An Exploration of Mental Health Help-Seeking Experiences among Women Combat Veterans

by

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Abstract

This phenomenological study explores the lived experiences of women combat veterans and their mental health help-seeking experiences. Semi-structured interviews were completed with ten women combat veterans. Using a hermeneutic phenomenological approach, the research sought to understand the phenomena of mental health help-seeking in women who served in combat. Seven themes and one subtheme captured the essence of the phenomena, which were explored through the following questions: "*What are the lived experiences of women combat veterans? Also, how have these experiences influenced mental health utilization?"* These themes are: 1) Sense of Purpose, 2) Gender Stereotypes and Harassment, 3) Proving Oneself and Earning Respect, 4) Isolation, Subtheme 4a) Sacrifice: Work/Life Balance, 5) The Price of War: Enduring, Unfinished Business, Nostalgia, and Closure, 6) Mental Health Help-Seeking in the Military: Stigma and Risks**,** and 7) Competent Care, Access to Care, and Continuity of Care. Implications for counselors, counselor educators/supervisors, as well as the relevance of research findings are discussed.

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List of Abbreviations

AG	Assistant Gunner
C-RAM	Counter Rocket, Artillery, and Mortar (detection system)
DOD	Department of Defense
EOD	Explosive Ordnance
FOB	Forward Operating Base
GAD	Generalized Anxiety Disorder
IDF	Indirect Fire
IED	Improvised Explosive Device
MASCAL	Mass Casualties
MDD	Major Depressive Disorder
MFLC	Military Family Life Counselor
MST	Military Sexual Trauma
PTSD	Posttraumatic Stress Disorder
SHARP	Sexual Harassment/Assault Response and Prevention
TTP	Tactics, Techniques, and Procedures
VA	Veteran's Administration
VBIED	Vehicle-Borne Improvised Explosive Device
VHA	Veteran's Health Administration
WCV	Women Combat Veterans

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Chapter 1: Introduction and Literature Review

Introduction

Women are increasingly joining the ranks of military service, with a projected growth of 18% by 2040 (Miller & Ghadiali, 2020). Despite this growth, men still make up the largest portion of those in military service, and thus are the ones more prominently addressed in research (Boros & Erolin, 2021). In 2020, women comprised 17.3% of personnel serving on Active Duty and 21.2% serving in the Guard and Reserves (Department of Defense [DOD], 2020). As women's military service has increased, this has opened doors for a wide range of roles (Kehle-Forbes et al., 2017; Zinzow et al., 2007), which include women not just serving in supporting roles, but also on the front lines or in combat operations (Boros & Erolin 2021; Koblinsky et al., 2017). In 2020, the DOD reported 399,608 women serving, up from 370,085 in 2017. Moreover, while the *overall* number of veterans is declining, the number of *women* veterans is increasing. The US Census Bureau (2020) reported the number of women veterans as high as 1.7 million having served in the military. This accounts for 9% of all veterans. With this growth, research suggests a link between military service and mental health problems (Taylor et al., 2020).

Each year, an increasing number of veterans are suffering from mental illness. Ganz et al. (2021) argue mental health concerns of veterans are higher than ever "with epidemic levels of suicide, posttraumatic disorder (PTSD), traumatic brain injuries (TBI), and other mental health related injuries" (p.1). Additionally, there is empirical evidence supporting the increased risk of

mental health issues among service members exposed to combat (Welsh et al., 2019). Many veterans are struggling with reconciling the atrocities of war and the traumas incurred during military service (Ganz et al., 2021; Khan et al., 2019). Numerous studies have found service members continue to suffer from mental illness far beyond their service in the military (Boros & Erolin, 2021; Kehle et al., 2017; Koblinsky et al., 2017; McCaslin et al., 2021; Zinzow et al., 2007). While in recent years, researchers have become interested in more studies that include women veterans (Taylor et al., 2017; Welsh et al., 2019), most of the work in this area has focused on male service members or male veterans. Limited attention is paid to the emerging data about one of the fastest growing minorities: the women combat veteran.

There is ample evidence discussing the mental health needs of women combat veterans. Among these mental health issues are depression, suicide ideation, PTSD, and TBI (Miller & Ghadiali, 2015; Welsh et al., 2019). Women veterans also suffer from Military Sexual Trauma (MST), sleep disturbances, eating disorders, and substance use disorder (Boros & Erolin, 2021). In addition, research shows women veterans have higher rates of PTSD and suicide than their civilian women counterparts (Khan et al., 2019; Zinzow et al., 2007). When left unaddressed, mental health issues can cause serious threats to quality of life, affecting multiple domains of functioning in areas such as employment, relationships with friends and loved ones, comorbid conditions both physical and psychological, homelessness, and threat to life (Boros & Erolin, 2021; Koblinsky et al., 2017).

Furthermore, less is known about the lived experiences of women combat veterans which may contribute to barriers as it pertains to mental health services utilization. Research indicates there are women veterans who may benefit from mental health care, yet they often do not seek out these services (Williston et al., 2020). While some of the literature addresses barriers (e.g.,

Strong et al., 2018; Taylor et al., 2020), this topic is often not the focus of the research. In addition, most of the research on mental health service utilization is specific to veteran health care settings (Kehle-Forbes et al., 2017; Koblinsky et al., 2017; Miller & Ghadiali, 2015). Hence, to better serve this growing population, it is crucial to explore barriers which may prevent women veterans from seeking mental health care. As such, this study explored the lived experiences of women combat veterans and sought to better understand barriers which may have prevented women combat veterans from seeking mental health care.

Operational Terms

For the purposes of use with this research study, the following terms have been operationally defined:

Veteran – (also referred to as "vets") a veteran is any person who served honorably on active duty in the armed forces (National Geographic Society, 2022)

Combat Veteran – combat veterans are individuals who serviced in a conflict zone while serving in the armed forces (Gang, n.d.)

Veteran Health Administration (VHA) - America's largest integrated healthcare system, providing care to 9 million enrolled Veterans each year (Veteran Health Administration, 2022)

Post-Traumatic Stress Disorder (PTSD) - a mental disorder that may develop after exposure to life-threatening or another traumatic event (American Psychiatric Association, 2013).

Military Sexual Trauma (MST)– refers to sexual assault and/or sexual harassment experienced during military service (Monteith et al., 2021)

Comrade – Merriam-Webster (2022) defines comrade as fellow Soldier

Statement of the Problem

There is research suggesting women combat veteran mental health needs may be unique (Adams et al., 2021; Carlson et al., 2013; Koblinsky et al., 2017). As the number of women combat veterans continue to increase, there is a plethora of data affirming a growing concern for their mental health. While the literature describes a host of factors associated with women veterans' need for mental health care (William et al., 2018), few studies explore their unique lived experiences, which may potentially impact help-seeking and subsequent service utilization. Understanding the experiences of women combat veterans may shed light on barriers to mental health utilization to better address this growing population's mental health needs.

Purpose of the Study

The purpose of this research study was to better understand the lived experiences of women combat veterans who had engaged in mental health services utilization. Researching the lived experiences of women combat veterans may shed light on barriers to mental health help-seeking in this population. Understanding these experiences may better inform counselors and other helping professionals on how to best serve this population and overcome existing barriers to mental health treatment.

Research Question

This study investigated the following guiding and supporting research questions: What are the lived experiences of women combat veterans who have engaged in mental health services? Additionally, how have these experiences influenced their utilization of mental health services?

Literature Review

In 2015, the Defense Secretary at the Pentagon overturned a long-standing rule which originally prohibited women from serving in certain military occupational specialties and combat roles. While women serving alongside men during deployments is not new, this change would open doors for an unprecedented number of women serving in direct combat roles. Given the increasing number of women combat veterans, there is a growing interest in understanding mental healthcare needs to better serve this population (Koblinsky et al., 2016, Taylor et al., 2020; Welsh et al., 2019).

To date, several studies have found evidence that suggests military stressors and involvement in combat deployments negatively impact mental health (e.g., Koblinsky et al., 2017; Taylor et al., 2020; Varga et al., 2018; Welsh et al., 2019). Yet because the U.S. Military is historically a male-dominated institution, previous studies predominantly centered around the male veteran or male combat veteran. As more women joined the ranks of the military, researchers began conducting studies that included both genders (e.g., Taylor et al., 2020; Welsh et al., 2019). Although some researchers focused their studies exclusively on women veteran participants (Boros & Erolin, 2021; Kehle-Forbes et al., 2017; Strong et al., 2017), these studies may not have differentiated their findings between those who served in combat. Despite these nuanced differences in research methodologies, these previous studies set the stage for the growing number of studies addressing the concerns for veteran mental health, including women combat veterans. The literature which follows identifies key concerns in mental health for military veterans. Due to the prevalence of mental health in veterans, this literature review includes an overview of veteran mental health, as well as mental health concerns which are of concern to women veterans, and more notably, the population researched in this study, the

women combat veteran. In addition, this review includes studies that describe factors influencing mental health service utilization for this population.

Mental Health Concerns

Only in recent years has the research on veterans focused more on women combat veterans' mental health (e.g., Creech et al., 2016; Koblinsky et al., 2017; Smith et al., 2020). One major mental health concern for veterans is PTSD (Creech et al., 2016; Washington et al., 2013). In the DSM-5, PTSD is characterized by exposure to a traumatic event (American Psychiatric Association, 2013). The National Institute of Mental Health (NIH) states factors that may increase the risk for PTSD can include living through dangerous events, getting hurt, seeing someone get hurt, seeing a dead body, feeling horror-helplessness or extreme fear, and having little to no social support after the event (n.d); all of which can occur as a result of combat exposure. For women in particular, exposure to combat can often lead to military trauma and other poor mental health outcomes. Military stressors (outside of sexual harassment and sexual assault) can include being wounded or injured, witnessing killings or injury, seeing injured or dead bodies, killing in combat, and perceived threat to life (Khan et al., 2019).

Given that many military veterans may be exposed to potentially traumatic events during combat, it is imperative to understand its prevalence. Statistics from the Veterans Affairs (VA, n.d.) report PTSD diagnosis rates for combat veterans as follows: Vietnam: 15% (or 15 out of every 100); Gulf War/Desert-Storm: 12% or (12 out of every 100); and Operations Iraqi Freedom (Iraq)/Enduring Freedom (Afghanistan): 11-20% (11 to 20 out of 100). Conflicts such as the Vietnam and Korean wars, including recent wars in the Middle East, can have devastating and long-term negative effects on veterans (Taylor et al., 2020). "Within Veteran's Administration (VA) primary care clinic samples, 45% of women veterans screened positive for

at least 1 psychiatric disorder," with PTSD being the highest at 30.9% (Miller & Ghadiali, 2020, p. 93). Similarly, researchers found the risk for PSTD and depression to be greater for women who experienced harassment in a combat environment (Creech et al., 2016; Stanton et al., 2022).

Yet other studies, such as Welsh et al. (2019), have yielded mixed results regarding gender differences in psychological distress such as PTSD. With respect to PTSD, some studies have yielded conflicting findings regarding gender differences. It is therefore prudent to acknowledge this dichotomy in previous research findings. For example, Welsh et al. (2019) identified three studies with contradictory findings with respect to PSTD rates: one cohort study showed women with higher rates, VA-based research showed higher percentages for men, with a meta-analysis showing no differences in gender. However, more recent studies (Adams et al., 2021; Levahot et al., 2018) have cited women veterans as being at greater risk and higher prevalence for PTSD and other mental health problems. Nevertheless, when compared to Vietnam-era women vets, Iraq and Afghanistan veterans were found to experience higher combat exposure and subsequent PTSD symptoms, which impacted their relationships (Creech et al., 2016). Ganz et al. (2021) argued because PTSD is often comorbid, early help-seeking and intervention is crucial to recovery.

In 2023, the Veterans Affairs (VA) National Center for PTSD named women as the fastest growing group of Veterans. Many women in the military have deployed in support of combat operations. In addition, the military has lifted previous restrictions of women serving in combat roles. As seen with previous conflicts, many war veterans return home with mental health challenges. Similarly, some of the stressor's women experience while deployed can place them at risk for PTSD and other serious conditions. Although women are not always trained for combat, they have engaged in combat missions in Iraq and Afghanistan which has exposed them

to direct and indirect fire, enemy threat, and loss of life (VA, 2023). Koblinsky et al. (2017) argued a considerable number of women veterans report mental health conditions related to their time in war. Coupled with other stressors such as exposure to sexual harassment and/or sexual trauma, feelings of isolation, and separation from family, these women are grappling with the negative effects on their mental health (VA, 2023). Yet so few women combat veterans prioritize their mental health needs.

As mentioned previously in the literature, so few women combat veterans seek treatment for mental health concerns. This is problematic because it is not just PTSD that women combat veterans struggle with. A recent study on Vietnam-era women veterans showed that in addition to PTSD, a majority of the participants struggled with Major Depressive Disorder (MDD) and/or Generalized Anxiety Disorder (GAD) due to wartime stress and sexual discrimination and harassment (Smith et al., 2020). Another major study conducted with women combat veterans from multi-war eras showed over 67.1% screened positive for depression, 38% for anxiety, 43% for sexual assault while in the military, and 40% for alcohol use/abuse (Washington et al., 2013).

Many women veterans struggle with Military Sexual Trauma (MST). Simply put, MST is sexual assault and/or sexual harassment experienced during military service. Although not a diagnosis or mental health condition, MST may cause many difficulties for individuals. In 2007, Zinzow et al. reported female veterans were more likely than males to experience sexual assault and high exposure to sexual harassment. Thomas et al. (2018) posit MST is understudied and underreported by women veterans; yet rates are estimated between 20-40%. There is ample research supporting the association of sexual harassment and PTSD in both women veterans who have experienced combat and those who served without seeing combat (e.g., Ceroni et al., 2022; Montieth et al., 2021; National Center for Posttraumatic Stress Disorder, 2016). More recently,

the Veteran's Health Administration (VHA) asserted that of 5.25 million veterans screened, at least 30% of women had screened positive for MST (VA, 2020). This is problematic because as a form of trauma, MST can negatively impact relationships, result in strong emotions or feelings of numbness, present difficulties in attention, concentration, memories, and sleep, and result in problems with health, drugs and/or alcohol (VA, 2021). Unfortunately, because women in the military are still a minority when compared to males, gender harassment and sexual harassment are common experiences (Demers, 2013). Many women veterans are left disenfranchised as they experience emotional and/or sexual abuse in the military (Burkhart & Hogan, 2013). When sexual assault and sexual harassment happens in a combat zone, the lasting effects of the trauma can be devastating. A study by Goldstein et al. (2017) surveyed 403 female veterans and found 90% reported having military trauma exposure. An important finding of this study was that sexual harassment and perceived life threat showed to strongly predict PTSD severity in women veterans. This research supports an earlier study by Carlson et al. (2013) which found the intersectionality of MST and combat exposure as having a negative impact on women veterans' mental health. It is not without stating, sexual harassment can have serious repercussions on the mental health of women veterans, with one of the worst being suicide and suicide ideation among women veterans (Khan et al., 2019). Yet few women seek treatment after sexual assault and even fewer report the event for fear of reprisal. In January 2023, a bill introduced by Congress aimed to reform how the military handles and prosecutes sexual assault cases in the military. Defense Secretary Lloyd Austin, who is a retired General and the Former Vice Chief of Staff of the U.S. Army, supported the act known as the Military Justice Improvement and Increasing Prevention Act of 2021. During an interview on June 23, 2021, Defense Secretary Austin had this to say: "We will work with Congress to amend the Uniform Code of Military

Justice, removing the prosecution of sexual assaults and related crimes from the military chain of command" (Jacobs, 2021). Two years after it had been introduced, it did not pass in Congress (GovTrack.us, 2023).

Nonetheless, the lasting effects of trauma (such as those who experienced sexual trauma and combat exposure) not only lead to suicide ideation but also another fundamental problem: homelessness. Koblinsky et al., (2017) argue not only do women return from combat suffering from PTSD, TBI, and MST, but in addition "[women] veterans are the fasting growing segment of the homeless veteran population" (p.122). Research indicates women veteran homelessness often stems from trauma exposure or substance use during service, as well as post-military mental health (Hamilton et al., 2011; Washington et al., 2010). Further, a systematic review by Tsai and Rosenhack (2015) showed both male and female veterans who struggled with substance use and mental illness were at increased risk for homelessness. This study, which included research spanning two decades, supports one reason why not addressing mental health can be problematic. In addition to suicidality, homelessness, addiction, and comorbidity, the research supports other consequences of mental health being left untreated. These include a lifetime of disability, incarceration, loss of employment, poor family relationships, domestic violence, and other social consequences (Ingelse & Messecar, 2016; Stecker et al., 2013). Moreover, for women veterans suffering from PTSD as a result of sexual trauma, negative impacts on overall health are exacerbated as they may experience "chronic pain, pelvic pain, menstrual problems, chronic fatigue, headaches, and gastrointestinal symptoms" (Kintzle et al., 2015, p. 395). Given the widespread presence of mental health concerns and their impact on women combat veterans, it is prudent to address stigma and potential barriers to mental health care access which may influence help-seeking in this population.

Mental Health Stigma

Undoubtedly, a considerable amount of research supports the growing need for mental health utilization among veterans. Yet as previously mentioned, research suggests veterans do not seek out care for their mental health. One major barrier to mental health seeking noted in the literature is stigma. Barriers to mental health often can include an individual's beliefs about mental illness and treatment as well as fear of being stigmatized by others (Vogt et al., 2014). These beliefs can include concern about stigma from loved ones, concern about stigma in the workplace, negative beliefs about mental illness, and negative beliefs about mental health treatment and/or treatment seeking. Many veterans refrain from seeking out care due to stigma associated with mental illness (Ingelse & Messecar, 2016; Strong et al., 2017). Stigma can be broken down into two categories: internalized stigma and external stigma. While these terms seem to slightly differ among the research, internalized stigma is often referred to as self-stigma, with externalized stigma coming from views or perceptions of how society may look upon an individual seeking mental health. Previous work by Pattyn et al. (2014) defined social (or public) stigma as "discrimination and devaluation by others," while self-stigma is defined as the "internalization of negative stereotypes about people who seek help" (p. 236). Despite minor differences in the literature, the consensus suggests stigma can often cause veterans to hesitate in seeking out help for their mental health conditions (Ganz et al., 2021; Ingelse & Messecar, 2016; Koblinsky et al., 2017; Pattyn et al., 2014; Strong et al., 2017).

Perspectives on Military Culture

To gain a better understanding of mental health stigma in the military, it is important to begin by examining the literature on how military culture may contribute or reinforce mental health barriers such as stigma. Many researchers agree that the military is a distinct subculture in

society (Boros & Erolin, 2021; Coll et al., 2011). Influences of military culture often include placing the needs of the unit or team members before oneself as well as showing emotional restraint (Coll et al., 2011, McCaslin et al., 2021). Service members often adopt a set of military values, beliefs, and behaviors as part of their acculturation to the military. Take for example the U.S. Army where newly recruited service members are taught about Army Values. These values include Loyalty, Duty, Respect, Selfless Service, Honor, Integrity, and Personal Courage – which make up the acronym LDRSHIP (or leadership). These values tend to be ingrained in military personnel as early as their first week of training as a Soldier. Ganz et al. (2021) posit three of these values (selfless service, honor, and personal courage) send messages of placing others first, facing fears and strong moral codes. Another influence in military culture is that of an adopted Warrior Ethos. This Warrior Ethos reads: "I will always place the mission first, I will never quit, I will never accept defeat, I will never leave a fallen comrade" ("Warrior Ethos," 2011, first paragraph). These messages, combined with the invisibility of mental illness, serve as a mask for soldiers as they may "inhibit an individual's willingness to engage in [counseling] (i.e., help-seeking behaviors)" (Ganz et al., 2021, p. 1). Simply stated, the service member adopts a mentality whereas quitting or appearing weak is not an option. A fellow service member, often referred to as a comrade, is not to be left behind. While for some, this is interpreted as teamwork, for others, it sends a message of putting others before self. Many of these widely accepted aspects of military culture may present a dichotomy to help-seeking for some service members in that they adopt a behavior of toughing it out (Ganz et al., 2021).

Furthermore, Ganz et al. (2021) found "military culture does not tend to foster an environment that is conducive to seeking mental health services" (p. 9). Additional research suggests despite the military's attempts to de-stigmatize mental illness, service members are

reluctant to seek out mental health services because of fear of losing their job, being separated from the military, denied promotion, losing a security clearance, or being accused of using mental illness as a way to avoid military duties (Boros & Erolin, 2021; Coll et al., 2011). With military culture contributing to internalized stigma, many veterans often seek out to solve their own problems. Kaplan (2019) posits many service members are "likely to perceive stigma and anticipate negative outcomes for seeking care, including career harm" (para. 5).

