma with family would only be met with "*well, that's your own fault because you knew what you were signing up for."* Many participants did not share their Army experiences with family because of the lack of acknowledgement of their service and feelings of being dismissed. Participant #2 divulged that her family had called her a "*glorified girl scout*" and "*at least you got a husband from it."* She said that despite all the incredible experiences she had in the Army, her marriage to her partner [whom she met while in the Army] was the only outcome from being in the Army her family cared about.

Participants whose spouse was also service members (i.e., more than half of participants) often found themselves sacrificing for the family. Participant #2 who discussed the strain of having children during deployments and how she and her spouse would take turns staying home to care for their children transitioned out of the Army. Interestingly, her quitting was issued as an involuntary separation from the Army due to parenthood that robbed her of years of service. She explained that ending her Army career was purposeful to maintain family stability, but it was handled quite differently by the Army. Four participants disclosed that their service member spouse had health issues that needed attention. For Participant #2, this meant "*we have to take*

turns being the strong one", to be well enough to care for their children. However, for Participant #19, she was "*in competition with [her] spouse over who is worse*" because being 'more ill' was the only way she was allowed to have reduced household responsibilities.

Friends and colleagues

All the participants shared that their social networks were disrupted by the Army lifestyle. It was noted that the regulations of Army culture impacted participants' ability to form social networks. The Army's rule that forbade enlisted personnel to associate at same level as officers made it difficult for female officers who were few in numbers to develop solid social networks. Participant #3, an officer, shared that she had to go out of her way after duty to *"create better friendships with other women who serve, because we're a small minority serving population—being an officer, your pool gets smaller.*" This was particularly poignant because men could organically form friendships with other men at their rant at work because of the sheer availability of peers.

Not only did enlistment status impact the ability to gain social support, but it was also difficult to have friends of the opposite gender due to skewed perceptions and assumptions of mixed gendered friendships. Several participants discussed the hardships of trying to have male friends. For example, Participant #2 stated,

> *I was once told that having male friends makes me look bad by a Non-commissioned officer (NCO) [upper enlisted soldiers] because people would talk about how they slept with me when they didn't and things like that. And I'm like, how do I not have male friends when I'm like, one of a handful of females.*

Such cautionary advice meant that participants were limited to socializing with other female service members that reduced their overall poll of friends.

Chapter 5 - Discussion

This study aims to understand female Army Veterans' experiences that influence their decision to seek or not to seek health services from the Veterans Health Administration (VHA). The themes that emerged from the data can be understood using the Vulnerability, Stress, and Adaptation (VSA; Karney & Bradbury, 1995) model. These themes highlight female service members' vulnerabilities and stressors and ways in which they adapted to cope with these stresses.

Vulnerabilities

Female service members' main vulnerability was their gender. There are multiple aspects of being female that make these service members vulnerable. The first aspect is the higher susceptibility of being sexually harassment in a pre-dominantly male environment. A military study found that people in work situations atypical for their gender were more likely to be harassed (Fitzgerald et al., 1999). Given that there are more males than females in the military, female service members are undoubtedly at risk of being sexually assaulted and harassed.

Female service members' inherent anatomy makes them vulnerable to the physical demands of their job. These demands may outweigh the capacity of the female anatomy. Determined to prove their worth, female service members endure the physical strain of training and refrain from accepting and/or seeking help. The male-dominated environment may put pressure on female service members to over-extend themselves physically that could lead to injuries. Multiple inherent factors may contribute to injuries such as female's low bone mass

(Evans et al., 2008), early onset of fatigue when working at a higher relative intensity (Epstein et al., 2013), and the need to compensate for inferior upper body strength (Ling et al., 2004).

The gynecological issues that come with being female is another vulnerability for female service members. The need to bounce back from childbirth can put female service members at risk for injury. Because pregnancy causes weight gain, stretch/split abdominal muscles, increased laicity in joints, pelvic organ (urethra, vagina, anus) movement, and hormone fluctuations, it takes at least a year to recover physically and emotionally from pregnancy (Wray, 2011). Because of the Army's brief recovery timeframe, females feel pressured to recover faster than their body can. This contributes to feelings of having no control of their own body. Further, since core muscles are impacted during pregnancy and childbirth, it can take up to two years or more for those specific areas to recover (Laing, 2015). Not healing fully puts new mothers in a precarious situation for further health complications and injuries.

Stressful Events

Personal vulnerabilities can predispose individuals to interpret and experience an event as stressful (Karney & Bradbury, 1995). The findings from this study highlights how the masculinized Army system stresses female service members on multiple levels. It is unlikely that male counterparts would interpret the same Army system to be as stressful. The masculinization of the Army contributes to the chronicity of sexism throughout the Army and that compromises the safety and well-being of female service members. The stress from sexual assaults and harassment is exacerbated when the VHA healthcare system fails to provide much needed services to assist in the healing process. The lack of support from family, friends and colleagues further exacerbates suffering.