For women in particular, acculturation into the military takes on added layers as exposure to a male-dominated military places women in the minority status of a hypermasculine military culture (Strong et al., 2018; Williams et al., 2018). Garcia et al. (2014) theorized traditional gender norms and/or stoic beliefs in association with help-seeking may be applicable to both men and women combat veterans. Men in the military are often told to 'suck it up or stop being sissies.' "Failures to 'tough it out' and 'push through'…are often associated with personal failure, weakness, and therefore vulnerability, which can result in devastating psychosocial trauma for the individual (Dabovich et al., 2019, as cited in Ganz et al., 2019, p. 2). For many women in the military subscribing to this culture of toxic masculinity, many may mask their psychological trauma to avoid being seen as weak. "Historically, soldiering has been constructed as a male pursuit, leaving females in the position of having to determine what strategies to use and actions to take to be accepted as women soldiers" (Demers, 2013, p. 494). Hence, it is not uncommon for women to conform to male standards to blend in or mirror their male counterparts (Boros & Erolin, 2021; Demers, 2013). Supporting the idea of conforming to self-reliance and stoicism, Garcia et al. (2014) noted women combat veterans' help-seeking may be influenced by these same norms.

In addition, despite more women serving in combat roles, they are often subject to gender-specific stereotypes as society downplays their role in the military. As a result, many women are left to grapple with mental illness consequences as they internalize these stereotypes which contribute to their reluctance to seek mental help. Women internalize these attitudes which then contributes to a women's feelings of stigma about their own mental health needs and help-seeking mindset, thus decreasing opportunities for help seeking (Ingelse & Messecar, 2016; Strong et al., 2018). A study conducted by Thomas et al. (2018) found women veterans faced concerns about gender bias as well as issues concerning respect and recognition which negatively impacted mental health seeking. Consequently, Tkachuk et al. (2021) argue "behaviors congruent with military values in civilian settings may limit treatment access and facilitate disconnect between civilian providers and veterans" (p. 2). Much of the barriers which exist exclusively in private practice or community settings is not well known, but given the complexities of military culture, culturally sensitive care from civilian providers is crucial in working with this population (Koblinsky et al., 2017; Tkachuck et al., 2021).

Mental Health Barriers

Research exploring barriers to mental health utilization with women combat veteran populations is scarce. Until recently, much of the knowledge gained on combat veteran mental health and mental health utilization has been largely conducted with male combat veterans in mind. Fewer studies focused on women veterans, with even less exclusively with women combat veterans. However, existing literature hosts major concerns for veterans who have served in combat. Factors which may affect help-seeking for combat veterans, regardless of gender, can include prevalence of mental health disorders, knowledge of disorders and resources, barriers which inhibit access to resources, motivation to seek help, and the types of resources available

(Taylor et al., 2020). A growing body of research supports the need for gender sensitive care (Kintzle et al., 2015; Koblinsky et al., 2017; Miller & Ghadiali, 2015). In homogenous studies with women combat veterans, barriers stressed in the literature include stigma, gender-sensitive care, and re-traumatization (Koblinsky et al., 2017; Miller & Ghadiali, 2015). Additional barriers can include previous experiences in the military, the ability to recognize mental health warnings, and knowledge of resources (Koblinsky et al., 2017). Some studies which included mixed cohorts consisting of women veteran's both with and without combat service have also identified barriers to care such as gender specific stereotypes (such as downplaying women's role in combat (Strong et al., 2013), fear of losing security clearances, fear of separation from service, fear of being seen as weak (Boros & Erolin, 2021), and lack of trust in providers (Kehle-Forbes et al., 2017). A mixed-gender study by Garcia et al. (2014) found logistical barriers (e.g., childcare and transportation) and attitudes toward psychotherapy as perceived treatment barriers. Moreover, a previous study by Stecker et al. (2013) also named similar barriers such as "concerns about treatment, emotional readiness for treatment, stigma, and logistical issues" (p. 281). Few studies listed a comprehensive list of barriers, however, McCaslin et al. (2021) cited financial, occupational, and other obligations in civilian life as barriers. It is important to note that while the latter two studies involved both male and women combat veterans, these barriers remain salient in both populations.

A growing body of research supports the need for gender sensitive care (Kintzle et al., 2015; Koblinsky et al., 2017; Miller & Ghadiali, 2015). Barriers can stem from a history of sexual trauma or PTSD combined with "predominantly male-dominated environments at VHA" (Kehle-Forbes et al., 2017, p. 4). These male-dominated environments can be unwelcoming or can sometimes be triggers for women, especially those who have experienced sexual assault by

another member of the military. For women who have had negative and/or traumatic experiences while serving, these unwanted behaviors may bear significant weight on their decision to utilize (or not to utilize) mental health services (Kehle-Forbes et al., 2017), especially at VHA locations.

Summary

The literature reviewed presented the mental health issues faced by women combat veterans. While some of the literature addresses barriers to mental health utilization, scholars are just beginning to focus their attention on this population. In addition, because much of the research has been conducted in VHA settings, barriers to mental health seeking named may not represent an exhaustive list nor apply to seeking outside the VHA. Additionally, because much of the previous research relied on surveys from quantitative studies, conducting a study specifically with the women combat veteran population utilizing qualitative methods could greatly inform the existing research. In this chapter, gaps and areas for further research are presented. Chapter two presents the prevalence of the current study and the variables this study sought to address. Chapter two also describes the methods and procedures utilized for the study, which includes descriptions of the participants, measures, procedures, and data analysis. Descriptive information and inclusion criteria are also described.

Chapter 2: Methodology

Description and Rationale of a Qualitative Design

This research study explored the lived experiences of women combat veterans' utilization of mental health services. The aim of the study was to identify barriers to mental health which influenced mental health service utilization among women combat veterans. There is a growing body of literature stating the mental health needs of this population are unique (Burkhart & Hogan, 2015; Ingelse & Messecar, 2016; Villagran et al., 2015). Yet little is understood about why so few seek mental health services, especially after departing the service. Given the rising numbers of women serving in combat, it is imperative helping professionals and service organizations understand the lived experiences of women in combat to best serve them. Utilizing a qualitative research design and methodology, this study investigated the following guiding and supporting research questions: What are the lived experiences of women combat veterans who engaged in mental health services? Additionally, how have these experiences influenced their utilization of mental health services?

A qualitative design lends itself because it focuses on the lived experience and seeks to interpret participants' viewpoints (Tracy, 2020). In this study, the viewpoint was that of female combat veterans and their experience with mental health services. Many research studies corresponding to the experiences of veterans and their use of mental health services has primarily focused on males or mixed gender studies (Ganz et al., 2021; McCaslin et al., 2021; Welsh et al., 2019). A qualitative design was specifically fitting for this study because it allowed the researcher to focus on an individual meaning which is oftentimes complex in social or human problems (Creswell & Creswell, 2018). For women combat veterans, this complexity may be seen in their lived experiences as members of a male-dominated institution such as the military.

Previous qualitative studies on mental health services utilization included only VHA settings or mixed gender studies (Adams et al., 2021; Ahearn et al., 2015; Kehle-Forbes et al., 2017), with very few focusing on mental health utilization during transition (Koblinsky et al., 2017). As such, this research employed a qualitative methods design, more specifically phenomenological research, to capture the essence of the lived experiences of individuals in this study (Bloomberg & Volpe, 2019; Creswell & Creswell, 2018). In this chapter, the researcher discusses research methods which include research design, data collection techniques, information on sample/informants, as well as their role as the researcher.

Phenomenology

Phenomenological study in qualitative research seeks to explore and understand the lived experiences of individuals as they describe it (Bhattacharya, 2018). However, oftentimes individuals describe their experiences in the form of opinions or perceptions (Peoples, 2021). Because phenomenology is concerned with raw experience, the researcher needs to be careful to be overly concerned with meaning making. To avoid this faux pas, the researchers sought to understand and richly describe the phenomena as it relates to the participants' discussion of their lived experiences and/or the feelings surrounding lived experiences (People, 2021; Tracy, 2020). The researcher accomplished this by guiding their participants through a process of in-depth inquiry by which the essence of a phenomenon of their lived experience was better understood (Bhattacharya, 2018; Tracy, 2020).

Hermeneutic Phenomenology

Rooted in the philosophical perspectives of Martin Heidegger (1889-1976), hermeneutic phenomenology recognizes the human experience is one that is always embedded in research, both for the participant and the researcher (Bloomberg & Volpe, 2019). In hermeneutic

phenomenology, the researcher's presuppositions are a valuable guide to the research and its interpretation. Heidegger believed because we cannot separate ourselves from the world, it is impossible to bracket our experiences (Peoples, 2021). It was therefore imperative to engage in self-reflexivity. Tracy (2020) described self-reflexivity as a process whereby the researcher is aware of his/her background and its' influence on the research. This is particularly important because researchers can often share demographics or a similar background to that of the target audience. In this study specifically, the researcher shared the identities of female and combat veterans, as well as having the experienced transitioning from military service to civilian life. The researcher recognized that as the instrument of the research, there may have been some guiding assumptions. Throughout the study, the researcher engaged in self-reflexivity to challenge their values, life experiences and beliefs as they engaged in data collection and subsequent data analysis.

Research Paradigm

Paradigms are ways of viewing knowledge and reality and can differ based on the researcher's ontology, epistemology, and axiology (Creswell & Creswell, 2018). The lens of the researcher was that of an interpretive point of view where one true reality does not exist, yet the ontology or nature of reality lies in one that is socially constructed. The ontology that the researcher asserted is that women combat veteran's lived experiences are diverse and better understanding these, may shed light on mental health service utilization. The researcher was aware that the nature of knowledge is subjective and co-created. During this study, the researcher understood the lived experiences of the population in this study may too have been subjective and co-created through the nature the interaction between researcher and participant. Because the epistemological nature of an interpretive paradigm is value-laden, the goal and focus of the

research was kept in mind as one which sought to understand and was subjective in nature, which fell in line with hermeneutical studies (Bhattacharya, 2017; Creswell & Creswell, 2018). Consistent with guidance set forth in Creswell and Creswell (2018) on axiology, the researcher was clear that while a high number of women combat veterans experience mental health challenges, this is not true for all. Likewise, not all women veterans who transitioned out of the military experience difficulties. It was therefore important to recognize the lived experiences and mental health utilization differed for these women. Lastly, consistent with interpretive paradigm, a good researcher is aware of their biases, subjectivities, and judgments and makes them explicit by writing them (Creswell & Creswell, 2018; Peoples, 2021). The researcher engaged in journaling during this process to minimize bias and "focus on the meaning participants held about the problem" (Creswell & Creswell, 2018, p. 182).

Procedures

Participants

The inclusion criteria for participants in this study were (a) women, (b) ages 21-70 years of age, (c) who had served in the U.S. Military for a period no less than 3 years, (d) had deployed at least once to a combat area of operation(s), (e) had been diagnosed with a mental illness (such as PTSD, Depression) or experienced other mental health related issues (such as MST, suicide ideation), and (f) were presently living in the U.S. Additionally, because military health benefits and access to care post-military is often contingent upon having received an honorable discharge from service, those who have a dishonorable or other than honorable service were excluded from this study. Creswell and Creswell (2018) stated the number of participants in a phenomenological study need not be large and typically ranges from 3-10. For phenomenological studies with an average research time of less than 8 months, Bhattacharya

(2017) recommends 5-7 participants to increase time for in depth inquiry and deep analysis. Previous qualitative studies addressing women veteran mental health have yielded between 4 and 10 participants (Boros & Erolin, 2021; Ingelse & Messecar, 2016). However, in qualitative studies, the sample size is less important than reaching saturation (Peoples, 2021; Tracy, 2020). The goal for this study was to recruit between 6-8 participants, keeping in mind flexibility to allow the data to reach a point of saturation (no new data can be obtained). A total of 10 participants were included in this study.

Participant Recruitment

This qualitative research study involved purposeful sampling which best fit the parameters of the study (Tracy, 2020). The researcher used various recruitment methods. For this research study, both convenience sampling and snowball sampling were used. Convenience sampling began at universities in Alabama and Georgia where students would fit the criteria, such as through university veteran centers. The researcher contacted Veteran Service Organizations (i.e., VFW, USO, Student Veteran Offices and DAV) and distributed recruitment flyers and study information in person and via email. Convenience sampling was particularly effective in reaching prior service women combat veterans who are enrolled in post-secondary education programs. Additionally, the researcher posted study information to social media platforms such as Facebook and LinkedIn, and veteran service organizations and groups which were women combat veterans or women veteran focused. Women veterans shared with others who met the criteria which facilitated snowball sampling. Snowball sampling is where researchers identify participants who fit the study and will ask them to share with other potential participants. Tracy (2020) posits snowball samplings can help the researcher access difficult to

reach or hidden populations. Snowball sampling proved particularly useful for reaching women combat veterans through word of mouth and sharing study information on social media.

In addition, the researcher distributed the flyer and study information via professional counseling organization listservs such as the Alabama Counseling Association as these included counselors, counselor educators and counseling supervisors who shared the information with potential participants. Recruitment began upon approval of this study through an Auburn University Institutional Review Board for research with the Human Subjects process.

Upon recruitment, participants were required to read an information letter in lieu of informed consent (Appendix A). Potential participants would be required to acknowledge an understanding of study parameters and choose to consent electronically prior to beginning the study. The information letter described the purpose of the study and outlined potential risks and benefits associated with the study, a statement on compensation, measures to protect confidentiality, and participant rights.

Data Collection

Previous qualitative phenomenological research about women veterans conducted using semi-structured interviews informed this study design (Ahearn et al., 2015; Boros & Erolin, 2021; Ingelse & Messecar, 2016; Taylor et al., 2020). Consistent with previous studies, the researcher conducted semi-structured interviews to allow for flexible questioning and probing (Tracy, 2020). Within phenomenological research, the research process aimed at gathering rich data and therefore should consider a combination of instrumentation (Peoples, 2021). For this study, the researcher utilized (a) a Qualtrics demographic survey which included screening criteria, (b) in depth semi-structured interviews conducted virtually, (c) Zoom platform to audio record interviews, (d) Zoom transcription of audio recorded interviews, and (e) journaling.

The interview protocol consisted of 21 semi-structured open-ended questions (Appendix E). Some of the questions included were: Have you ever been diagnosed with a mental health disorder? In which type of settings have you received counseling? What were these experiences like for you? How were they the same/different? Have you experienced any barriers to seeking counseling? The researcher also remained flexible and asked follow up questions. According to Battacharya (2018) and Peoples (2021), it is good practice for dissertation students to be flexible and change interview questions as appropriate or have some follow-up questions for additional probing. The researcher allowed for a natural flow of discussion and some of the questions were addressed organically. To engage the essence of the phenomenon, the researcher maintained a focus on the experience vs. feelings. The interviews lasted 90 minutes except for two interviews reaching 120 minutes. This allowed the researcher to implement richness in the in-depth interview and for the participants to share rich data. The interview was recorded as this afforded the opportunity for the researcher to listen to the interview as many times as needed during data analysis. Oftentimes, audio recordings include transcripts which can be helpful as well, however, Bhattacharya (2018) stresses checking transcriptions for accuracy. The researcher found it beneficial to utilize the audio recording while checking transcripts for accuracy. Because researchers are encouraged to journal about their "thoughts, hunches, emotions, [and] connections…to existing literature" while transcribing (Bhattacharya, 2018, p. 131), the researcher engaged in writing notes and memo to journal transposition throughout the study.

Data collection began with the completion of informed consent. Participants completed an online Qualtrics demographic survey which will include screening criteria (Appendix D). The study survey was accessed by participants anonymously through either the QR code or the survey link. The average completion time was about 5 minutes. Participants who met the

screening criteria were sent directly to an external link in Calendly, where they could schedule their one-on-one interview with the researcher. By setting up an external scheduling link, the researcher was able to add an extra layer of security so that the anonymous surveys and Zoom interviews would remain separate from each other. Prior to the interview, the researcher reviewed the information letter with participants before beginning the in-depth semi-structured interview. The semi-structured interview took place utilizing a Zoom platform to facilitate both video and audio interview recording.

To protect participant identities, all participant video recordings were deleted from the Zoom platform and Zoom cloud upon completion of all interviews. In addition, the researcher also deleted video recordings previously saved to a password-protected folder after verifying the integrity of audio recordings and transcripts. Audio recordings and transcripts were kept separate in password-protected folders and saved with an alpha-numeric descriptor. Zoom links were password protected with a waiting room enabled for additional security. Information stored on the researcher's laptop was password protected to add an additional layer of security. Lastly, participants were given the option to be de-identified or use a pseudonym of their choosing for subsequent research documents and manuscripts.

Data Analysis

Creswell and Creswell (2018) recommend a five-step process for data analysis which involves: (a) organizing the data, (b) reading the data, (c) coding the data, (d) generating descriptions and themes, and (e) representing the description and themes. The researcher organized the data by downloading recordings and transcripts upon completion of interviews. The transcripts were checked for accuracy through a process whereby the researcher listened to the audio recording. All transcripts were then uploaded to MAXQDA for organization. Data

which was transcribed incorrectly was corrected. Additionally, the researcher created a spreadsheet to account for the demographic data of the participants. Next, the researcher re-read the data to get a sense of what the participants meant. Through the interviews and after, the researcher engaged in notetaking and journaling. When manually coding the data, the researcher organized and highlighted codes phrases in MAXQDA. A second round of coding involved a separate spreadsheet listing potential categories and themes as well as the addition of in-vivo coding. The researcher used Tesch's Eight Steps in the Coding Process checklist to guide the coding process (Creswell & Creswell, 2017). A fourth step involved assigning themes according to the information provided. These themes are supported by direct quotes from the participants to validate such themes. The researcher remained flexible in how she represented the themes and descriptions. To minimize and challenge potential researcher bias, the themes and codes were sent to two reviewers for feedback. This resulted in condensing themes from ten down to seven themes and recategorizing one theme to a subtheme.

In this phenomenological data analysis, the goal was to illuminate the lived experiences to present the essence of the themes (Peoples, 2021). The researcher was able to carefully identify experiences vs. feelings associated with events. Analyzing data was emergent and inductive. The researcher delineated hermeneutic data analysis steps through journaling to address biases and projection of meaning. By engaging in inductive analysis, the researcher remained open to a method where one can "learn as you go" by keeping an open mind about what may arise from the research (Saldana, 2021).

Reliability and Validity

Reliability and Validity address threats to qualitative rigor (People, 2021). To ensure qualitative rigor as a sole researcher study, the researcher journaled to address researcher bias

and adopt rich descriptions of participants' lived experiences. This included transparency in identifying how the researcher's past experiences may have shaped interpretations (Creswell & Creswell, 2018). The researcher entered the study with the assumption that mental health needs of women combat veterans are unique. This assumption was challenged through reflexivity and further peer feedback and debriefing. Further, throughout the interviews, the participants were asked to give examples of their experience to minimize the researcher's assumptions. Thus, the journaling process was an extremely important contribution to the study's reliability and validity since the researcher shared multiple identities with the participants as well as similar lived experiences. Shared identities between researcher and participants include being woman and having served in multiple combat deployments. In addition, the researcher had similar experiences to the participants which were relatable (e.g. held leadership positions, having experienced or witnessed harassment, feeling a sense of pride, and struggles with isolation and/or non-sexual harassment). Journaling included the researcher's own processing of meaning making and how they received the data. The journaling process also included thoughts about how the information presented is different or similar to that of the existing literature and their own experiences.

Additionally, guided by Tracy's (2020) Eight "big tent" framework, the researcher examined these criteria against my research conducted before, during and after the study. The Eight 'big tent' framework enhances research quality by providing researchers with a framework for qualitative rigor. These eight areas include: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethical and meaningful coherence (Tracy, 2020). While it is not mandatory for all criteria to be met, addressing those that were can significantly strengthen the quality of research. Thus, the researcher has engaged in the exploration of worthy topics and

ethical considerations when planning and as the research study has been conducted. In considering the worthiness of the topic, the researcher has engaged in conducting a review of the literature during separate periods of time throughout the last two years. Not only has the researcher found the topic relevant but also timely given the nature of the growing population to be addressed in the study. Taking into consideration ethical concerns, the researcher has engaged in relevant training in preparation for submitting the IRB and research practice as well as considered resources for participants who may experience emotional distress because of the interview. Another ethical consideration has been the voluntary nature of the research study with no penalty for withdrawal.

During the process of data analysis, the researcher utilized a hermeneutic theoretical framework. Throughout the interview process, the researcher used hermeneutic phenomenology by engaging in use of the hermeneutic circle. Peoples (2021) describes the use of the hermeneutic circle as one in which the researcher engages in the process of journaling and follow-up interviews to review experiences and challenge assumptions and interpretations of a phenomenon. The researcher engaged in journaling during and after the interviews. Although the researcher did not conduct follow up interviews, participants were asked to clarify, explain, and provide examples to minimize researcher assumptions, given the background of the researcher and shared identities with the participants. That is, being a woman who has served in combat. Lastly, Creswell and Creswell (2018) posit using multiple validity procedures can strengthen research. In addition to the strategies above, the researcher integrated peer debriefing to assist in the interpretation of data.

Summary

In this chapter, the description and rationale of the study's qualitative design as hermeneutic phenomenology, the research paradigm, procedures, including participants, participant recruitment, data collection, data analysis, reliability, and validity of the study are presented. Chapter three presents the study findings.

Chapter 3: Findings

"There's a lot of room for exploration of counseling with combat veterans, the advances that women have made and being accepted into combat roles. But it is laughable when congress and the military were reevaluating allowing women in combat…myself and female battle buddies were going out on the road every day on combat missions. We're like what do you mean you're reevaluating? We are here. We're doing the job." Tina, Participant

"I've lost multiple Soldiers…I never cried…because I am a leader, and I am supposed to be strong, and I am supposed to have it together. You can't show any type of wavering, because that trickle down into formation. Yeah, it's a lot. It's a lot to bear." Lily, Participant

"At the end of the day, we don't want to feel like we're a burden on anybody else…or that it's exhausting to deal with us." Teagan, Participant

The purpose of this qualitative research study was to explore the experiences of mental health help-seeking among women combat veterans. The study sought to better understand the lived experiences of women veterans who had served in the military and deployed to combat, as

well as how some of these experiences factor into their mental health help-seeking behaviors. The following research questions guided the exploration of this phenomenon: What are the lived experiences of women combat veterans who have engaged in mental health services? Additionally, how have these experiences influenced their utilization of mental health services?

In this chapter, I present the key findings of the research study. Using a 22-question semi-structured interview protocol, individual interviews were conducted with ten women combat veterans, all which had completed their military service, received an honorable discharge, and lived in the United States. The women in this study were asked to select pseudonyms prior to beginning the interview process. A general overview of the demographic population for this study can be found in Table 1 below:

Table 1

Participant Demographics 1

	Age	Race/ Ethnicity	Military Rank Type	Length of Service	Deployment locations	Do you have a service connected disability?
Participant 1	40	White	Enlisted	16-20 years	Iraq Afghanistan	Yes, for physically related conditions only
Participant 2	33	Asian	Officer	6-10 years	Iraq	Yes, for both physically and mentally-related conditions
Participant 3	40	I prefer not to answer	Enlisted	6-10 years	Iraq	No
Participant 4	41	White	Enlisted	16-20 years	Afghanistan	Yes, for both physically and mentally-

						related conditions
Participant 5	51	White	Officer	More than 20 years	Iraq Afghanistan	Yes, for both physically and mentally-related conditions
Participant 6	38	White	Officer	6-10 years	Iraq Afghanistan	Yes, for both physically and mentally-related conditions
Participant 7	24	Asian	Enlisted	3-5 years	Iraq	Yes, for both physically and mentally-related conditions
Participant 8	42	Two or more races: Not Hispanic	Officer	More than 20 years	Iraq Afghanistan	Yes, for both physically and mentally-related conditions
Participant 9	39	Hispanic or Latino	Enlisted	11-15 years	Iraq Afghanistan	Yes, for both physically and mentally-related conditions
Participant 10	33	White	Officer	11-15 years	Afghanistan	Yes, for both physically and mentally-related conditions

*All participants were female, served in the US Army, and received an honorable discharge

Discussion of Themes

The interviews lasted 1.5 hours each and were conducted virtually utilizing the Zoom video platform. The length of the interviews and the nature of using open-ended questions allowed for the researcher to engage participants in deep and thick descriptions of their experiences from which themes were gathered. The data captured the phenomenon of what it is

like to be a women veteran who have served in combat. The findings of this study provide insight into how these lived experience tie into mental health utilization of these women combat veterans. Closely following Tesch's eight steps for data analysis: the researcher followed a step-by-step process which included: familiarization with the data by reading transcripts and revisiting audio recordings, generating initial codes, generating themes, condensing themes, and revisiting themes. Themes were also modified as a result of a peer review process. This resulted in final themes chosen to represent the lived experiences discussed during interviews. All data was manually coded in MAXQDA software for organization of documents. Subsequently, interview documents were printed to facilitate themes revision. The findings from this study are represented and described by seven themes and one subtheme. The themes helped capture the essence of the phenomena: *What are the lived experienced of women combat veterans? Also, how have these experiences influenced mental health utilization?* These themes are: 1) Sense of Purpose, 2) Gender Stereotypes and Harassment, 3) Proving Oneself and Earning Respect, 4) Isolation, Subtheme, 4a) Sacrifice: Work/Life Balance, 5) The Price of War: Enduring, Unfinished Business, Nostalgia, and Closure, 6) Mental Health Help-Seeking in the Military: Stigma and Risks**,** and 7) Competent Care, Access to Care, and Continuity of Care.

These themes are further discussed in detail below:

Theme 1: Sense of Purpose

The participants interviewed shared their reasons behind joining military service. A sense of purpose seemed to stand out the most. This sense of purpose resonated in some participants desiring to serve something bigger than themselves and others looking for direction. Some of the women interviewed expressed a desire to serve, stemming from a history of family in the

military. One participant, Jay, was fourth generation military, while others had fathers and grandfathers serve as was the case for Shar, Nille, and Amber.

Teagan stated the following when sharing about her grandpa who served:

> You know, you should surely serve something larger than yourself. There are good people around the world that deserve a person to stand up for them.

Barb, another participant, had very few memories of her dad. Her desire to serve was influenced by him nonetheless:

> My father passed away when I was 7 months old, so I never really knew him. What I do know is that he volunteered for Vietnam. He dropped out of high school when he was 17, and volunteered and served about 5 years, and so I just knew that would be some connection to him that I could have, and I knew he'd be proud of me for it.

For some of the other participants, a sense of purpose stemmed from looking for direction in life. Lily worked as a waitress in a restaurant before joining and had this to say:

> I worked with a lady. I was, you know, 18 or so, and she was probably in her mid-40s. And I just remember thinking I needed to start making better choices, or she was my future…even at that age I had the wits to say I don't want her future to be my future, and I need to make some kind of change…She was really great lady, but I was at a crossroads where you have to make a decision. I have to do something, and this is not it for the rest of my life. I didn't see anything positive coming out of my current situation, so I needed to make a change in the military.

Tina, who also found herself looking for direction, talks about one day she gets a cold call from a recruiter and falling in love with Army:

> I just kind of thought he was a telemarketer…he's got all this information about school and how the GI Bill is going to pay for it while you're in the service. So, the plan was that I was gonna go in for 4 years. Get some experience, maybe a little bit more discipline, because I wasn't the greatest student in the world, you know. I wanted to get a little more discipline. And then once I get out, go to college, and see where life takes me from there. Instead, I fell in love with the service; fell in love with my job. I ended up staying for 20 years instead of just 4.

All participants communicated a sense of pride for their time in service, with none of the participants expressing remorse or regret over having served.

Theme 2: Gender Stereotypes and Harassment

Many of the women shared having experienced sexual harassment and/or sexual assault. Additionally, the women interviewed discussed common stereotypes attributed to women in the military. During the interviews, the women shared their strategies for coping with gender stereotypes and harassment. These coping mechanisms included sarcasm, fighting back with similar comments or profanities ("dishing it back out"), trying to blend in, and dismissing harassment as part of the job.

Gender stereotypes involved labeling and naming of women who were perceived as unapproachable or not willing to sleep around with their fellow male service members. These names oftentimes included b***ch, dyke, or prude. Similarly, women who were too friendly or who were seen around males – even if they were the only female on the team – were seen as willing to 'put out' or engage in promiscuous and/or sexual behaviors. Here is what some of the participants responded with when asked *what was it like to serve as a female in a male-dominated institution?*

Amber candidly spoke about this same dichotomous label that is placed on women:

> In the Army, you are with labeled a wh*re because you sleep around…or you're a b****, or you're like a prude, you know? So, it's like you are always walking the thin line of how am I going to be labeled? How are people seeing me because they tell you perception is reality in the Army, and it really is. Someone perceives you as doing something, even though you are totally innocent, you have done a single thing. If they see you as that person, that's who you are, which is really disheartening, because on the male side, it is not like that at all.

Tiffany sounded frustrated and very matter-of-fact stated:

> You either have to be screwing somebody, or you know just that whole stereotype. Yeah, you're either a dyke or a whore, one of the two. You're not anything in between.

Similarly, Shar shared:

> You know in the Army they say you're either a b**** or a slut, well I was the b****.

Barb was deployed when she learned one of her fellow female battle buddies had been sexually assaulted:

> You have no idea what to do…it's like oh, I have to protect myself here as well, not just from the enemy, but from someone who wears the same uniform as me. We wear the same flag on our shoulders. That inherent trust you think comes with being in the military, like that's my battle buddy. Everyone's my battle buddy. But as females we have to analyze that level of trust that we put into someone and stay alert even when we do go on deployment.

Tina spoke about her experience with sexual harassment from officers who held more rank than her. One incident resulted in her deciding to file a restricted report is one where the incidents(s) and perpetrators get reported but the victim can remain anonymous.

> A couple were flirty and expressed wanting to have a sexual relationship even though I was married…There was one that I worked with for years. He was always very flirty, and I always turned him down. I would say, you know that is inappropriate and we are not going to do this. It got to the point that he was harassing me so much I had to take it up with my commander. I told him I filed a restricted report but did not identify to him who the perpetrator was. He [the commander] kept pushing and pushing about needing to know the details of what when on. I eventually gave him the report and he read everything and nitpicked at how I handled it. He then victim blames me for not being able to shut the soldier down more effectively.

Lily recalled a time early in her career when she was just 19 and a sergeant tried to take advantage of her:

> I was a private first class at the time and one of the sergeants had made a copy of my physical fitness test records so that she could white out my name and use it as her own. I didn't know what to do so I reported it to one of the other sergeants. He tells me to put my number on this piece of paper and I will take care of it. Well, this m****f****** starts calling me. He starts driving by my house. He says, "I know you weren't at work; I saw your car during lunch. I never gave him my address so he must have looked it up. I was so scared, and I thought I did something wrong, and I don't understand this sh**. This went on for weeks and I finally told one of the female sergeants. Thinking back to

that it's like I'm an f****** kid. I don't understand any of this s***. He has the power, he's in a position of authority.

Jay shared about two separate incidents where she experienced unwanted/unwelcome touching:

> Somebody walked behind me and rubbed the nape of my neck. A bunch of my buddies and I had just returned from deployment. I thought it was one of them. I stood up and had my fist clenched because I was going to punch one of these guys. Well, it was my commander, and he walked by, and just smiled and waved at me in front of everybody. I was so embarrassed, and the negative attention was on me as the female. Everybody was looking at me and I sat down thinking to myself, I didn't f***king do it.
>
> On a different occasion, while I was deployed, one of my superiors traveled to our base. He was using my office and had asked for a CD-Rewritable. When I bent over to get it from the bottom drawer, he hit me on the butt because my uniform pocket was not tucked in. He said you know; your pocket is popped out. I said, 'no sir,' and he said, 'well don't let it happen again' and then he winked at me.

Amber shared her experiences with harassment and the Army's Sexual Harassment/Assault Response and Prevention (SHARP) program:

> I think on a daily basis there is some form of sexual harassment multiple times throughout every single day in the military, whether it's directed at another female or whatever. I think there's always some form of sexual harassment – it's just like here in the military. And because there are enough leaders who voice their true opinions about SHARP to whoever is in the room, there are zero boundaries…so whenever they are going through the SHARP process, it's a check the block thing…Like once I saw the

whole process play out, and how they described it, and its essentially so that it's her fault that this happened to her.

As mentioned previously, many of the participants shared how they avoided harassment. Tiffany tried her best to blend in:

> My friend pointed out, you know, when you cut your hair like that it's your superpower. Always having my hair super short was my power. Here it kept me, protected me…. It was just easier to just play a role of I'm just one of the boys then to be a woman.

Barb, who is now in her 40s, wishes she knew more about how to stand up for herself and fellow female battle buddies:

> I think over time confidence builds. I wish I would have the confidence I have now and go back to when I was 23 and relive some of those situations. I would know exactly what to say and how to approach it. I'd be able to stand up for myself.

Some of the women resorted to taking on attitudes similar to those of their males as a way of fitting in. Nille shared this about her experiences with harassment:

> It's always there [sexual harassment]…and when you are new to a team [on deployment], they smell it, they smell the 'fresh meat'….one day I'm stretching and this guy tells me 'you know what, in another life, I would have tapped that a**….So you kind of have to dish it back out and give them a piece of their own medicine.

Shar stated she didn't feel like she was ever harassed, however, she did go on to share the following:

> I never had a problem, but because people would say stupid pick up lines to me, I would just laugh and say, I'm sorry does that ever actually work for you, because it's not working here. So, I guess I would take a different approach. I did have an E7 [Sergeant

> First Class – who was also my instructor] make some innuendos. [One day] I am looking at my grade and it's a 99% and I know I missed some answers. He looks at me and says, 'you owe me.' He was always flirty, and I always turned him down and would say something like, hey, you know this is inappropriate.

Another participant, Carol, spoke about having been raised with brothers and learning how to speak up for herself:

> I have always been told that I'm very intimidating and I've been told this by guys…I'm not tooting my own horn, but I've always been a pretty good-looking chick, but I've also been a 'leave me the f*** alone type of person. So that kind of stuff never really happened to me, but if it did, I don't give a s*** what your rank is.

Not all participants felt the same about harassment in the military, one participant, Teagan, shared her views:

> Yes, there definitely is harassment [in the military]. I mean, but again, I think it's like how people deal with it. I don't have a lot of respect for people that want to complain about it. Because again, like I said before, it happens in the civilian world too. I'm not saying either of those is right, but it's kind of like, put your big camo pants on and go to work every day. If you will do everything professionally and be professional, then you usually don't have that stuff follow you repeatedly, because you haven't given it any attention.

Theme 3: Proving Oneself and Earning Respect

Theme 3 is the idea that as a woman in the military, one must prove they belong there and work harder to earn the respect of their male peers. Many of the women expressed just wanting to be a part of the team. Throughout the interviews, Nille shared her pride in serving and

working alongside special missions' teams during deployment. This respect came at a price which she explains here:

> You always have to be strong…Every place you go you have to constantly proving something. It's exhausting. You're constantly fighting. I love it. It was me. Like I could not do any other job. I couldn't be in a cubicle. But it's exhausting because you wanted to enjoy being in it, I just wanted to be like everybody else. But you are always the female, the only female…so you stand out. So, you have to shoot straight, you have to be on point more, carry as much or more. So, it was exhausting, it was a fight, never ending. Always a fight.

Lily shared similar feelings in line with the theme of having to prove something in order to gain respect and recognition among her male peers:

> I always had to run the fastest. I was second-guessed all the time. If they said we had to do something, you just had to be extra, to prove that you belong there at the table. So, I always had to be bigger than I was. I have to prove myself twice, and I know every female says this: I have to work twice as hard to do stuff that guys are doing at about 50 [percent], and I am going 200%. And I am basically equal? I'm hardly equal, so I have to work 3 times as hard. That would be the entirety of my 13 additional years of service.

Later, Lilly went on to add: It doesn't matter what you do, it doesn't matter that I'm tabbed out [referring to special skills tabs], I'm still just a female.

Shar found herself having to prove herself many times. She shared volunteering to be the assistant gunner (AG) which is a member of a two-person team in which one carries a machine gun weighing 84 lbs while the other carries a tripod weighing 44 lbs.

> I found that it pushed me harder because I hated it when people told me I couldn't do something because I was woman. So, they were looking for someone to volunteer to be an AG. I didn't even know what the hell that was and no one was making eye contact with the instructor, so I raised my hand and got to carry the tripod.

Amber expressed feeling like her work was never enough:

> I would work my a** off but you know my male counterparts not, and he would get the same opportunities as me. So, it was definitely a lot harder.

Tina talked about the higher in rank and the more responsibilities, it seemed as if she was fighting harder to earn her keep:

> I went to other units, and it seems like it got harder when I got into leadership positions. I had to fight for the same respect that the guys got. I had to prove that much more that I was just as capable as my male counterparts. I was always under a microscope and if I did something wrong, they were very quick to reprimand whereas my male counterparts could be more relaxed. They could make the same mistakes that I did, and they weren't as scrutinized. It was very tough, but they did tell me people in that position in the company only lasted about 3 months. I ended up lasting an entire year in that job. I fought tooth and nail to prove I was just as good as everyone else. In the end it still wasn't enough – they shipped me off somewhere else. It was probably one of the toughest times in my career because it mentally broke me down.

Carol discussed perceptions about women in the military. Her experience includes seeing the gender disparities and women marginalized despite their accomplishments. With this came the perception that women engaged in unethical behaviors in order to earn privileges and promotions:

> Any type of promotion you got; it was immediately [assumed] she screwed her way to the top. You had to work twice as hard to get any type of recognition without the stigma which is frustrating. It doesn't matter what your job is, how long you've been doing it, how much you know the regulations inside out. You could be ten times better than Joe McGee and if he's a guy, he automatically gets it, and no one assumes anything about him.

Tiffany shared an experience at the beginning of her deployment when she was not included in pre-mission briefs with her male team members. She had to earn her respect.

> I wasn't even included in the briefs on our mission. They would just come get me and grab my gear and put it in the truck for me. I'm like f******* seriously!? But the big aspect about deployment is you are respected based off your work. So, if I can pull you out of a truck and save your life in combat, I automatically have your respect. If I can dictate in the middle of an Improvised Explosive Device (IED) going off in a firefight and run a MASCAL (Mass Casualty event where medical services are resourced), you will never question me, because I am doing all the right things and I can speak the lingo…you know I never had a problem with THAT version of respect in either deployment.

Theme 4: Isolation

Isolation presented itself in various domains throughout these women's journeys. Isolation was seen as being the only female on the team or in the unit. Isolation also presented itself after returning home from deployment. Other examples of isolation came from deploying as a single entity where you joined a team but returned home to units where others did not have

shared experiences. Others had no one to come home to. Lastly, the theme of isolation was seen post-separation where many of these women struggled with identity and connection with others. Tiffany shared:

> Personally, I have witnessed or been a portion of the most extreme violence in the world: rape, murder, well technically murder if you count shooting somebody and they're not popping back up – meaning they probably died…and the gamut of the aftermath of war itself, which are the most violent things on earth – and you are party to that. So, there you've gone through the most extreme sh** in life – there is no coming back from that…so the line [of morality] is blurred for us. So, add to that the societal norm of how a woman is supposed to be through a veteran's eyes or through a civilian's eyes, and I am neither of those. I do not fit in any of those molds…and there are very few women like me.

Amber discussed feeling alone while deployed:

> It's really hard, because there's already very few females, so you're already limited. As for me as a lieutenant, you know I could really only be friends with other lieutenants, and by the time my by the time my friends promoted to Captain and I was still a lieutenant, it was like, okay, well, there goes that friend. So, it's like we have a very small pool of people who we can be friends with. And then on the other side if your friends, with like all the male lieutenants what are they going to say about that? Yeah. But oh, you're getting around It's just I always had to constantly think of how do I want to set myself apart so that I would never get those labels?

Shar shared:

> I was the only female [of that rank] on the FOB, so I really didn't have anyone to hang with….

Nille explained when individuals deploy as a member of a smaller team and then return stateside to join unit members that had not deployed:

> You come back, and you just don't feel the same. You know the unit and the guys, but it's not the same bond. So, everybody just bottles everything up.
>
> Civilians don't understand. They think there's something wrong with you because you want to go back. They don't understand we were willing to die for them.

Teagan shared about not having many female battle buddies, being a leader and not showing weakness in front of Soldiers:

> You have battle buddies, and you are relying on the people to your left and right, and no one you could talk to. I mean there are definitely days as a female where I had my crap together, and the I went to the person that I know I couldn't walk into the office, shut the door and break down.

Barb struggled with connection upon return. She expounded on her experience:

> I was starting to date before and putting myself out there and then it's kind of like came crashing down at once. I was like, oh, I can't talk to people like, especially if they aren't military-affiliated in any way, you know, like they're not going to understand where I'm coming from. My kind of like crude and macabre kind of like laughter at things that are morbid. And the thing, you know, like, I think that was like one of my coping mechanisms. It is just like laughing at inappropriate things. And if someone's not in the military, I feel like they don't understand it. Yeah, it made it hard to form relationships

> that didn't already exist. And then it was definitely putting a strain on relationships that did exist with friends and stuff. Because I was isolating myself.