Female service members are not only vulnerable to sexual assault and harassment, but silently endure the violence against them. Reports made are seldom dealt with satisfactorily that makes acting futile. A survey completed to study violence risk factors showed that almost 4.57% of the female soldiers reported sexual violence perpetration within the first 36 months (about 3 years) of service (Bernecker, et. al., 2018) and this is only from the soldiers who were surveyed. The stress here is twofold – being physically and psychologically harmed and not getting any legal recourse.

The findings suggest that sexism is prevalent in double standards that favor males and hinder females, gendered assumptions that disadvantage females, and limited opportunities for female service members. Sexist attitudes can influence the exhibition of the sexual double standard. People's attitudes towards men and women affect whether they endorse the sexual double standard and the mechanisms that perpetuate the sexual double standard partially stem from people's general views of traditional gender roles (Zaikman & Marks, 2014). The Army's endorsement of sexist attitudes is stressful for female service members.

The inferior quality of medical and mental health care available to female service members further add to their stress. The lack of knowledge of and sensitivity to the needs of the female body appears to be a major concern that serves as a barrier in seeking healthcare for female service members. Restrictive gender norms in healthcare systems related to masculinity are linked to behavioral risks (e.g., substance use, suicide, and injury) and delayed health seeking (Hay et al, 2019). Gender inequalities in health persist with little response from health systems, which is not surprising because our models of health systems do not guide us to consider or address gender inequalities (Hay, et al, 2019). This widespread inferior healthcare in the VHA system where staff are dismissive of our female service members and providers are lacking

essential training to meet the unique needs of the female body needs attention. Inefficient healthcare systems are barriers to overall well-being.

Another major stressor is the lack of family and other social support. Female service members appear to not receive the accolades for their role in the Army their male counterparts do. There appears to be a downplay of the importance of female service members and a lack of understanding of the stresses they face that is not always the case for their male counterparts. The lack of female representation in the Army makes it a challenge to form friendships and social networks with other female service members that could lead to isolation and exacerbate stress. The lack of support systems can create a vicious cycle where stressful events challenge the capacity to adapt, which then contributes to the perpetuation or worsening of those events, which in turn further challenges and perhaps overwhelm a person's capacity to adapt (Karney & Bradbury, 1995).

(Mal)Adaptation

Female service members' adaptation processes veer on the side of maladaptive coping strategies. Personal vulnerabilities can affect the capacity to adapt under high levels of stress (Karney & Bradbury, 1995). In this study, the inherent vulnerabilities of being female appears to inform the use of maladaptive processes to cope with stressors related to functioning in a male-dominated environment. Thus, these service members cope with Army-related stressors by minimizing symptoms and enduring pain and suffering in silence. They have given up on the justice system that has failed to protect and provide retribution for crimes committed by their perpetrators. The decision to not report incidents of assault and harassment is motivated by the need for self-preservation, to avoid being called out and shamed by fellow service members. The need to toe the line, to adhere, to ignore, pretend and not cause any ripples are reasons for their

silence. This docility can be considered a form of assimilation. Assimilating with the rest of the troop allows service members to blend in and not be seen. The U.S. Training command claims that assimilating soldiers into the Army is of critical importance to build of group cohesion (Burroughs & Ruth, 2022). Assimilation involves rejecting a minority status in favor of that of the majority, and can include passing, the masking of a true social identity and the appearance of moving into a new group (Tajfel, 1981). This process of assimilation is akin to denying the core of the self and attempting to assume the identity of the dominant group. If this is expected by service members while serving in the Army, it is not surprising that they struggle with their sense of self after transitioning out of the Army.

Female service members adapt to a system that dismisses them by playing up their rank and position. They adorn their complete ensemble of Veteran memorabilia at healthcare appointments. This strategy is adaptive if the process allows them to feel pride and dignity but maladaptive if it robs service members of their autonomy and authenticity. Poor adaptation may allow stressful events to perpetuate or worsen whereas adequate adaptation may help to alleviate them (Karney & Bradbury, 1995). Another strategy that could serve as either an adaptation or maladaptation depending on the circumstances is the decision to transition out of the Army. This strategy is an option that female service members use to maintain family stability that can be considered an adaptation, but it is a maladaptation if it is a forced choice.

The interplay between the vulnerability of being female and the stressors of Army life that are predicated on masculinity is complex. The capacity to adapt and solve problems under elevated levels of stress is informed by personal, internal vulnerabilities. What appears to be adaptive at the moment may not in fact be maladaptive in the long run. The need to survive appears to be the antecedent for the maladaptive processes used by female service members.

Limitations

The following limitations need to be considered when interpreting the findings of the study. The differences in racial background between the researcher and participants may have impacted the willingness of non-white participants to fully disclose the negative aspects of their experiences. This could lead to downplaying or omitting events that may have impacted results. Although a few of the participants were known to the researcher, it was observed that one participant omitted a few incidents known to the researcher. This observation could be related to racial differences, the assumption that the researcher already knew the information, or not realizing the significance of the incident.