Subtheme 4a: Sacrifices: Work/Life Balance

In addition to feeling isolated in their units, many women reported the impact of also being away from loved ones. Many of these women talked about the sacrifices they made in their relationships and roles as mothers and partners.

Teagan shared:

> I think the mental health piece of expecting people to miss important things [family events, birthdays, funerals, kids' sports] because what we were doing were doing [the mission/training] was more important makes it difficult. I think the military preaches mental health and ways to fix it, but they don't practice it.

When asked about what counselors need to know about women combat veterans, Teagan also responded with the following:

> I think that there has to be some kind of recognition for what we did. It required an extra level of effort to serve in this capacity, expect the things we expected of ourselves, which kind of comes from a female perspective which I don't really ever like to navigate. But the impact of our service is a lot different when we're having children, being the foundation for a family and juggling all that, while at the same time having a career. By the time we [my husband and I] were field grade officers, my entire paycheck paid for all of the childcare. So, I was essentially paying childcare providers to raise and look after my kids, so I could go to the job that I loved, and that was how much I really valued my career.

Lily discussed the sacrifices she was willing to make during back-to-back military training and deployments:

> I was willing at that point in my career to sacrifice the happiness of my children. They were second, NO, tenth fiddle to my career…He [my husband] is calling me a bad mom. So, I'm thinking maybe the kids are better off with him than me.

Carol recalled speaking on the phone with her daughters while she was deployed to Iraq:

> They were ages 3 and 4 at the time. It was my first time leaving them for a long time…it sucked really bad. I am in a mitch-matched uniform, physical fitness uniform with combat boots. I've got a freaking helmet on and a flak jacket [anti-ballistic vest], and I am running to the command headquarters to use the VoIP phone to call them. All I could do was laugh and cry at the same time. My commander was looking at me like I'm crazy, because I am dressed in the wrong uniform, completely out of regulation, just laughing and crying. It's not easy leaving your two little girls behind.

Shar didn't have kids, but she experienced isolation as a result back-to-back deployments and not having time to settle down in between:

> I didn't have any kids, I was not in a relationship, probably because I was deploying all the time. So, then I decided I'm going back [getting deployed]. I didn't have a social life because I was never home enough. Forget dating guys…you can't say hey I'm going to war, and I'll be back in a year, hold that thought…I was 40 years old and had not been on a date in 6 or 7 years, nor been asked out.

Barb shared her insight about being a women combat veteran:

> In a lot of ways, we're the same as male veterans who have seen combat. But perhaps there is more we have dealt with because of societal roles, gender roles, and being a

female deployed. Plus leaving our male spouse or partner at home puts a different kind of strain on relationships.

Nille shared:

> When getting back from deployment, we got off the bus. I didn't get to meet with my husband. He was there, but the battalion came down and they had other plans.

Similar to Nille, Carol explained arriving back in the United States and attending the Welcome Home ceremony troops have upon arrival:

> I came home and my daughters were in Wisconsin, and I was at Fort Hood. There was nobody on the field for me.

Theme 5: The Price of War: Enduring, Unfinished Business, Nostalgia and Closure

"I've lost multiple Soldiers…I never cried…because I am a leader, and I am supposed to be strong, and I am supposed to have it together. You can't show any type of wavering, because that trickle down into formation. Yeah, it's a lot. It's a lot to bear." Lily, Participant

When asked what they would want counselors to know about being a woman combat veteran, Nille replied, "Our ability to endure; understand our ability to just endure the suck nonstop." Theme 5: The Price of War encompasses the essence of what it meant for these women to go war. In this theme, many women spoke about enduring, whether as a combat Soldier or as the Soldier in a leadership position. Returning from deployment came with a sense of nostalgia as well as a sense of unfinished business and lack of closure.

Here is what Barb has to say about her wartime experiences:

> Being a leader in combat: You don't show you're scared. You need to be able to make a decision in the moment, whether to go to the guard tower or run to a bunker, just making sure I looked out for everyone else. Be confident in my decision and exuding confidence

to my Soldiers to help them understand that it is going to be okay, and we'll get through everything together.

About loss of life: We lost lots of Soldiers that first deployment, and those blackouts would happen. My second deployment we lost 3 Soldiers and it kind of affected us all.

In Afghanistan, our mission was both inside and outside the wire. At all times we had to pull security in case of a complex attack. We would have indirect fire multiple times a day…you are operating at full heart rate 24/7. Outside the wire, we advised Afghan National police forces, and I was also a gender integration advisor trying to get more female Afghans to incorporate into the Afghan Police force. In the US we have legitimate issues and problems with equality, but over there, they are just trying to literally live every day, not die and be beheaded.

I would put my body and brain in such frazzled states and just try to make it to a weekend so that I could rest…you know, try to dive within myself and figure things out. But it took me years, years for me to understand that I needed help, outside help.

Carol recalled her first experience with incoming mortars and what it was like once she returned to the U.S.

Mortars came over the wall, that only happened like 2 or 3 times, and at that point we had been so used to hearing it from afar that it's kind of didn't faze us. The only time it really like fully phased us is when it like hit right outside of where we were sleeping…

We were at Forward Operating Base Falcon when the ammo point got hit. I'm like, holy f**** this is seriously happening, this is not something I am used to. It kept getting louder and louder. I couldn't get the strap to my helmet on. I kind of panicked…So on the

whole drive back I am like shi**ing my pants, because I'm up in the turret, and my eyes are looking everywhere.

When asked about how she coped, Carol responded:

> Obviously, its f**** me up a little bit, but my brain works to compartmentalize. I put that in a little box and filed it away as f***ed up sh***, I just left it there, and that's kind of where it stays.
>
> There are certain smells that really mess with my brain. There was a place in Georgia, a convenience store run by Hindu, and they had incense burning. It instantly gave me a headache and I would feel physically sick because it's the same smell from all the shops over there [Iraq].

Tiffany discussed her mission which included identifying high-value enemy targets, aka terrorists.

> During the first half of our deployment, the rules of engagement were if a person shoots at you, you take them down. You take down the building and everything that is near him. Then halfway through, they switched it, and we weren't allowed to do anything anymore. We lost a lot of people. At one point, we were looking for hands at one point in time to roll fingerprints in the system; find a head and hold it up. Seeing if they were a registered offender or someone we were looking for. And you're picking up pieces – of suicide bombers.
>
> Working in the medical field, I saw lots of stuff: gunshot wounds, amputations, lots of stuff blown up. It's so weird the things you remember. You remember someone that's blown up. The blast itself. This person who on the exterior looks perfectly find, and may have broken ankles, but you can't even tell their body is jelly….There was another

instance where this guy's vehicle, six of them blew up, caught fire on the inside, draping their bodies out with metal…we had many MASCALS, fluid, blood, brains dripping. One time I had this dudes' fluid dripping all down me, and you get int the shower and you are washing it off, and there is stuff collecting in the drain.

The biggest thing I do is compartmentalize, which has helped me out most of the time. I was also really good friends with the K-9 unit, so I got to hang out with the dogs during deployment. That was one way to decompress.

Coming home: I'd be driving somewhere, and I would be avoiding things on the road, like trash – because in Iraq we would avoid trash on the roads during convoys because it could be an IED…. I remember being a gunner in the turret, and my eyes constantly being everywhere. Then there is the looking for my weapon, but I am not deployed anymore., It's like an emptiness, almost like a dissonance – you're out of place like you don't belong here [back in the US].

When I got home after my second tour, my first tour was a little easier, I think, because I didn't understand the gravity of it and I think that I compartmentalized it so well, that I just left it as a box in the back. With trauma that is what you do, you compartmentalize and then it compounds. And if you don't ever deal with it, it turns into a mess…. The second tour I had more rank and I felt it was my responsibility to hold the task force together through the losses, through the trauma. I had this nickname, Joan of Arc because I could go through anything, and I didn't die. I've had close calls with death.

Shar recalled her Forward Operating Base undergoing a complex attack:

There was a VBIED (Vehicle Born Improvised Explosive Device) that was supposed to hit on the left side but got stuck in the mud. Our EOD (explosive ordnance disposal) team

> guys blew it up. Oh my God, it was huge. And there were people trying to cut through the wire with suicide vests on. What they did not know was that's when our shift change was, so our attack helicopters, we had twice as many, so we shot them down.
>
> I remember being scared sh*tless when I first arrived in theater – you hear the whistle of an incoming mortar round would go off. And people who'd been there for a while would just get up and walk around. They're like, hey, if you hear the whistle, then the boom, your alive, f*** it. It is crazy, you know.

When discussing what she remembered most about her deployments once she was back home, Shar shared, "I remember hearing stuff and the smells. The smells come back to me, the smell of blood, iron in the blood, that metallic smell. I don't remember any of the severe casualties' names, but somebody could walk up to me, and I remember their injuries."

Similar to Shar and Barb, Nille recalled the loss of life and that smell:

> It was really bloody [in Afghanistan], but that team right there, I bonded with those guys, they were like my brothers from another mother more than anything. The stupidity is I never felt fear nor sadness. You don't think about what you are stepping on. One of the guys stepped on an IED, and we were treating him, And the TTP – tactic, technique, and procedure – for the Afghan enemy – is they put one down and they know we will respond to the injured, so they just put a cluster of sh** all around.
>
> What I remember the most: the mixture of blood. Because people don't understand, when that happens [an attack], people sh** their pants, people piss their pants, your bladders blow out. You have a mixture you know. A 762 [bullet from an AK-47 rifle used by the enemy] does some real f**** up sh** on people's body.

Lilly called the attack which led to her (TBI) or traumatic brain injury and other events during her deployments:

> So, the C-RAM went off and 6 of us got injured. I get knocked down and the round goes right above – through like a diagonal line.
>
> I have Soldiers getting injured, others getting killed, And I mean, I don't know, that does something to your soul…We have route clearance on the road and the second vehicle trips the wire. It blew the f**** vehicle like to 500 meters away.

Teagan recalled some of the losses during her deployment:

> We also lost a Soldier due to friendly fire…we lost contractors…we lost a Soldier to a VBIED attack, and another was injured.

Anytime a Soldier gets killed, the military would implement a communications blackout. Communications blackouts are when a military unit shuts down all outgoing communication like emails and phone calls for seven days. Soldiers knew a fellow combat veteran had passed if there was a comms blackout. The threat of indirect fire always constantly placed Soldiers at risk for injury and/or death. Jay recalled her time being deployed to FOB Shank in Afghanistan:

> I was there for five months before I was moved to another FOB. When I was there, we had 128 rounds of Indirect Fire (IDF). Every time some got killed, we would have a comms blackout.

Some of the women expressed a feeling of nostalgia about the war. One participant, Barb, shared what it was like to come back home after her tour in Afghanistan.

> I was seeing everything on the news and keeping up with it…I had emails from my interpreter, asking if I would do a reference for him to expedite his visa because his

> family was in danger of being threatened by the Taliban. I felt so terrible…I didn't hear from him for a couple of days, so I'm thinking the worst.

Nille, who showed a bracelet she wears to remember an Afghan counterpart she lost during the war, shared her feelings of nostalgia and wanting to go back to Afghanistan, wanting closure. When asked what closure she was looking for, she responded:

> I don't know. I just needed to go back. Three weeks before we left, we had lots of casualties and it stuck with me. I needed to go back. I should not have left, but you can't control it [referring to having to leave back to the US after her 6-month rotation was complete].

Theme 6: Mental Health Help-Seeking in the Military: Stigma and Risks

Many of the women believed the stigma of mental health help-seeking still exists in the military. In addition to stigma, some of the women expressed fears of losing their careers. Others shared this idea of either being a leader or being a woman and not wanting to come off as weak. Barb subscribed to this idea that you cannot show weakness nor seek help, especially as a female leader in the military:

> Of course, there is this large umbrella of everyone saying take care of yourself. Do what you need to get the help you need, and then at the same time, I'm looking around and I'm the only female company command in an Infantry battalion – which was always held by a man. I can't let physical things or mental things get in my way to show weakness. It's not going to happen…It was the perception that other people would have of me that I felt like I couldn't. I just didn't want to admit weakness.

Nille had similar thoughts on not showing weakness and how this would be perceived by others:

> It's a stigma. You can't. And as a female, you can't when you are losing people left and right. I was f**k*ng, you know, soaked in their blood while coming back [from a combat mission]. I'm seeing the guys watch me to see my reaction. So, you just f**k*ng shove it down, and you just burn all your emotions in. Then they say, she's f**k*ng cold, she has no emotions. You have to be, because the minute a tear f---- comes down, then there like AHA!

Jay says about Stigma:

> I think it's still a big problem and a lot of people break because they don't get that help early on because they're scared of what it's going to do to their career.

Carol:

> If you go to counseling, you're a p*****. You are told you don't have to go to counseling. You just talk it out with your battle buddies. Just go for a drink.

One participant named Tiffany, who sought help for her mental health shared her experiences coming back to her unit a few weeks after receiving care at an in-patient facility:

> Once you come back from all that, people walk on eggshells. They don't want to talk to you about anything, because you came back from a program, and they look at you as weaker and worse off. You just opened a giant wound back up, put salt and vinegar and tequila on it, and then you're expected to function back in the unit that treated you like sh**. You don't know how to talk to anybody right now, like you're still raw. What are you supposed to do with yourself? So just this ostracization of you as a person before and after was really big.

Amber talked about remarks and behaviors from leaders can oftentimes discourage seeking out a mental health professional:

> It's a horrible stigma to it...They still call the six floor [at the hospital on the military base] the crazy floor because it's where behavior health is. They always talk poorly about people who have to get sent in for psychiatric holds…Soldiers who are trying to get the help they need where it's just seen as very negative because it's taking time away from their duty day. Like they couldn't handle the military and they're not cut out for it. Like you have to be a specific type of person to be okay in the military.

Amber also went on to state:

> If you are okay in combat, killing people and no remorse, then you are not okay. And I think we make this a perception, that you should be okay, killing the enemy. And if it affects you, then it's not for you. And I do not think that's true. I think, if it does not affect you in some way, then there's something more deeply wrong with you than there is anyone else.

Tina argued there had been a push for mental health improvements in the military, however, there is still the issue of trusting the system and fear of losing your career, so no one admits to needing help:

> There is definitely an increase in people seeking mental health, but there is still a stigma…you're going to mental health just to get out of work…. When returning from deployments, the military had Chaplains on hand as well as Mental Health professionals. When we returned from deployments, we had to complete our Post Deployment Health Assessment (PDHA) surveys, and of course nobody put anything on there that was going to indicate that we weren't perfectly fine.

Carol had these things to say about mental health stigma and not getting mental health care sooner:

> I don't eat a whole lot of meat now, just because all the meat hanging up there [in Iraq], I can't stand the trash and weave in and out of potholes [because of trash and hidden IEDs on the road]. Like there is a lot of s*** that I probably should have talked to somebody about and I just didn't think it would help. Like what are they going to do, give me pills and tell me to come to counseling. But then I go to counseling and my leaders b*tch at me for going. You know, it wasn't something you did, I guess.
>
> Right now, I am making time because I realized my mistake back then was I should have dealt with the sh**bags and stigma, that I would have sought help right away because I am paying for it now. If I would have not been so worried about just trying to be a good Soldier, I would have been a good Soldier with good mental health at the same time.

Stigma and showing strength were not the only barrier to mental health help-seeking. For some of the women, the loss of security clearances and decreased career progression opportunities could follow as a result of help-seeking, which resulted in a mental health diagnosis. Lily and Nille discussed the fear of losing their security clearances. This can result in reduced opportunities. Teagan shared similar thoughts:

> We were kind of always told, hey, if you go see behavioral health, you aren't going to get your security clearance. On my first deployment I had sleeping issues, really, really bad sleeping issues and to get Ambien you had to go to behavioral health. I mean I pushed for months because I didn't want that on my record.

Theme 7: Competent Care, Access to Care, and Continuity of Care

The women in this study shared their experiences with mental health help-seeking. Mental health help-seeking settings were both on and off the military installation and included in-patient and outpatient settings on the military installation. Services on the installation included

civilian providers at military treatment facilities, military medical personnel such as social workers, and civilians hired as Military Family Life Counselors (MFLC). Outside the installation care included in-patient facilities, private practice, counselors sourced through Military One Source, as well as providers at the Veteran's Health Administration (VHA). The women in this study reported diagnoses of PTSD, MDD, and anxiety, amongst other disorders. Some of the women reported struggling with anger, readjustment, and sleep difficulties. A few of the women reported sarcasm/humor and compartmentalizing as a form of coping. A majority had experienced and/or witnessed harassment. Sexual assault, which involved unwanted touch (not to exclude rape), was reported by at least half of the participants who were interviewed. One participant struggled with TBI (traumatic brain injury).

Seven of the women in the study had shared about receiving mental health diagnoses, while the remaining three had not been diagnosed but has struggled with mental health concerns. All ten women had experienced visiting with mental health professional (three while serving on active duty, six while both on active duty and after leaving service, and one only having visited a mental health professional after departing military service). Seven of the ten women visited with a mental health professional within the last year. This information is seen here below in Table 2:

Table 2

Participant Demographics 2

	Mental Health DX	Struggled with or experienced mental health challenges?	Have you ever visited a mental health professional?	Over the past year, have you visited a mental health professional?	Over the past year, how many times have you seen a mental health professional?
Participant 1	Yes	Yes	Yes, while on active duty	No	Zero/None

Participant 2	Yes	Yes	Yes both while on active duty and after departing active duty	No	Zero/None
Participant 3	No	Yes	Yes after I departed active duty	Yes	Between 7-12 visits
Participant 4	No	Yes	Yes both while on active duty and after departing active duty	Yes	More than 12 visits
Participant 5	Yes	Yes	Yes both while on active duty and after departing active duty	Yes	Between 1-2 visits
Participant 6	No	Yes	Yes while on active duty	No	Zero/None
Participant 7	Yes	Yes	Yes both while on active duty and after departing active duty	Yes	Between 3-6 visit
Participant 8	Yes	Yes	Yes both while on active duty and after departing active duty	Yes	More than 12 visits
Participant 9	Yes	Yes	Yes both while on active duty and after departing active duty	Yes	Between 3-6 visits
Participant 10	Yes	Yes	Yes while on active duty	Yes	Between 7-12 visits

This last theme encompassed the challenges these combat women veterans faced with quality care, access to care, and continuity of care. Many communicated their frustrations and disappointment with the care received and their difficulties in getting the care they needed. Tiffany, who had received diagnoses of PTSD, MDD, and sleep disorder and is a survivor of Military Sexual Trauma (MST), spoke about her difficulties and disappointment with the mental health care systems. She spoke about her experience with continuity of care after leaving an in-patient facility as well as her current experiences with care post-military.

> Great therapist, great environment, worst transition care afterwards. I was doing Eye Movement Desensitization and Reprocessing (EMDR) in my therapy [at the in-patient facility]; I didn't get any of that when I came out. The majority of the stuff they were doing didn't work. I struggled through my last 2.5 years in the military.
>
> The VA sucks. I have a shrink. She's great, but I just talked to her about my day and that's it. There is no homework, there's no therapy. The drug dealer I have [referring to her psychiatrist] I never can remember once talking. Trying to get more out of the VA is almost impossible. The first six months of getting out was getting it all established, and then once it was established, it was availability of care was s***. I have to drive an hour and 40 minutes to get there…my shrink is telehealth so it's not as personal. So, in some respects it's easier to talk about some things, but I guess my expectation of mental health was that I'd have homework, and you check on me, and I'd have more appointments than this. I get that specialty stuff, like EMDR, or other referral to different things because of my extensive history, but there is no maintenance so it's very frustrating. So instead of staying progressive in my mental health care because it's not like you just go to a program and you're good, I think the concept is oh, well, we spent the money, and we

> sent you to your program. You are good. That is not how it works. You just open the whole wound, and then you expect me to be good to go afterwards without any real follow up care like I should be seeing somebody twice a week. And at least one of those should be EMDR. I should not have to come out of pocket for any of it, I really should not. I think that is ridiculous. And it's super frustrating, and I get it just gets overwhelming where I'm tired all the time.

Nille, who did not openly share her mental health diagnosis but shared about being medically retired for physical and mental health related conditions. She talked about seeing therapists while on active duty and after leaving active duty.

> I've seen 7 or 8 different ones [therapists] on post. This one guy was the worst, he was connected to the unit. All we did was shoot the breeze; there is no way you're gonna open up. Men cannot empathize because all they do is compare and push back.
>
> I now choose to go further away to get better care. The VA is garbage, but I choose to go to the one further out. The one nearby treat mainly Air Force, and they don't understand, it is not the same. I wish I would have never left Fort Bragg because Special Forces are there, the center of the universe, so at least the providers know what it's like [to work with people who've deployed].

Teagan who found herself hypervigilant ever years after redeploying shared:

> For almost 8 years, I think that I kind of dealt with it until I had kids. I started to realize that what I had been through may have made me a better parent but made me a worse parent at the same time. I had a lot of hyper vigilance. There was a lot of home environment. frustration and stress and I couldn't fix anybody else. So, I needed to medicate myself. so that I would not cause harm to anyone else at that point. I was not at

a place where there were any self-harm thoughts. This came much later. It was hyper vigilance and thinking why do people design a house where you get to all the kid's rooms before you get to me? I should be the first sign of defense. My husband was at Ranger School, and I was up almost hourly checking all the rooms, walking the perimeter inside the house, you know, to check for things, making sure all my kids were okay and still breathing .

I eventually sought help and go the medication I needed. To begin with, I was really using Military One Source because of the stigma. If you went through Military One Source, nobody had to know about it, and it didn't go on a military record. You knew every time you filled out a sheet of paper what your answers needed to be because you wanted to keep your career and your way of life.

I've been to a couple of civilian providers and some through telehealth. Honestly, it's interesting to think that the people on base are out of touch. Then I talk to a civilian provider, and you don't feel that same aura. And they're even more geographically separated from the military base. So, then the question becomes, whose agent? Is the person on the military base whose agent and whose agent are a person off the military base. Like in a court case who is representing who? The civilian providers don't have institutional understanding but at least they understood that it was something beyond their experience and perhaps were a little more attentive when you discussed your issues. So, I felt more supportive, I guess.

Shar recalled having a tough time prioritizing her own mental health. She often placed her Soldiers and the mission first. Struggling to make connections, she shared:

> When I came home, I didn't have any family living in town, so I pretty much isolated myself for a long time. I tried to call several times to make an appointment because I needed some medication at a bare minimum, because I knew this was not normal. I didn't have a life…I remember that last time it happened [when I tried to get an appointment and couldn't], I just cried myself all the way home saying I guess I am not going to get any help…. I had anger. My anger was really high, I was struggling to make personal connections, I had anxiety.

Shar shared when she finally got the help she needed, this was a game changer for her:

> My therapist, she's like [Shar],' you are a normal person that has been through some extraordinarily abnormal things that you had to normalize in your head. The fact that you went to the bathroom every morning and that you could get shot at was normal to you. That is not normal for everyone else. But it's not their fault that that's not normal. So, you technically can't get mad at the person who b**** about their new cell phone when it's the worst day of their life and yours was losing Soldiers that you couldn't save.

In an attempt to reduce stigma and increase service members' access to confidential care, the military hired Military Family Life Counselors who are embedded counselors in military units. These counselors are distinct from counselors in military treatment facilities in that these counselors do not take clinical notes, do not keep records, and only have a requirement to report threats to life. Jay, a combat veteran who had experienced sexual harassment and assault in the form of unwanted touching and who currently struggles with PTSD, anxiety, and sleep issues, shared about her experience with a Military Family Life Consultant (MFLC):

> I was in the military. So, I would get the military answers [to my problems]. Drive on, drink water, get more involved in your unit functions or your spouse's unit

functions…those sorts of things. I wanted something more outside the box. I did not want the typical MFLC who was tied to our company after our deployment. First we had one that was nice, then they switched our MFLC. Now you have somebody who can put their hat on and take it off. I wanted somebody who always had their hat on. You are a counselor, not my buddy. I don't want you around when you take your cap off, and you like to tease us about something or tease somebody about something you don't like. I want you to always have your counselor's hat on. I don't want it to be like we're friends.

Jay shared some other experience with help through Military One Source:

Well, let's see the Military One Source counseling that you can go through like the that process is so difficult because I did try that at one point, and it's like I got kicked off of the website. It had to start all the way back over and was like screw this I would rather not have a counselor then go through this. I mean, we pay for our counseling versus doing the free counseling through the military.

Barb reflected on the impact of her time serving in the war in Afghanistan and her reaction to the withdrawal of troops.

I was diagnosed with PTSD, anxiety, and depression at that point, and I just kept seeing the images that the media was playing, and then I would see flashbacks to hiding in a bunker and going to meet Afghan counterparts. Some of that fear and anxiety that I would feel started to come out, and I would wake up in the middle of the night just sweating. And all those things really made me realize it affected me a whole lot more than I wanted to give it credit for, and I was thinking. You know, with the draw down like. Did we just waste all this time and effort, and people's lives over there for nothing,

because we know what's gonna happen? What was the point? It felt worthless, but then therapy definitely helped me understand it wasn't entirely worthless.

Lily shared her experiences with mental health seeking:

> Around 2015, I started therapy and started taking medications. I had a bag I used to keep because of how much medicine they put me on. I was like a chemistry experiment, and I don't understand what is happening. I just know that you're telling me that you're giving me this drug and I should take it. I don't even know how to monitor my changes in behavior. The psychiatrists, they're not going to talk to you about all your problems. I'm thinking but you're the one who diagnosed me…then my first experience with my psychologist was that she would fall asleep when I was talking to her.
>
> My next therapist, she was good. For years, I would go in. I was exhausted, like it was too much work. Then slowly I graduated from seeing her twice a week, every two weeks, monthly. She used Cognitive Behavior therapy. That worked for me. She did not solve my problems for me. I would say she coached me through it. I felt supported and like I was in a safe environment. I felt whether she said it, or I knew it, this is my job. This is what I have to do to get healthy.
>
> Transition care [from active duty to departing the military] is a sh**show. I fell off the grid for a year, then I had to fight it. It took me 2 years to get into the VA system to get mental health because they are so backed up. They didn't have my PTSD listed and my TBI from my injury in Afghanistan was never documented.

When asked what changes they would recommend or what they would like counselors to know, the women discussed continuity of care, counselor competencies, recognition of service/combat service, and increased accessibility to care. While many of the women

recognized they faced unique challenges as a woman serving in combat, most of them stressed the importance of their recognition of serving in combat more so than the intersectionality of being a woman. Many of the women expressed the importance of having more female providers, with a few expressing that male providers were okay (so long as they didn't marginalize their service). For some women, who had experienced sexual assault, a female provider would be necessary. Additionally expressed wanting to see programs specifically aimed at addressing PTSD in women combat veterans, not just programs aimed as Military Sexual Trauma.

Barb stated: In a lot of ways, we are the same as male veterans that have seen combat.

Nille stressed that counselors needed to understand the ability of Soldiers to endure in combat and understand that trust-building is a must:

> If they are going to treat military people, have an idea. If they are not military, at least, watch some stuff that is out there…and as a provider know that it's not a one-way street, because for me it's hard for it to just be about me. I need to know the person, not your struggle and sh** but what qualifies you – as a human!

Lily also shared sentiments similar to Barb and Nille:

> I don't think it's about females, like there's a specific treatment for females. I think it is more an understanding of what Soldiers go through. Yeah, it's the human experience.

In a similar vein, Jay thinks it is also about recognition of service and being in combat: I think ultimately, we are veterans, not just women vs. male.

Many of the women discussed counselors having an understanding of military service and providing combat therapeutic interventions which includes the use of cognitive behavior therapies, homework, and methods such as EMDR). Nille, Tiffany, and Lilly all stressed the importance of the therapeutic alliance and trust, which emanated through statements such as

"don't be a robot…be aware of your body language…mirror language…don't dismiss me: I don't want to tell you my secrets so I can be dismissed."

Continuity of care came up for many of the women when transitioning between inpatient and outpatient services. Many women talked about the lack of linkage services when departing active duty and waiting for approval and appointments through the VA. Even as a retiree, depending on location, some are not able to see a provider in a military treatment facility since many of the military bases only offer some care to retirees, and this does not always include care with mental health providers as many of those are focused on the active duty Solider. Continuity of care with the same provider or frequent appointments available was a factor for some, as well as difficulties in obtaining referrals for care. Quality came up when some of the participants discussed the disconnect between psychoeducation, medication management, and the linkage to talk therapy/counselor services. Some of the women would rather drive further to obtain better quality of care or providers who were competent in working with combat veterans.

Teagan talked about her experience with counselors lacking competencies in working with combat veterans:

> You realize they have no clue what you are talking about. And it just makes you feel worse about the whole process, when the whole thing should be making you feels someone better and make you feel mature and responsible for addressing issues, so you can move forward instead of being in a place of deterioration…so then you end up with different providers…repeating yourself 1000 times.

Tina shared her thoughts on what the future and programs and counselors should focus on:

> There is a lot of work to do. I don't know that it is just one thing. There is sexual trauma, PTSD, and the loss of identity leaving the military as well. There is so much to unfold….

> There is a lot of room for exploration and counseling with combat veterans and the advances that women have made, not just in combat but achieving being accepted into combat roles.

Lastly, Tiffany shared how she was tired of fighting the system for care and wants to see more programs aimed at women who have served in combat and struggle with PTSD:

> I am so exhausted from fighting the medical system all the time and trying to find a place in the world post-miliary. I don't have the energy to fight for more mental health care. But it's exhausting and it is sad because you get out of the military, and it's like they drop you. There needs to be somewhere women can go, an actual combat program. Where if you are a woman who has been through actual combat, then you can go to group counseling, but a homogenous group. But not just for military sexual trauma, that's important too, but one that focuses on PTSD for women combat veterans.

Summary

The findings in this chapter capture the essence of the lived experiences of the women combat veteran and the mental health utilization of the ten women who participated in this study. The study was guided by the research questions: What are the lived experiences of women combat veterans who have engaged in mental health services? Additionally, how have these experiences influenced their utilization of mental health services? The themes emerged support what has been found previously in the existing literature on mental health seeking but also add to what little is known about the growing population of women combat veterans and their mental health utilization. The study findings are further discussed in chapter four.

Chapter 4: Discussion

Introduction

The findings conferred in this research study offer a glimpse into the lives of ten women who were deployed to combat. The lived experiences shared by the participants illuminate their struggles with mental health and mental health help-seeking. The purpose of this study was to explore and understand the lived experiences of women combat veterans and how these experiences influenced their mental health help-seeking behaviors. Through the lens of a hermeneutic phenomenological approach, the researcher was able to capture the essence of the human experience of ten women combat veterans who participated in the study (Bloomberg & Volpe, 2019). A substantial portion of studies involving women combat veterans are derived from surveys in quantitative studies and/or heterogeneous populations (Ganz et al., 2021; Goldstein et al., 2017; McCaslin et al., 2021; Welsh et al., 2019). Therefore, with qualitative inquiry in mind, the researcher designed a 21-question interview protocol to give voice to the participants to better understand the population of women combat veterans. More importantly, the semi-structured interview was aimed at answering the following research questions: What are the lived experiences of women combat veterans who engaged in mental health services? Additionally, how have these experiences influenced their utilization of mental health services?

By following an inductive analysis approach, the researcher used both initial coding and in-vivo coding, which provided for a bottom-up approach to the theme emerged from the data. This technique, along with keeping memos, allowed the researcher to keep an open mind and a learn as you go mentality throughout the study (Saldana, 2021). Seven themes and one subtheme emerged: 1) Sense of Purpose, 2) Gender Stereotypes and Harassment, 3) Proving Oneself and Earning Respect, 4) Isolation, Subtheme 4a) Sacrifice: Work/Life Balance, 5) The Price of War: Enduring, Unfinished Business, Nostalgia and Closure, 6) Mental Health Help-Seeking in the

Military: Stigma and Risks**,** and 7) Competent Care, Access to Care, and Continuity of Care. This chapter will discuss those research findings, implications, limitations of the study, and recommendations for future research.

Discussion of Research Findings

Literature on the impact of war has previously supported the notion that many combat veterans struggle to reconcile with trauma and other mental health related issues far beyond their return home from deployment (Boros & Erolin, 2021; Ganz et al., 2021; Khan et al., 2019; Kehle et al., 2017; Koblinsky et al., 2017; McCaslin et al., 2021; Zinzow et al., 2007). Consistent with previous studies, many of the women who participated in this research struggled with PTSD, anxiety, sleep problems, suicide ideation as well as traumatic brain injuries (TBI) and military sexual trauma. The participants shared about their service in the military, their experiences in combat, their struggles with isolation and harassment, the stigma of mental health-seeking and other factors which impacted their mental health and mental health help-seeking behaviors.

Theme 1: Sense of Purpose

An effective way for providers to understand military culture is to begin by asking veterans why they joined the military (Hall, 2011). The first interview question prompted participants to share reasons why they joined. The women in the study chuckled as many had to think years back to a younger version of themselves to recall their reasons. The desire to serve something bigger than self as well as looking for direction drove the women in the study to join the military. Mankowski and colleagues described these reasons as calling and opportunity, in their 2015 study titled *Why Women Join the Military*. In a similar vein, Hall (2011) named these as a family tradition and an escape. Despite variances in naming conventions, the women in this study exuded a sense of pride and recalled a sense of purpose as they retold their experiences of

joining. Once in the service, many of these women participants shared their experiences breaking glass ceilings as they joined the ranks of men, becoming the first women to complete various rigorous trainings, join combat units, and hold leadership positions never before held by women both in stateside assignments and in deployments to Iraq and Afghanistan. In addition, many of the women expressed an eagerness to deploy with their fellow teammates to be part of something bigger. For many of the women, their early beginnings of military service were met with excitement and opportunity. The harsh realities of combat of what these women would be facing were unbeknownst to them at the time of their enlistments and commissioning into service.

Theme 2: Gender Stereotypes and Harassment

Despite the growing numbers of women joining the ranks of the military and the military's integration of the SHARP training program and reporting system, many continue to be plagued by gender stereotypes and sexual harassment. Previous studies showed that harassment in a combat environment has a severe negative impact on unit cohesion and leads to mental health struggles for women (Creech et al., 2016; Stanton et., 2022). The women in this study shared about these negative stereotypes and the negative impact it had on their professional relationships and the impact on connecting with other women for fear of who were also labeled. Given the limited number of women in combat units and in combat environments, compounded with the military's strict rules on fraternization amongst the different ranks, this often led to isolation and its negative effects on the participants' mental wellness. Many of the women in the study found themselves having to determine strategies and actions for avoiding this negative and unwanted attention, which often included taking an attitude more in line with male gender role norms (Demers, 2013).

Theme 3: Proving Oneself and Earning Respect,

Emerging from the data was the theme that both as a woman in the military and in combat, the women had to prove themselves to fit in and be accepted. This theme emerged from the question *What was it like to serve as a woman in a male-dominated institute such as the military?* In addition to constant exposure to sexual harassment and gender stereotypes, many of the women reported that they constantly fought to earn respect and prove themselves worthy of having a seat at the table. The women echoed the sentiment that if you work hard enough, you would be respected by teammates for your work ethic, despite harassment. Many of the women seemed more willing to tolerate harassment and/or dismiss it as part of the culture. What emerged was the idea that so long as you work hard, you earned respect in other ways – such as 'pulling your weight' so that you are regarded as an asset – and not just female. However, despite proving themselves and 'earning respect,' women were subject to forms of nonsexual harassment based off being female. Vogt et al. (2013) defined nonsexual harassment as nonsexualized behaviors and attitudes which are hostile, degrading, objectifying, or discriminating against an individual based on sex, gender, orientation, and race/ethnicity. Previous literature strongly supports nonsexual harassment to significantly be associated with later symptoms of PTSD and depression (Stanton et al., 2022). The experiences of the women in this study involved being demeaned, singled out and treated as inferior, which is consistent in previous accounts of women serving in the military (Burkhart & Hogan, 2015). The women discussed working harder but not being recognized and losing opportunities to male counterparts, despite meeting all qualifications - on the basis of being female. Oftentimes, many of them were unwelcome on their teams because some of the men or leadership did not want to have to 'deal with having a woman' on their team. To this day, women in the military continue to face gender bias, and struggle to earn the respect and recognition they work so hard for (Thomas et al.,

2018). These unwelcoming environments are detrimental as the women reported feeling exhausted from the endless fighting when really, all they want is to be a member of the team.

Theme 4: Isolation and Subtheme 4a: Sacrifice – Work/Life Balance

Most recently, the VA (n.d.) argued feelings of isolation and separation from family can have negative effects on mental health. Isolation emerged as a theme in various settings. Several factors can lead to isolation. First, because of the nature of combat units having fewer women assigned, compounded by negative stereotypes, many women veterans reported feeling lonely. Both Koblinsky et al. (2017) and Lehavot et al. (2018) found social connectedness and social support to be crucial in minimizing negative effects during and after combat deployments. Moreover, low social support was found to be a predictor of war-related PTSD (Lehavot et al., 2018). The women in this study discussed the negative impact of isolation on their mental health. Second, many of the women reported also having difficulties upon returning from war because many either did not have family to return home to. Others felt social connectedness was lacking upon their return home.

While previous research discusses the impact war has on family and loved ones upon return (Boros & Erolin, 2021; Creech et al., 2016; Koblinsky et al., 2017), a gap in the literature exists when it comes to an understanding the psychological processes a service member goes through to compartmentalize themselves – in their roles as the role of parent and combat Soldier. What is less known in the research is also the impact of deployment on establishing healthy relationships. The research namely speaks to saving those romantic relationships – such as marriage – once they have already been established. It is unknown to the researcher whether the difficulty in establishing intimate relationships is more prevalent in women than in men who return from repeated deployments to combat zones. Women in this study discussed sacrificing

work/life balance and its psychological impact of leaving children behind. In addition, many of the women shared about the difficulties in establishing romantic relationships due to fraternization policies as well the repeated deployments. The question becomes, “do gender norms come into play?” Given the fact that men as well as women serve in the role as parents, it is worthy to further explore this concept given the gap in the literature. Moreover, a few of the women argued that gender-normed roles of women in society made it difficult to establish relationships.

Theme 5: The Price of War: Enduring, Unfinished Business, Nostalgia and Closure,

While some studies have explored the negative impact of combat on mental health (Taylor et al., 2020; Varga et al., 2018), and others on mental health and mental health utilization among women veterans (Boros & Erolin, 2021; Kehle-Forbes et al., 2017; Strong et al., 2017), to the knowledge of the researcher, no studies have explored the experiences of women in combat. The question *What was it like to serve in combat*? provides a glimpse into the lived experiences of the women in this study who served in multiple deployments to combat zones in Iraq and Afghanistan. Through this powerful question and follow-up prompts, such as ‘tell me what experiences you had during the war” and “what was it like for you to return from the war.” The discussions depicted the gruesome realities of war which included loss, compartmentalization, and endurance. Women expressed avoiding being seen as well as they suppressed and compartmentalized their emotions.

Interestingly, the women expressed a sense of loss stemming from war which came with nostalgia, and feelings of wanting to return to finish the mission. This is perhaps the most complex to explain but at the core it seems related to the sense of purpose discussed in Theme 1, yet more complex than that. Perhaps it is related to the Warrior Ethos many military members

learn (placing the mission first, not quitting, not accepting defeat, and never leaving a fallen comrade). Many of the women lost Soldiers in combat, and many worked alongside Iraqi and Afghan counterparts, so this may account for the feeling that the mission – although they had returned stateside – was still not finished. Many of the women expressed they experienced a lot of dissonance as they returned from the wars – feeling out of place and as if they do not belong.

Theme 6: Mental Health Help-Seeking in the Military: Stigma and Risks

Previously literature exploring military culture and wartime veterans help-seeking behaviors the military as distinct subculture in society where emotional restraint is often present and socialized (Boros & Erolin, 2021; Coll et al., 2011; McCaslin et al., 2021). Soldiers take on a mentality of toughing it out as they begin to adopt a set of beliefs engrained in the military. The women in this study communicated a sense of selfless service and putting the needs of others before their own as a salient barrier to their own help-seeking. The U.S. Army, where all ten women previously served, stresses the importance of a set of values, more importantly, that of selfless service.

> Selfless Service: Put the welfare of the Nation, the Army, and your subordinates before your own. Selfless service is larger than one person. In serving your country, you are doing your duty loyally without recognition or gain. The basic building block of selfless service is the commitment of each team member to go a litter further, endure a little longer, and look a little closer to see how he or she can add to the effort.

The notion of selfless service was communicated by the women in this study, especially as they held positions of increased responsibility to the military mission, the unit, and the Soldiers they led. Moreover, because of the struggle to fit in and be accepted in a hypermasculine environment, many were not willing to seek help.