Another limitation of the study was not considering predisposition factors which may have implications on the findings. Only one participant disclosed that her deployment triggered childhood abuse that she did realize was unresolved. Participants were not asked to disclose events that occurred prior to Army service that may have been retriggered during their service. This omission could potentially impact perceptions or adaptations during their service. Last, while the role of qualitative studies is not to generalize the findings, a larger and more diverse participant group that included more than Army Veterans would have allowed comparisons of themes across groups.

Clinical Implications

The clinical implications of this study focus on what providers can do to better serve the needs of female service members. There is an acute need for providers to be socio and culturally attuned to Army life especially the unique experiences of female service members. It is also essential to know how the Army culture conditions females to minimize symptoms and remain silent. Apprehension in reporting or disclosing abuses and atrocities experienced as a service

member is common. Providers need to thread this topic sensitively and provide ample space and time for service members to develop trust in the therapeutic relationship. Utilizing trauma-informed treatments is essential when working with the female service members. It is important to provide a space for empowering individuals in their environment. Such empowerment should include focusing on developing self-advocacy skills and the ability to decipher the appropriate time and place for activism and assuming more adaptive coping.

Providers should conceptualize service members' experiences by integrating the various cultural identities of the client and how they intersect with the context of working in a male-dominated environment. This framework would allow providers to gain a systemic view of clients' presenting issue that in turn could help destigmatize clients' struggles and provide context to situate their experience. This process facilitates externalization and potential development of systemic interventions.

It would be important for providers to be aware of the indoctrination of Army assimilation and the challenges this poses to service members after transitioning out of the Army. Reversing assimilation which entails losing oneself to a group, can be difficult if not impossible for some. Preparing service members for their transition out of the Army should entail a process of acculturating back to civilian life to help facilitate the discovering or reinventing one's sense of self.

Last, providers need to prepare to work with Army-related trauma through coursework and specialized clinical training. Further, providers need to explore their own reactions to working with Army personnel, be aware of their own values regarding military culture, and how it could impact the therapeutic alliance with clients. This development of the self of the therapist is a vital part of becoming an effective therapist. For example, providers who may have strong

negative reactions toward masculinized systems may need to resolve personal issues that may interfere with their ability to be present, patient, and compassionate towards clients who struggle with modifying maladaptive coping, self-advocacy and/or transitioning out of the Army.

Further Research

The findings of this study have implications for further research. It would be beneficial to extend this study to include other branches of the military such as the Air Force, Marines etc. Because customs, cultures and traditions vary across branches, it may shed light on other factors that serve as barriers to seeking healthcare for female service members. Information obtained could be valuable for healthcare systems like the Veterans Affairs that serve all branches of the military.

Obtaining a more diverse sample of participants is recommended for future research. Including a more racially and ethnically diverse group would enhance our sociocultural understanding of female military populations. Research should also include service members of all ranks. Since separation of officer and enlisted personnel is an important aspect of Army regulations, comparing these two groups can further inform clinical practice. It would also be advantageous to use civilian interviewers in future qualitative research. While heuristic inquiry has its benefits, a civilian's perspective may reveal aspects of military life that military-connected personnel ignore or take for granted.

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Appendix A - Interview Questions

Introduction: The purpose of this interview is to get a better understanding of your experience in the military, how your service has affected your health, family, and social life, and the utilization of services offered by the military.

Military experience

1. Could you please describe your military service?
    a. What were the best parts and most challenging parts of your service?
2. Who have you shared the best parts of your military service with?
    a. How did you decide with whom to share your best experiences with?
3. Who have you shared the challenging parts of your military service with? Were any of them health/mental health care providers?
    a. How did you decide with whom to share your challenging experiences with?
    b. How was sharing these experiences helpful or not helpful? Was it what you expected?
4. What other experiences have you had in the military that would be important for me to know?

Health-related issues

5. Has your service with the military affected your physical health?
    a. If so, how?
6. Has your service with the military affected your mental health?
    a. If so, how?
7. What health resources did you access for your physical health?
    a. How helpful or useful were these resources?
    b. Were you ever denied health services? If yes, can you elaborate?
8. What health resources did you access for your mental health?
    a. How helpful or useful were these resources?
    b. Were you ever denied mental health services? If yes, can you elaborate?
9. What current health services do you utilize following military service?
10. What if anything, prevents you from utilizing military services for physical or mental health?
    a. Probe for availability, accessibility, convenience, and affordability.

11. What other health-related experiences have you had in the military that would be important for me to know?

Family support

12. Has your service with the military affected your family relationships (e.g., significant other, family of origin, children)?
    a. If so, how?
13. What family-related resources did you utilize in the military?
    a. How helpful or useful were these resources?
    b. What family-related support have you found helpful following military service?
14. What if anything, prevents you from utilizing family-related services offered by the military?
15. What other family related experiences would be important for me to know?

Social support

16. Has your service with the military affected your friendships?
    a. If so, how?
17. How would you describe the social support that you received from the military?
    a. How helpful or useful were this social support?
    b. What military-related social support have you found helpful following military service?
18. What if anything, prevents you from remaining connected to other service members or veterans?
19. What other social experiences would be important for me to know about?