Koblinsky et al. (2017) argued because of their previous experiences, many women may experience negative attitudes toward help-seeking. Vogt et al. (2014) argued some veterans may be reluctant to seek help due to negative beliefs about having a mental illness. However, in contrast, the women did not express stigma about struggling with mental health or being diagnosed with a mental health disorder. Consistent with Pattyn et al. (2014) findings about social stigma (such as devaluation or discrimination by others), women in this study were more reluctant to seek help due to stigma and fear of how they would be seen by members of their unit. Dabovich et al. (2019) argued the tendency is for service members to tough it out, push through, and not appear weak. Many of the women in this study subscribed to Dabovich and colleagues' (2019) view on self-stigma, internalizing their beliefs about help seeking (not to be confused with the mental health condition itself). Much of the literature about military culture posits that military environments of stoicism and self-reliance may often not be in line with help-seeking (Boros & Erolin, 2021; Coll et al., 2021; Garcia et al., 2014). The women in this study internalized these negative beliefs about help-seeking as being incompatible with the warrior mentality.

Additional barriers to mental health help-seeking include the risk of losing careers or leadership positions since the diagnosis of a mental health disorder could very well limit or end military careers. The women shared their fear of losing the security clearance needed for their jobs which involved matters of national security. Fear of losing security and jobs was consistent with previous studies (Boros & Erolin, 2021; Coll et al., 2021).

Lack of trust in providers was a key factor for those women who sought out mental health care while serving on active duty. Many of the units in the military had in-house social workers who were also service members who worked alongside these same women. In addition, the

military began a program to hire civilian counselors under the Military Family Life Counselor (MFLC) program which was embedded in each unit to provide confidential non-clinical counseling to service members. While some of the women stated these services were a bit more confidential, there was still a lack of trust and lack of rapport due to perceptions of the MFLC having competing reporting responsibilities and were therefore seen as loyal to the command leadership interests and not the Soldiers. To avoid stigma, many of the women sought confidential care by accessing a counselor off the military installation via Military One Source. However, barriers included not being able to find a professional specializing in PTSD or trauma, or the inability to obtain referrals for care. In addition, barriers included civilian counselors who lacked competencies in working with military personnel, both on and off the military installation.

In one study, a lack of leader support significantly decreased mental health help-seeking in Soldiers (McGuffin et al., 2021). The women in this study discussed the military environment and challenges to help-seeking as it would often be perceived negatively by unit leadership. Even when the women had not experienced this directly, others' experiences increased the perception that mental health help-seeking would be frowned upon, and they therefore felt oftentimes discouraged to challenge that notion.

McCaslin et al. (2021) named other barriers, such as financial and obligations to civilian life, for the women in this study, many pay out of pocket to receive better services, and for more options for telehealth. However, paying for care is a financial burden for some. For others, civilian life obligations such as caring for children and other family members, limited help-seeking, and for some of the women as they continue to repeat behaviors of putting self before others. Lastly, logistical barriers remain an issue for women in remote access areas or those seeking more options to care (Stecker, 2013).

Theme 7: Competent Care, Access to Care, and Continuity of Care

The women in this research study were asked to share their experiences with mental health care seeking. Three areas of importance emerged: access to care, continuity of care and the availability of competent care. Many shared their struggles obtaining care after separating from the military. Many discussed the need for continuity of care between inpatient and outpatient settings. Koblinsky et al. (2017) and Tkachuk et al. (2021) addressed a gap in the literature concerning culturally sensitive care from civilian providers. Competent counselors were those who were knowledgeable in working with combat veterans and did not marginalize the experiences and contributions of women in combat. General knowledge of military culture and/or professional dispositions such as nonjudgmental body language and empathetic listening were crucial. Competent care included having more options for care such as EMDR services or access to counselors who used other modalities. Many of the women hoped for something more than just talk therapy, including psychoeducation about the effects of psychotropic medication. Access to care included the availability of appointments, and access to providers more frequently. The women in this study reported difficulties navigating the mental health care system post-military with many not knowing where to begin or who to ask. Direct experiences with the VA health care system included long waits for care to be established and infrequent availability of providers. Additional obstacles included constant changeover of providers. Negative experiences with the VA shared by other veterans had a significant negative impact on the study participants' willingness to engage in mental health services through the VA. It is important to note that for some women veterans who are married to service members who are still active, treatment availability options may look different as they may experience less difficulties with accessibility.

Implications for the Counseling Profession

The findings in this study have significant implications for professional counselors and counselor educators and supervisors. Opportunities for advocacy and consideration for how to work with this population stem from the findings.

Because courses in counseling military veterans are often not required as part of the key core curriculum in many CACREP programs, there appears to be a deficit in counselor knowledge, skills, and abilities (KSAs) in working with military populations, more specifically those service members who have deployed to combat. With the most recent addition of the mental health series job classification in the government/federal system, this offers a renewed opportunity for hands-on experiences with veterans, mentorship with experienced clinicians and opportunities for counselor educators to learn and counselor education programs to implement training and offer continuing education to increase counselor competencies with serving this population. To increase counselor skills with this population, counselor educators could can potentially infuse military counseling curriculum into courses designed at increasing multicultural competencies as well as courses in trauma and addiction.

When working with women combat veterans, counselors may want to keep in mind the impact of combat exposure and combat leadership roles and how these may intersect and/or create conflict and dissonance with traditional gender roles. Additionally, given the prevalence of exposure to sexual trauma and harassment (both sexual and nonsexual) in the military, counselors need not assume all experiences of women combat veterans are the same. For example, some women may feel their experiences of combat are minimized or marginalized if their counselor were to only focus on sexual trauma and/or sexual harassment. In a similar vein, gender roles or harassment may be less salient for some women combat veterans, and therefore

maintaining counselor openness and curiosity be helpful. Moreso, because women combat veterans' experiences with mental health providers are so varied, it could be helpful to ask for positive and negative prior experiences as well as provide psychoeducation about the therapeutic process and what to expect. Empowerment through collaborative treatment planning approaches with women combat veterans could also be helpful. Counselors may also want to consider normalizing the help-seeking with this population. Further, given the sense of pride and the sense of purpose experienced by service members, including the women in this study, counselors may want to help clients cope with transition post-military and working with possible loss of identity and meaning making.

Notwithstanding, both counselors and counselor educators can serve as advocates to the profession to help increase support, increase mental health literacy, and inform programs on how to best serve women combat veterans. Opportunities may exist in counselor training programs where the linkage between student-veterans and counselors-in-training students may present an opportunity for hands-on experience working with combat veterans who may also be students. Community outreach efforts may consist of providing free of cost services to women combat veterans where counselors-in-training, under the supervision of experienced licensed counselors, could provide counselors services during practicum and internship.

Implications for Helping Organizations

This research brought to light the need for linkage of information to mental health care options and services post-separation. During exit from military service, service members often go through a transition program to help with career transition, education opportunities, and linkage to disability services. However, there appears to be a gap in the continuity of care as well as information on where to go to access these services. While the VHA is one option, many of

the women in this study expressed frustration with transition care immediately upon exit from service. Women combat veterans could benefit from transition care post-military. This could be in the form of referrals to care for up to 6 months post-military. Currently, service members are entitled to services via Tricare insurance for 90 days after departing the military. However, many move home after departing the military and often do not know where to go to make appointments or seek help. This becomes problematic as they await the establishment of care with VA providers at their new location. Therefore, a liaison during the transition could provide valuable linkage for service members looking to establish care, especially in the case of mental health care which often remains neglected.

Limitations of the Study

Due to the small sample size in this study, the results may not be generalizable to all women combat veterans. Furthermore, despite study criteria including all branches of the military, the participants of this study exclusively served in the U.S Army, therefore it is difficult to say for certain if the study findings would have been different with a more heterogenous sample. However, it is important to note that even smaller numbers, as is the nature of qualitative studies, can still significantly add to the existing literature.

Unforeseen limitations to the study included in-group differences of women combat veterans; in that those who were currently married to a service member who is still serving on active duty may have increased access to care options and therefore experiences may differ significantly. Additionally, this study did not account for women combat veterans who may live overseas because of being married to an active-duty service member or those working/living overseas post-military.

Recommendations for Future Studies

Recommendations for future research include conducting studies which involve the exploration of counselor knowledge, skills, and abilities (KSAs) in working with women combat veterans. Potential focus areas could include exploration of counselors' perceived bias/beliefs as well as effective treatment modalities when working with this population. Given the inability of the women in the studies to differentiate between mental health professional roles (i.e., social workers, psychiatrists, MFLC, psychologists, and military behavior health practitioners), it would be extremely beneficial to conduct future studies exploring mental health literacy with this population. Lastly, recommendations for future studies may include mixed studies which continue to explore mental health experiences and this population's perceived effectiveness of different mental health modalities (CBT, EMDR, CPT, Narrative Therapy, among others) as well as mixed gender studies which explore the impact of repeated deployments on establishing and maintaining social and intimate relationships post-war.

Summary

Researching the lived experiences of women combat veterans and their mental health help-seeking behaviors contributes to what we know about the women veteran population while addressing some gaps. Many of the women who participated in the study only recently left the service, and while military and veteran programs are ample, knowledge of mental health service options remains scarce, and accessibility is still a challenge. Moreover, preconceived notions and beliefs about help-seeking continue to be relevant barriers.

While many of the women argued for homogenous groups in counseling settings such as VA clinics. The need for wanting homogenous groups was less about gender and more about the validation of combat service. Harassment remains an issue in military culture, but more salient was the marginalization of women's combat service and the lack of services to address combat-

related issues such as PTSD. The bottom line is that women do not want to be treated special but want recognition, respect, and reliable care. Lastly, stigma appeared to still to be embedded in military culture and discourage help-seeking behaviors, leaving many veterans struggling for years before seeking care while on active duty. The findings in this study are meaningful because it helps raise awareness of the growing population of women combat veterans who struggle with mental health care and mental health utilization. The early experiences of mental health seeking combined with harassment and marginalization during military service provide a lens through which professional counselors and counselor educators can work with these individuals. Consequently, further research with women veterans is strongly recommended. Lastly, this study offers a basis for advocacy from the profession, as this would be of significant benefit to this population.

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Chapter 5: Manuscript

In 2020, women comprised 17.3% of personnel serving on Active Duty and 21.2% serving in the Guard and Reserves (Department of Defense [DOD], 2020). As women's military service has increased, this has opened doors for a wide range of roles (Kehle-Forbes et al., 2017; Zinzow et al., 2007), which include women not just serving in supporting roles, but also on the front lines or in combat operations (Boros & Erolin 2021; Koblinsky et al., 2017). In 2015, the Defense Secretary at the Pentagon overturned a long-standing rule which originally prohibited women from serving in certain military occupational specialties and combat roles. Given the increasing number of women combat veterans, there is a growing interest in understanding mental healthcare needs to better serve this population (Koblinsky et al., 2016, Taylor et al., 2020; Welsh et al., 2019).

To date, several studies have found evidence that suggests military stressors and involvement in combat deployments negatively impact mental health (e.g., Koblinsky et al., 2017; Taylor et al., 2020; Varga et al., 2018; Welsh et al., 2019). Yet because the U.S. Military is historically a male-dominated institution, previous studies predominantly centered around the male veteran or male combat veteran. As more women joined the ranks of the military, researchers began conducting studies that included both genders (e.g., Taylor et al., 2020; Welsh et al., 2019). Although some researchers focused their studies exclusively on women veteran participants (Boros & Erolin, 2021; Kehle-Forbes et al., 2017; Strong et al., 2017), these studies may not have differentiated their findings between those who served in combat. Despite these nuanced differences in research methodologies, these previous studies set the stage for the growing number of studies addressing the concerns for veteran mental health, including women

combat veterans. The literature which follows identifies key concerns in mental health for military veterans.

Literature Review

Mental Health Concerns

Only in recent years has the research on veterans focused more on women combat veterans' mental health (e.g., Creech et al., 2016; Koblinsky et al., 2017; Smith et al., 2020). One major mental health concern for veterans is PTSD (Creech et al., 2016; Washington et al., 2013). In the DSM-5, PTSD is characterized by exposure to a traumatic event (American Psychiatric Association, 2013). For women in particular, exposure to combat can often lead to military trauma and other poor mental health outcomes. Military stressors (outside of sexual harassment and sexual assault) can include being wounded or injured, witnessing killings or injury, seeing injured or dead bodies, killing in combat, and perceived threat to life (Khan et al., 2019).

Given that many military veterans may be exposed to potentially traumatic events during combat, it is imperative to understand its prevalence. Statistics from the Veterans Affairs (VA, n.d.) report PTSD diagnosis rates for combat veterans as follows: Vietnam: 15% (or 15 out of every 100); Gulf War/Desert-Storm: 12% or (12 out of every 100); and Operations Iraqi Freedom (Iraq)/Enduring Freedom (Afghanistan): 11-20% (11 to 20 out of 100). Conflicts such as the Vietnam and Korean wars, including recent wars in the Middle East, can have devastating and long-term negative effects on veterans (Taylor et al., 2020). "Within Veteran's Administration (VA) primary care clinic samples, 45% of women veterans screened positive for at least 1 psychiatric disorder," with PTSD being the highest at 30.9% (Miller & Ghadiali, 2020, p. 93). Similarly, researchers found the risk for PSTD and depression to be greater for women who experienced harassment in a combat environment (Creech et al., 2016; Stanton et al., 2022).

More recent studies (Adams et al., 2021; Levahot et al., 2018) have cited women veterans as being at greater risk and higher prevalence for PTSD and other mental health problems. When compared to Vietnam-era women vets, Iraq and Afghanistan veterans were found to experience higher combat exposure and subsequent PTSD symptoms, which impacted their relationships (Creech et al., 2016). Ganz et al. (2021) argued because PTSD is often comorbid, early help-seeking and intervention is crucial to recovery. Koblinsky et al. (2017) argued a considerable number of women veterans report mental health conditions related to their time in war. Coupled with other stressors such as exposure to sexual harassment and/or sexual trauma, feelings of isolation, and separation from family, these women are grappling with the negative effects on their mental health (VA, 2023). Yet so few women combat veterans prioritize their mental health needs. This is problematic because it is not just PTSD that women combat veterans struggle with. A recent study on Vietnam-era women veterans showed that in addition to PTSD, a majority of the participants struggled with Major Depressive Disorder (MDD) and/or Generalized Anxiety Disorder (GAD) due to wartime stress and sexual discrimination and harassment (Smith et al., 2020). Another major study conducted with women combat veterans from multi-war eras showed over 67.1% screened positive for depression, 38% for anxiety, 43% for sexual assault while in the military, and 40% for alcohol use/abuse (Washington et al., 2013).

Many women veterans struggle with Military Sexual Trauma (MST). Simply put, MST is sexual assault and/or sexual harassment experienced during military service. There is ample research supporting the association of sexual harassment and PTSD in both women veterans who have experienced combat and those who served without seeing combat (e.g., Ceroni et al., 2022; Montieth et al., 2021; National Center for Posttraumatic Stress Disorder, 2016). More recently, the Veteran's Health Administration (VHA) asserted that of 5.25 million veterans screened, at

least 30% of women had screened positive for MST (VA, 2020). This is problematic because as a form of trauma, MST can negatively impact relationships, result in strong emotions or feelings of numbness, present difficulties in attention, concentration, memories, and sleep, and result in problems with health, drugs and/or alcohol (VA, 2021). When sexual assault and sexual harassment happens in a combat zone, the lasting effects of the trauma can be devastating. A study by Goldstein et al. (2017) surveyed 403 female veterans and found 90% reported having military trauma exposure. An important finding of this study was that sexual harassment and perceived life threat showed to strongly predict PTSD severity in women veterans. This research supports an earlier study by Carlson et al. (2013) which found the intersectionality of MST and combat exposure as having a negative impact on women veterans' mental health.

Mental Health Stigma

Undoubtedly, a considerable amount of research supports the growing need for mental health utilization among veterans. Yet as previously mentioned, research suggests veterans do not seek out care for their mental health. One major barrier to mental health seeking noted in the literature is stigma. Barriers to mental health often can include an individual's beliefs about mental illness and treatment as well as fear of being stigmatized by others (Vogt et al., 2014). These beliefs can include concern about stigma from loved ones, concern about stigma in the workplace, negative beliefs about mental illness, and negative beliefs about mental health treatment and/or treatment seeking. Many veterans refrain from seeking out care due to stigma associated with mental illness (Ingelse & Messecar, 2016; Strong et al., 2017. Previous work by Pattyn et al. (2014) defined social (or public) stigma as "discrimination and devaluation by others," while self-stigma is defined as the "internalization of negative stereotypes about people who seek help" (p. 236). Despite minor differences in the literature, the consensus suggests

stigma can often cause veterans to hesitate in seeking out help for their mental health conditions (Ganz et al., 2021; Ingelse & Messecar, 2016; Koblinsky et al., 2017; Pattyn et al., 2014; Strong et al., 2017).

Perspectives on Military Culture

To gain a better understanding of mental health stigma in the military, it is important to begin by examining the literature on how military culture may contribute or reinforce mental health barriers such as stigma. Many researchers agree that the military is a distinct subculture in society (Boros & Erolin, 2021; Coll et al., 2011). Influences of military culture often include placing the needs of the unit or team members before oneself as well as showing emotional restraint (Coll et al., 2011, McCaslin et al., 2021). Service members often adopt a set of military values, beliefs, and behaviors as part of their acculturation to the military. Ganz et al. (2021) posit three of these values (selfless service, honor, and personal courage) send messages of placing others first, facing fears and strong moral codes. Another influence in military culture is that of an adopted Warrior Ethos. This Warrior Ethos reads: "I will always place the mission first, I will never quit, I will never accept defeat, I will never leave a fallen comrade" ("Warrior Ethos," 2011, first paragraph). These messages, combined with the invisibility of mental illness, serve as a mask for soldiers as they may "inhibit an individual's willingness to engage in [counseling] (i.e., help-seeking behaviors)" (Ganz et al., 2021, p. 1). Furthermore, Ganz et al. (2021) found "military culture does not tend to foster an environment that is conducive to seeking mental health services" (p. 9). Additional research suggests despite the military's attempts to de-stigmatize mental illness, service members are reluctant to seek out mental health services because of fear of losing their job, being separated from the military, denied promotion, losing a security clearance, or being accused of using mental illness as a way to avoid military

duties (Boros & Erolin, 2021; Coll et al., 2011). With military culture contributing to internalized stigma, many veterans often seek out to solve their own problems. Kaplan (2019) posits many service members are "likely to perceive stigma and anticipate negative outcomes for seeking care, including career harm" (para. 5).

For women in particular, acculturation into the military takes on added layers as exposure to a male-dominated military places women in the minority status of a hypermasculine military culture (Strong et al., 2018; Williams et al., 2018). Garcia et al. (2014) theorized traditional gender norms and/or stoic beliefs in association with help-seeking may be applicable to both men and women combat veterans. For many women in the military subscribing to this culture of toxic masculinity, many may mask their psychological trauma to avoid being seen as weak. "Historically, soldiering has been constructed as a male pursuit, leaving females in the position of having to determine what strategies to use and actions to take to be accepted as women soldiers" (Demers, 2013, p. 494). Hence, it is not uncommon for women to conform to male standards to blend in or mirror their male counterparts (Boros & Erolin, 2021; Demers, 2013). Supporting the idea of conforming to self-reliance and stoicism, Garcia et al. (2014) noted women combat veterans' help-seeking may be influenced by these same norms. As a result, many women are left to grapple with mental illness consequences as they internalize these stereotypes which contribute to their reluctance to seek mental help.

Mental Health Barriers

Research exploring barriers to mental health utilization with women combat veteran populations is scarce. Until recently, much of the knowledge gained on combat veteran mental health and mental health utilization has been largely conducted with male combat veterans in mind. Fewer studies focused on women veterans, with even less exclusively with women combat

veterans. However, existing literature hosts major concerns for veterans who have served in combat. Factors which may affect help-seeking for combat veterans, regardless of gender, can include prevalence of mental health disorders, knowledge of disorders and resources, barriers which inhibit access to resources, motivation to seek help, and the types of resources available (Taylor et al., 2020). In homogenous studies with women combat veterans, barriers stressed in the literature include stigma, gender-sensitive care, and re-traumatization (Koblinsky et al., 2017; Miller & Ghadiali, 2015). Additional barriers can include previous experiences in the military, the ability to recognize mental health warnings, and knowledge of resources (Koblinsky et al., 2017). Some studies which included mixed cohorts consisting of women veteran's both with and without combat service have also identified barriers to care such as gender specific stereotypes (such as downplaying women's role in combat (Strong et al., 2013), fear of losing security clearances, fear of separation from service, fear of being seen as weak (Boros & Erolin, 2021), and lack of trust in providers (Kehle-Forbes et al., 2017). Few studies listed a comprehensive list of barriers, however, McCaslin et al. (2021) cited financial, occupational, and other obligations in civilian life as barriers. It is important to note that while the latter two studies involved both male and women combat veterans, these barriers remain salient in both populations.

A growing body of research supports the need for gender sensitive care (Kintzle et al., 2015; Koblinsky et al., 2017; Miller & Ghadiali, 2015). Barriers can stem from a history of sexual trauma or PTSD combined with "predominantly male-dominated environments at VHA" (Kehle-Forbes et al., 2017, p. 4). These male-dominated environments can be unwelcoming or can sometimes be triggers for women, especially those who have experienced sexual assault by another member of the military. For women who have had negative and/or traumatic experiences

while serving, these unwanted behaviors may bear significant weight on their decision to utilize (or not to utilize) mental health services (Kehle-Forbes et al., 2017), especially at VHA locations.

Methods

Utilizing a hermeneutical phenomenological approach, this study investigated the following guiding and supporting research questions: What are the lived experiences of women combat veterans who engaged in mental health services? Additionally, how have these experiences influenced their utilization of mental health services? A qualitative design was specifically fitting for this study because it allowed the researcher to focus on an individual meaning which is oftentimes complex in social or human problems (Creswell & Creswell, 2018). For women combat veterans, this complexity may be seen in their lived experiences as members of a male-dominated institution such as the military.

Procedures

Participants

The research participants in this study consisted of women living in the U.S., ages 21-70 years of age who had served in the U.S. Military for a period no less than 3 years, received an honorable discharge, and had deployed at least once to a combat area of operation. Additionally, participants had either been diagnosed with a mental illness or experienced other mental health related issues.

Participant Recruitment

Recruitment began upon approval of this study through an Auburn University Institutional Review Board for research with the Human Subjects process. This qualitative research study involved purposeful sampling which best fit the parameters of the study (Tracy, 2020). For this research study, both convenience sampling and snowball sampling were used.

Convenience sampling began Veteran Service Organizations (i.e., VFW, USO, Student Veteran Offices and DAV). Additionally, convenience sampling was particularly effective in reaching prior service women combat veterans who are enrolled in post-secondary education programs. Lastly, research information was posted to social media platforms such as Facebook and LinkedIn, and veteran service organizations and groups which had an online presence of women veterans. Women veterans shared with others who met the criteria which facilitated snowball sampling. A total of 10 women participated in this study.

Data Collection

For this study, the researcher utilized (a) a Qualtrics demographic survey which included screening criteria, (b) in depth semi-structured interviews conducted virtually, (c) Zoom platform to audio record interviews, (d) Zoom transcription of audio recorded interviews, and (e) journaling. The interview protocol consisted of 21 semi-structured open-ended questions. Some of the questions included were: Have you ever been diagnosed with a mental health disorder? In which type of settings have you received counseling? What were these experiences like for you? How were they the same/different? Have you experienced any barriers to seeking counseling? The researcher also remained flexible and asked follow-up questions.

Data collection began with the completion of informed consent. Participants completed the online Qualtrics demographic survey which included screening criteria The study survey was accessed by participants anonymously through either the QR code or the survey link. The average completion time was about 5 minutes. Upon completion of the demographic survey, participants scheduled their one-on-one interview via an external link through Calendly. The one-on-one semi-structured interview took via Zoom platform to facilitate audio interview recording and transcripts. The interviews lasted approximately 90 minutes, allowing for rich, in-

depth interviews. After verifying the integrity of audio recordings and transcripts, data was kept separate in password-protected folders and saved using alpha-numeric descriptors. Participants were given the option to be de-identified or use a pseudonym of their choosing before and during interviews.

Data Analysis

Analyzing data was emergent and inductive. The researcher delineated hermeneutic data analysis steps through journaling to address biases and projection of meaning. By engaging in inductive analysis, the researcher remained open to a method where one can "learn as you go" by keeping an open mind about what may arise from the research (Saldana, 2021). The researcher organized the data by downloading recordings and transcripts upon completion of interviews. The transcripts were checked for accuracy through a process whereby the researcher listened to the audio recording. All transcripts were then uploaded to MAXQDA for organization. Data which was transcribed incorrectly was corrected. When manually coding the data, the researcher organized and highlighted codes phrases in MAXQDA. A second round of coding involved a separate spreadsheet listing potential categories and themes as well as the addition of in-vivo coding. To minimize and challenge potential researcher bias, the themes and codes were sent to two reviewers for feedback. Peer feedback resulted in seven themes and one subtheme.

Reliability and Validity

Creswell and Creswell (2018) posit using multiple validity procedures can strengthen research. Guided by Tracy's (2020) Eight "big tent" framework, the researcher examined these criteria against my research conducted before, during and after the study. The Eight 'big tent' framework enhances research quality by providing researchers with a framework for qualitative

rigor. These eight areas include: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethical and meaningful coherence (Tracy, 2020). While it is not mandatory for all criteria to be met, addressing those that were can significantly strengthen the quality of research. Thus, the researcher has engaged in the exploration of worthy topics and ethical considerations when planning and as the research study has been conducted. In considering the worthiness of the topic, the researcher has engaged in conducting a review of the literature during separate periods of time throughout the last two years. Not only has the researcher found the topic relevant but also timely given the nature of the growing population to be addressed in the study. Taking into consideration ethical concerns, the researcher has engaged in relevant training in preparation for submitting the IRB and research practice as well as considered resources for participants who may experience emotional distress because of the interview. Another ethical consideration has been the voluntary nature of the research study with no penalty for withdrawal.

Reliability and Validity address threats to qualitative rigor (People, 2021). To ensure qualitative rigor as a sole researcher study, the researcher journaled to address researcher bias and adopt rich descriptions of participants' lived experiences. This included transparency in identifying how the researcher's past experiences may have shaped interpretations (Creswell & Creswell, 2018). The researcher entered the study with the assumption that mental health needs of women combat veterans are unique. This assumption was challenged through reflexivity and further peer debriefing to assist in the interpretation of the data. Further, throughout the interviews, the participants were asked to give examples of their experience to minimize the researcher's assumptions. Thus, the journaling process was an extremely important contribution to the study's reliability and validity since the researcher shared multiple identities with the

participants as well as similar lived experiences. Shared identities between researcher and participants include being woman and having served in multiple combat deployments. In addition, the researcher had similar experiences to the participants which were relatable (e.g. held leadership positions, having experienced or witnessed harassment, feeling a sense of pride, and struggles with isolation and/or non-sexual harassment). Journaling included the researcher's own processing of meaning making and how they received the data. The journaling process also included thoughts about how the information presented is different or similar to that of the existing literature and their own experiences.

Findings

The women in this study shared their experiences with mental health help-seeking. Mental health help-seeking settings were both on and off the military installation and included in-patient and outpatient settings on the military installation. Services on the installation included civilian providers at military treatment facilities, military medical personnel such as social workers, and civilians hired as Military Family Life Counselors (MFLC). Outside the installation care included in-patient facilities, private practice, counselors sourced through Military One Source, as well as providers at the Veteran's Health Administration (VHA).

Represented and described are seven themes and one subtheme. The themes helped capture the essence of the phenomena: *What are the lived experienced of women combat veterans? Also, how have these experiences influenced mental health utilization?* These themes are: 1) Sense of Purpose, 2) Gender Stereotypes and Harassment, 3) Proving Oneself and Earning Respect, 4) Isolation, Subtheme, 4a) Sacrifice: Work/Life Balance, 5) The Price of War: Enduring, Unfinished Business, Nostalgia, and Closure, 6) Mental Health Help-Seeking in the

Military: Stigma and Risks**,** and 7) Competent Care, Access to Care, and Continuity of Care. These themes are further discussed below.

Theme 1: Sense of Purpose

The participants interviewed shared their reasons behind joining military service. A sense of purpose seemed to stand out the most. This sense of purpose resonated in some participants desiring to serve something bigger than themselves and others looking for direction. Some of the women interviewed expressed a desire to serve, stemming from a history of family in the military. One participant, Jay, was fourth generation military, while others had fathers and grandfathers serve as was the case for Shar, Nille, and Amber.

Teagan stated the following when sharing about her grandpa who served:

> You know, you should surely serve something larger than yourself. There are good people around the world that deserve a person to stand up for them.

For some of the other participants, a sense of purpose stemmed from looking for direction in life. Lily worked as a waitress in a restaurant before joining and had this to say:

> I have to do something, and this is not it for the rest of my life. I didn't see anything positive coming out of my current situation, so I needed to make a change in the military.

All participants communicated a sense of pride for their time in service, with none of the participants expressing remorse or regret over having served.

Theme 2: Gender Stereotypes and Harassment

Many of the women shared having experienced sexual harassment and/or sexual assault. Additionally, the women interviewed discussed common stereotypes attributed to women in the military. During the interviews, the women shared their strategies for coping with gender stereotypes and harassment. These coping mechanisms included sarcasm, fighting back with

similar comments or profanities ("dishing it back out"), trying to blend in, and dismissing harassment as part of the job.

Gender stereotypes involved labeling and naming of women who were perceived as unapproachable or not willing to sleep around with their fellow male service members. These names oftentimes included b***ch, dyke, or prude. Similarly, women who were too friendly or who were seen around males – even if they were the only female on the team – were seen as willing to 'put out' or engage in promiscuous and/or sexual behaviors. Here is what some of the participants responded with when asked *what was it like to serve as a female in a male-dominated institution?*

Amber candidly spoke about this same dichotomous label that is placed on women:

> In the Army, you are with labeled a wh*re because you sleep around…or you're a b****, or you're like a prude, you know? So, it's like you are always walking the thin line of how am I going to be labeled? If they see you as that person, that's who you are, which is really disheartening, because on the male side, it is not like that at all.

Barb was deployed when she learned one of her fellow female battle buddies had been sexually assaulted:

> You have no idea what to do…it's like oh, I have to protect myself here as well, not just from the enemy, but from someone who wears the same uniform as me. We wear the same flag on our shoulders. That inherent trust you think comes with being in the military, like that's my battle buddy. Everyone's my battle buddy. But as females we have to analyze that level of trust that we put into someone and stay alert even when we do go on deployment.

Theme 3: Proving Oneself and Earning Respect

Theme 3 is the idea that as a woman in the military, one must prove they belong there and work harder to earn the respect of their male peers. Many of the women expressed just wanting to be a part of the team. Throughout the interview, Nille shared her pride in serving and working alongside special missions' teams during deployment. This respect came at a price which she explains here:

> You always have to be strong…Every place you go you have to constantly proving something. It's exhausting. You're constantly fighting. I love it. It was me. Like I could not do any other job. I couldn't be in a cubicle. But it's exhausting because you wanted to enjoy being in it, I just wanted to be like everybody else. But you are always the female, the only female…so you stand out. So, you have to shoot straight, you have to be on point more, carry as much or more. So, it was exhausting, it was a fight, never ending. Always a fight.

Carol discussed perceptions about women in the military. Her experience includes seeing the gender disparities and women marginalized despite their accomplishments. With this came the perception that women engaged in unethical behaviors in order to earn privileges and promotions:

> Any type of promotion you got; it was immediately [assumed] she screwed her way to the top. You had to work twice as hard to get any type of recognition without the stigma which is frustrating. It doesn't matter what your job is, how long you've been doing it, how much you know the regulations inside out. You could be ten times better than Joe McGee and if he's a guy, he automatically gets it, and no one assumes anything about him.

Theme 4: Isolation

Isolation presented itself in various domains throughout these women's journeys. Isolation was seen as being the only female on the team or in the unit. Isolation also presented itself after returning home from deployment. Other examples of isolation came from deploying as a single entity where you joined a team but returned home to units where others did not have shared experiences. Others had no one to come home to. Lastly, the theme of isolation was seen post-separation where many of these women struggled with identity and connection with others. Tiffany shared:

> Personally, I have witnessed or been a portion of the most extreme violence in the world: rape, murder, well technically murder if you count shooting somebody and they're not popping back up – meaning they probably died…and the gamut of the aftermath of war itself, which are the most violent things on earth – and you are party to that. So, there you've gone through the most extreme sh** in life – there is no coming back from that…so the line [of morality] is blurred for us. So, add to that the societal norm of how a woman is supposed to be through a veteran's eyes or through a civilian's eyes, and I am neither of those. I do not fit in any of those molds…and there are very few women like me.

Nille explained when individuals deploy as a member of a smaller team and then return stateside to join unit members that had not deployed:

> You come back, and you just don't feel the same. You know the unit and the guys, but it's not the same bond. So, everybody just bottles everything up.
>
> Civilians don't understand. They think there's something wrong with you because you want to go back. They don't understand we were willing to die for them.

Subtheme 4a: Sacrifices: Work/Life Balance

In addition to feeling isolated in their units, many women reported the impact of also being away from loved ones. Many of these women talked about the sacrifices they made in their relationships and roles as mothers and partners.

Teagan shared:

> I think the mental health piece of expecting people to miss important things [family events, birthdays, funerals, kids' sports] because what we were doing were doing [the mission/training] was more important makes it difficult. I think the military preaches mental health and ways to fix it, but they don't practice it.

Shar didn't have kids, but she experienced isolation as a result back-to-back deployments and not having time to settle down in between:

> I didn't have any kids, I was not in a relationship, probably because I was deploying all the time. So, then I decided I'm going back [getting deployed]. I didn't have a social life because I was never home enough. Forget dating guys…you can't say hey I'm going to war, and I'll be back in a year, hold that thought…I was 40 years old and had not been on a date in 6 or 7 years, nor been asked out.

Theme 5: The Price of War: Enduring, Unfinished Business, Nostalgia and Closure

When asked what they would want counselors to know about being a woman combat veteran, Nille replied, "Our ability to endure; understand our ability to just endure the suck nonstop." Theme 5: The Price of War encompasses the essence of what it meant for these women to go war. In this theme, many women spoke about enduring, whether as a combat Soldier or as the Soldier in a leadership position. Returning from deployment came with a sense of nostalgia as well as a sense of unfinished business and lack of closure.

Tiffany discussed her mission during deployments:

> Working in the medical field, I saw lots of stuff: gunshot wounds, amputations, lots of stuff blown up…we had many MASCALS, fluid, blood, brains dripping. When I got home after my second tour, my first tour was a little easier, I think, because I didn't understand the gravity of it and I think that I compartmentalized it so well, that I just left it as a box in the back. With trauma that is what you do, you compartmentalize and then it compounds. And if you don't ever deal with it, it turns into a mess.

When discussing what she remembered most about her deployments once she was back home, Shar shared, "I remember hearing stuff and the smells. The smells come back to me, the smell of blood, iron in the blood, that metallic smell. I don't remember any of the severe casualties' names, but somebody could walk up to me, and I remember their injuries."

Nille, who showed a bracelet she wears to remember an Afghan counterpart she lost during the war, shared her feelings of nostalgia and wanting to go back to Afghanistan, wanting closure. When asked what closure she was looking for, she responded:

> I don't know. I just needed to go back. Three weeks before we left, we had lots of casualties and it stuck with me. I needed to go back. I should not have left, but you can't control it [referring to having to leave back to the US after her 6-month rotation was complete].

Theme 6: Mental Health Help-Seeking in the Military: Stigma and Risks

Many of the women believed the stigma of mental health help-seeking still exists in the military. In addition to stigma, some of the women expressed fears of losing their careers. Others shared this idea of either being a leader or being a woman and not wanting to come off as weak. Carol:

> If you go to counseling, you're a p*****. You are told you don't have to go to counseling. You just talk it out with your battle buddies. Just go for a drink.

One participant named Tiffany, who sought help for her mental health shared her experiences coming back to her unit a few weeks after receiving care at an in-patient facility:

> Once you come back from all that, people walk on eggshells. They don't want to talk to you about anything, because you came back from a program, and they look at you as weaker and worse off. You just opened a giant wound back up, put salt and vinegar and tequila on it, and then you're expected to function back in the unit that treated you like sh**.

Amber talked about remarks and behaviors from leaders can oftentimes discourage seeking out a mental health professional:

> It's a horrible stigma to it...They still call the six floor [at the hospital on the military base] the crazy floor because it's where behavior health is. They always talk poorly about people who have to get sent in for psychiatric holds.

Theme 7: Competent Care, Access to Care, and Continuity of Care

This last theme encompassed the challenges these combat women veterans faced with quality care, access to care, and continuity of care. Many communicated their frustrations and disappointment with the care received and their difficulties in getting the care they needed. Tiffany, who had received diagnoses of PTSD, MDD, and sleep disorder and is a survivor of Military Sexual Trauma (MST), spoke about her difficulties and disappointment with the mental health care systems. She spoke about her experience with continuity of care after leaving an in-patient facility as well as her current experiences with care post-military.

> Great therapist, great environment, worst transition care afterwards. I was doing Eye Movement Desensitization and Reprocessing (EMDR) in my therapy [at the in-patient facility]; I didn't get any of that when I came out. The majority of the stuff they were doing didn't work. I struggled through my last 2.5 years in the military.

When asked what changes they would recommend or what they would like counselors to know, the women discussed continuity of care, counselor competencies, recognition of service/combat service, and increased accessibility to care. While many of the women recognized they faced unique challenges as a woman serving in combat, most of them stressed the importance of their recognition of serving in combat more so than the intersectionality of being a woman. Many of the women expressed the importance of having more female providers, with a few expressing that male providers were okay (so long as they didn't marginalize their service). For some women, who had experienced sexual assault, a female provider would be necessary. Additionally expressed wanting to see programs specifically aimed at addressing PTSD in women combat veterans, not just programs aimed as Military Sexual Trauma.

Many of the women discussed wanting counselors to have an understanding of military service and providing combat therapeutic interventions which includes the use of cognitive behavior therapies, homework, and methods such as EMDR). Also stressed the importance of the therapeutic alliance and trust, which emanated through statements such as "don't be a robot…be aware of your body language…mirror language…don't dismiss me: I don't want to tell you my secrets so I can be dismissed." Continuity of care came up for many of the women when transitioning between inpatient and outpatient services. Many women talked about the lack of linkage services when departing active duty and waiting for approval and appointments through

the VA. Even as a retiree, depending on location, some are not able to see a provider in a military treatment facility since many of the military bases only offer some care to retirees, and this does not always include care with mental health providers as many of those are focused on the active duty Solider. Continuity of care with the same provider or frequent appointments available was a factor for some, as well as difficulties in obtaining referrals for care. Quality came up when some of the participants discussed the disconnect between psychoeducation, medication management, and the linkage to talk therapy/counselor services. Some of the women would rather drive further to obtain better quality of care or providers who were competent in working with combat veterans.

Tina shared her thoughts on what the future and programs and counselors should focus on:

> There is a lot of work to do. I don't know that it is just one thing. There is sexual trauma, PTSD, and the loss of identity leaving the military as well. There is so much to unfold…. There is a lot of room for exploration and counseling with combat veterans and the advances that women have made, not just in combat but achieving being accepted into combat roles.

Lastly, Tiffany shared how she was tired of fighting the system for care and wants to see more programs aimed at women who have served in combat and struggle with PTSD:

> I am so exhausted from fighting the medical system all the time and trying to find a place in the world post-miliary. I don't have the energy to fight for more mental health care. But it's exhausting and it is sad because you get out of the military, and it's like they drop you. There needs to be somewhere women can go, an actual combat program. Where if you are a woman who has been through actual combat, then you can go to group

counseling, but a homogenous group. But not just for military sexual trauma, that's important too, but one that focuses on PTSD for women combat veterans.

Discussion

Researching the lived experiences of women combat veterans and their mental health help-seeking behaviors contributes to what we know about the women veteran population while addressing some gaps. Many of the women who participated in the study only recently left the service, and while military and veteran programs are ample, knowledge of mental health service options remains scarce, and accessibility is still a challenge. Moreover, preconceived notions and beliefs about help-seeking continue to be relevant barriers.

While many of the women argued for homogenous groups in counseling settings such as VA clinics. The need for wanting homogenous groups was less about gender and more about the validation of combat service. Harassment remains an issue in military culture, but more salient was the marginalization of women's combat service and the lack of services to address combat-related issues such as PTSD. The bottom line is that women do not want to be treated special but want recognition, respect, and reliable care. Lastly, stigma appeared to still to be embedded in military culture and discourage help-seeking behaviors, leaving many veterans struggling for years before seeking care while on active duty**.**

Implications for the Counseling Profession

The findings in this study have significant implications for professional counselors and counselor educators and supervisors. Opportunities for advocacy and consideration for how to work with this population stem from the findings. Because courses in counseling military veterans are often not required as part of the key core curriculum in many CACREP programs, there appears to be a deficit in counselor knowledge, skills, and abilities (KSAs) in working with

military populations, more specifically those service members who have deployed to combat. With the most recent addition of the mental health series job classification in the government/federal system, this offers a renewed opportunity for hands-on experiences with veterans, mentorship with experienced clinicians and opportunities for counselor educators to learn and counselor education programs to implement training and offer continuing education to increase counselor competencies with serving this population. To increase counselor skills with this population, counselor educators could potentially infuse military counseling curriculum into courses designed at increasing multicultural competencies as well as courses in trauma and addiction.

When working with women combat veterans, counselors may want to keep in mind the impact of combat exposure and combat leadership roles and how these may intersect and/or create conflict and dissonance with traditional gender roles. Additionally, given the prevalence of exposure to sexual trauma and harassment (both sexual and nonsexual) in the military, counselors need not assume all experiences of women combat veterans are the same. For example, some women may feel their experiences of combat are minimized or marginalized if their counselor were to only focus on sexual trauma and/or sexual harassment. In a similar vein, gender roles or harassment may be less salient for some women combat veterans, and therefore maintaining counselor openness and curiosity be helpful. Moreso, because women combat veterans' experiences with mental health providers are so varied, it could be helpful to ask for positive and negative prior experiences as well as provide psychoeducation about the therapeutic process and what to expect. Empowerment through collaborative treatment planning approaches with women combat veterans could also be helpful. Counselors may also want to consider normalizing the help-seeking with this population. Further, given the sense of pride and the sense

of purpose experienced by service members, including the women in this study, counselors may want to help clients cope with transition post-military and working with possible loss of identity and meaning making.

Notwithstanding, both counselors and counselor educators can serve as advocates to the profession to help increase support, increase mental health literacy, and inform programs on how to best serve women combat veterans. Opportunities may exist in counselor training programs where the linkage between student-veterans and counselors-in-training students may present an opportunity for hands-on experience working with combat veterans who may also be students. Community outreach efforts may consist of providing free of cost services to women combat veterans where counselors-in-training, under the supervision of experienced licensed counselors, could provide counselors services during practicum and internship.

Implications for Helping Organizations

This research brought to light the need for linkage of information to mental health care options and services post-separation. During exit from military service, service members often go through a transition program to help with career transition, education opportunities, and linkage to disability services. However, there appears to be a gap in the continuity of care as well as information on where to go to access these services. While the VHA is one option, many of the women in this study expressed frustration with transition care immediately upon exit from service. Women combat veterans could benefit from transition care post-military. This could be in the form of referrals to care for up to 6 months post-military. Currently, service members are entitled to services via Tricare insurance for 90 days after departing the military. However, many move home after departing the military and often do not know where to go to make appointments or seek help. This becomes problematic as they await the establishment of care with VA

providers at their new location. Therefore, a liaison during the transition could provide valuable linkage for service members looking to establish care, especially in the case of mental health care which often remains neglected.

Limitations of the Study

Due to the small sample size in this study, the results may not be generalizable to all women combat veterans. Furthermore, despite study criteria including all branches of the military, the participants of this study exclusively served in the U.S Army, therefore it is difficult to say for certain if the study findings would have been different with a more heterogenous sample. However, it is important to note that even smaller numbers, as is the nature of qualitative studies, can still significantly add to the existing literature.

Unforeseen limitations to the study included in-group differences of women combat veterans; in that those who were currently married to a service member who is still serving on active duty may have increased access to care options and therefore experiences may differ significantly. Additionally, this study did not account for women combat veterans who may live overseas because of being married to an active-duty service member or those working/living overseas post-military.

Recommendations for Future Studies

Recommendations for future research include conducting studies which involve the exploration of counselor knowledge, skills, and abilities (KSAs) in working with women combat veterans. Potential focus areas could include exploration of counselors' perceived bias/beliefs as well as effective treatment modalities when working with this population. Given the inability of the women in the studies to differentiate between mental health professional roles (i.e., social workers, psychiatrists, MFLC, psychologists, and military behavior health practitioners), it

would be extremely beneficial to conduct future studies exploring mental health literacy with this population. Lastly, recommendations for future studies may include mixed studies which continue to explore mental health experiences and this population's perceived effectiveness of different mental health modalities (CBT, EMDR, CPT, Narrative Therapy, among others) as well as mixed gender studies which explore the impact of repeated deployments on establishing and maintaining social and intimate relationships post-war.

Summary

This research study offers a glimpse into the lives of ten women who were deployed to combat. The lived experiences shared by the participants illuminate their struggles with mental health and mental health help-seeking. The purpose of this study was to explore and understand the lived experiences of women combat veterans and how these experiences influenced their mental health help-seeking behaviors. Through the lens of a hermeneutic phenomenological approach, the researcher was able to capture the essence of the human experience of ten women combat veterans who participated in the study (Bloomberg & Volpe, 2019

The findings in this study are meaningful because it helps raise awareness of the growing population of women combat veterans who struggle with mental health care and mental health utilization. The early experiences of mental health seeking combined with harassment and marginalization during military service provide a lens through which professional counselors and counselor educators can work with these individuals. Consequently, further research with women veterans is strongly recommended. Lastly, this study offers a basis for advocacy from the profession, as this would be of significant benefit to this population.

Appendix A

INFORMATION LETTER
for a Research Study entitled
"An Exploration of Mental Health Help-Seeking Experience Among Women Combat Veterans"

DEPARTMENT OF
SPECIAL EDUCATION, REHABILITATION, AND COUNSELING

INFORMATION LETTER
For a Research Study entitled
"An Exploration of Mental Health Help-Seeking Experiences among Women Combat Veterans"

You are invited to participate in a research study to explore mental health help-seeking experiences among women combat veterans. This study is being conducted by Kaycee Colón Roberts, Doctoral Student, under the direction of Dr. Chippewa M. Thomas, Professor, in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You are invited to participate because you are a woman combat veteran, over the age of 21, living in the US, who has served in the military for at least 3 years and have received an Honorable discharge. Additionally, you have engaged in mental health help-seeking AND have either been diagnosed with a mental health condition OR struggled with mental health – even if you have not received a diagnosis.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to complete an anonymous 22 question demographic survey online via Qualtrics link. This survey can be completed from a personal laptop or cellphone. Upon completing the survey and meeting the criteria for this study, you will be invited to participate in a one-on-one semi-structured interview to be conducted via zoom. Your total time commitment for the survey will be 10-15 minutes, with the interview averaging between 60-90 minutes to allow for in-depth and rich discussion. During the interview, you will be able to answer with as much or as little information as you like regarding your experiences.

Are there any risks or discomforts? Your email address will be asked when scheduling your individual interview and upon completion of the interview. However, this information will be collected separately from the demographic survey to keep your privacy. The demographic survey will be accessed anonymously via Qualtrics link. This survey will not be linked to your interview. Your one-one-one individual interview will be audio-recorded which might be identifiable, but the audio recording will remain confidential and only available to the responsible researchers. You have the right to withdraw from the study at any time without penalty. As a participant, you are not expected to experience any physical or psychological discomfort due to the nature of the information being collected. If by chance the participant experience psychological distress, the researcher will properly help you identify a mental health professional in your local area. You can also visit the Psychology Today website to find a therapist near your location: **https://www.psychologytoday.com/us.**

Are there any benefits to yourself or others? The information collected may or may not benefit you directly; however, the information learned from this study may help to inform practice of mental health professionals and service organizations who work with military veterans, more specifically women combat veterans.

Will you receive compensation for participating? Participants completing both the survey and interview will have the opportunity to be entered to receive one of three $25 e-gift cards. Upon completion of all interviews for this study, the Primary Investigator (PI) will utilize participant email addresses to draw winners for the three e-gift cards. Distribution of e-gift cards will be sent electronically to the three winners via email address. This identifiable information will be kept separately to protect your privacy.

Are there any costs? If you decide to participate you will not incur any direct costs.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary and there is no penalty for withdrawing.

Any data obtained in connection with this study will remain anonymous. I will protect your privacy and the data you provide by securely storing the data. The data will be stored in the locked files and the password protected computer. Information obtained through your participation will be used to complete the dissertation requirement and may be published in professional journals or presented at professional conferences, but the identities of all research participants will stay anonymous.

If you have questions about this study, please ask them now or contact Mrs. Kaycee Colón Roberts, Primary Investigator at kcr0035@auburn.edu or the supervising faculty member Dr. Chippewa M. Thomas who can be contacted at thoma07@auburn.edu.

If you have question about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334)-844-5966 or email at IRBadmin@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION ABOVE, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS AGREEMENT TO DO SO. YOU MAY PRINT A COPY OF THIS LETTER TO KEEP.

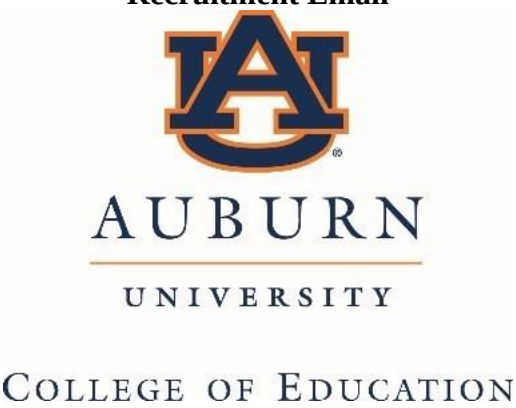
o I consent, begin the study

o I do not consent, I do not wish to participate

Primary Investigator, Kaycee Colón Roberts, MS, ALC, NCC, CTP
Auburn University, Counselor Education and Supervision Doctoral Candidate
kcr0035@auburn.edu

_____ _____

Appendix B
Recruitment Email



DEPARTMENT OF
SPECIAL EDUCATION, REHABILITATION, AND COUNSELING

Greetings!

My name is Kaycee Colon Roberts, and I am a doctoral candidate completing my PhD in Counselor Education and Supervision at Auburn University. As part of my dissertation, I am seeking participants for my research study titled: *"**An Exploration of Mental Health Help-Seeking Experiences among Women Combat Veterans.**"* This study is being conducted under the direction of Dr. Chippewa M. Thomas, Professor, in the Auburn University Department of Special Education, Rehabilitation, and Counseling.

I am asking for your assistance in distributing information regarding my dissertation research study along with the attached research flyer to participants who might meet eligibility criteria and/or organizations who may service women combat veterans (i.e. outreach & service organizations, community, and private practice and/or non-profit organizations, colleges & universities).

The purpose of this research study is to explore the experiences of mental health help-seeking among women combat veterans. More specifically, this study will investigate: What are the lived experiences of women combat veterans who have engaged in mental health services? Additionally, how have these experiences influenced their utilization of mental health services?

An individual would be eligible if they are a women combat veteran, age 21 and over, currently living in the United States. Individuals must have served at least 3 years in the U.S. military, received an honorable discharge, and had deployed at least once to a combat zone. In addition, the women combat veteran must have engaged in mental health help-seeking AND has either diagnosed with a mental health condition OR have struggled with mental health – even if you have not received a diagnosis.

The study consists of an online survey and a follow up one-on-one interview. The 22-question anonymous demographic survey is accessed via a Qualtrics link and should take about 10-15 minutes to complete. At the end of the survey, participants who meet eligibility criteria will be invited to schedule a 60 to 90-minute individual one-on-one interview that will be conducted via the online Zoom platform.

Participants completing both the survey and interview will have the opportunity to be entered to receive one of three $25 gift cards. Participation is completely voluntary, and you may withdraw at any time with no penalty. All information is confidential, and all data collected will be stored on password-protected programs and folders on a password-protected computer.

To participate in this research study, simply click on this link:
https://auburn.qualtrics.com/jfe/form/SV_2gZAoZJyKeI6WVM

Alternatively, you can use your mobile device to scan this QR to access the survey:

Please contact Kaycee Colon Roberts at kcr0035@auburn.edu, or Dr. Chippewa M. Thomas at thoma07@auburn.edu if you have questions about this research. Please feel free to share this email and flyer with anyone who might be interested in participating. I would really appreciate your support in this endeavor!

Kind Regards,
Principal Investigator: Kaycee Colon Roberts
Doctoral Candidate,
Counselor Education and Supervision, Auburn University

Appendix C
Paricipant Email

COLLEGE OF EDUCATION
DEPARTMENT OF
SPECIAL EDUCATION, REHABILITATION, AND COUNSELING

Greetings,

My name is Kaycee Colon Roberts. I am a doctoral student in the Counselor Education and Supervision program at Auburn University. As part of my dissertation, I am seeking participants for my research study titled: ***"An Exploration of Mental Health Help-Seeking Experiences among Women Combat Veterans."*** This study is being conducted under the direction of Dr. Chippewa M. Thomas, Professor, in the Auburn University Department of Special Education, Rehabilitation, and Counseling.

The purpose of this research study is to explore the experiences of mental health help-seeking among women combat veterans. More specifically, this study will investigate: What are the lived experiences of women combat veterans who have engaged in mental health services? Additionally, how have these experiences influenced their utilization of mental health services?

An individual would be eligible if they are a women combat veteran, age 21 and over, currently living in the United States. Individuals must have served at least 3 years in the U.S. military, received an honorable discharge, and had deployed at least once to a combat zone. In addition, the women combat veteran must have engaged in mental health help-seeking AND has either diagnosed with a mental health condition OR have struggled with mental health – even if you have not received a diagnosis.

The study consists of an online survey and a follow up one-on-one interview. The 22-question anonymous demographic survey is accessed via a Qualtrics link and should take about 10-15 minutes to complete. At the end of the survey, participants who meet eligibility criteria will be invited to schedule a 60 to 90-minute individual one-on-one interview that will be conducted via the online Zoom platform. Participants completing

both the survey and interview will have the opportunity to be entered to receive one of three $25 gift cards. Participation is completely voluntary, and you may withdraw at any time with no penalty. All information is confidential, and all data collected will be stored on password-protected programs and folders on a password-protected computer.

To participate in this research study, simply click on this link:
https://auburn.qualtrics.com/jfe/form/SV_2gZAoZJyKeI6WVM

Alternatively, you can use your mobile device to scan the QR to access the survey:

Please contact Kaycee Colon Roberts at kcr0035@auburn.edu, or Dr. Chippewa M. Thomas at thoma07@auburn.edu if you have questions about this research. Please feel free to share this email and flyer with anyone who might be interested in participating. I would really appreciate your support in this endeavor!

Kind Regards,
Principal Investigator: Kaycee Colon Roberts
Doctoral Candidate, Counselor Education and Supervision, Auburn University

Participant Email
Page 2 of 2

Appendix D
Participant Demographic Questionnaire

Please respond to the following questions and do not provide any identifying information.

1. What is your gender? [Qualifier question]

o Male
o Female

2. What is your age? Write in Numeric Form. [Qualifier question]

o _____ Fill in the blank.

3. Did you serve in the military for at least three years? [Qualifier question]

o Yes
o No

4. Have you ever deployed to a combat zone? [Qualifier question]

o Yes
o No

5. What type of discharge did you receive from the military? [Qualifier question]

o Honorable
o Dishonorable
o Other than Honorable

6. List the locations of the combat zones you were deployed to.

o_____

7. Type of separation

o drawdown
o Expiration Term of Service or REFRAD
o Retirement
o Medical
o Resignation

8. Do you have a service-connected disability through the VA?

o No
o Yes, for both physically related and mental health-related conditions
o Yes, for physically related conditions only
o Yes, for mental health-related conditions only

9. Have you ever been diagnosed with a mental health disorder?

o Yes
o No

10. Have you struggled with or experienced mental health challenges/concerns, even if never diagnosed?

o Yes
o No

11. Have you ever made a visit to a mental health professional?

o No
o Yes, while on active duty
o Yes, after I departed from active duty
o Yes, both while on active duty and after departing active duty

12. Over the past year, have you visited a mental health professional?

o Yes
o No

13. Over the past year, how many visits have you made to a mental health professional?

o Zero/None
o Between 1-2 visits

o Between 3-6 visits
o Between 7-12 visits
o More than 12 visits

14. In which Branch of Military did you serve?

o US Army
o US Air Force
o US Navy
o US Marine Corps
o US Coast Guard

15. What was your highest military pay grade at time of separation, discharge, or retirement?

o E1-E4
o E5-E6
o E7-E9
o W01-05
o O-1 to O-3
o O-4 to O-6
o O-7 or above

16. Length of Service. How long did you serve in the military?

o 3-5 years
o 6-10 years
o 11-15 years
o 16-20 years
o More than 20 years

17. What year did you depart from active duty? Please enter the year in number form:

_____

18. Please select the category that best describes your race/ethnicity (select only one response):

o American Indian or Alaska Native
o Asian
o Black or African American
o Hispanic or Latino
o Native Hawaii or Other Pacific Islander
o White
o Two or More Races
o I prefer not to answer

19. Highest Degree

o High School/GED
o Some College
o AA degree
o BS/BS degree
o MS/MA or above
o PhD

20. **What is your marital status?**

o Single
o Married, or in a domestic partnership
o Divorced
o Separated
o Dating or in a relationship, not living together
o Other (please specify)

21. Children (age in years)

o Yes
o No

22. What is your current employment status?
o Employed full time
o Employed part-time
o Unemployed
o Student
o Retired
o Homemaker
o Self-employed
o Other: Please specify)

Appendix E

Interview Protocol

Opening Script: "Thank you for your interest in this study and for meeting with me today. I am conducting a study to explore the lived experiences of women combat veteran's in regard to mental health help-seeking". At any time, if you would like to discontinue this interview you are free to do so and under no obligation to continue. This information during this interview will be used to complete the research for my dissertation. The interview will last 60-90 minutes to allow for rich discussion and understanding of your experiences. This interview will be audio recorded only, and you can select or be assigned a pseudonym. The information contained in this interview is confidential and measures will be taken to ensure any information you share is not identifiable to your persons in the analysis process. I would also like to ask if you have any questions regarding the information letter you received. Would you like to choose a pseudonym at this time? Do you have any other questions?

Questions:

1. What led you to join the military? (Rapport building question)
2. With the military being a male-dominated institution, can you describe your experience of being a woman in the military?
3. What was it like to deploy to a combat zone? To return home?
4. How would you describe military culture as it pertains to mental health?
5. It is said many veterans struggle with mental illness but often, do not seek help, have you had any experience with this? Follow up questions: What are some reasons you may not have sought help?
6. Have you ever been diagnosed with a mental health disorder?
7. If yes, what has your experience been on being a women combat veteran with a mental health disorder? If not, do you have any mental health concerns? How has this impacted your life?
8. Have you ever sought help for mental health? What was your experience like?

9. In which type of settings have you received counseling?
10. What were these experiences like for you? How were they the same/different?
11. Have you experienced any barriers to seeking counseling?
12. Latency – how long after leaving active duty or redeploying did you wait before seeking out help for mental health?
13. It is said there is a stigma associated with mental health seeking. Can you tell me if you have experienced this?
14. Have you ever experienced sexual harassment or been the subject of a sexual assault?
15. Describe any prior military experience which has influenced your willingness to seek help?
16. Have you experienced any barriers to seeking mental health?
17. Can you describe any positive experiences as they related to mental health seeking?
18. Is there anything else about your experience in the military that you would like to share?
19. If given the opportunity, what are some recommendations or changes you would like to see at it pertains to mental health access for women combat veterans?
20. What would be important for counselors to know about counseling this population of women combat veterans?
21. Is there anything else in general you would like to share or would like for me to know?

Appendix F
Recruitment Flyer

PARTICIPANTS NEEDED

For a Study titled "An Exploration of Mental Health Help-Seeking Experiences among Women Combat Veterans"

The purpose of this research study is to explore the experiences of mental health help-seeking among women combat veterans. More specifically what are the lived experiences of women combat veterans who have engaged in mental health services.

Participants will be asked to:

- Complete an anonymous 22-question demographic survey online via Qualtrics link (10-15 minutes)
- Schedule and complete an interview to be conducted over Zoom where they will be asked questions and have a chance to share their unique experiences (approx. 60-90 minutes in duration)

Participants who complete both the survey and interview will have an opportunity to be entered to receive 1 or 3 gift cards valued at $25.

Are you eligible?

- Age 21 or older
- Living in the United States
- Are you a woman veteran who has served in combat?
- Did you serve in the military for at least 3 years?
- Did you receive an honorable discharge upon departing the military?
- Have been diagnosed with a mental health disorder OR has struggled with mental health related challenges (such as depression, anxiety, suicide ideation, trauma, etc.)?
- Have received counseling or considered seeking out counseling services?

To participate in this research study, simply click on this link:
https://auburn.qualtrics.com/jfe/form/SV_2gZAoZJyKeI6WVM

Or use your mobile device to scan the QR to access the survey.

For questions?
Kaycee Colon Roberts at kcr0035@auburn.edu
Dr. Chippewa M. Thomas at thoma07@auburn.edu.

Principal Investigator: Kaycee Colon Roberts, Doctoral Candidate, Auburn University,
Dissertation Chair: Dr. Chippewa M. Thomas, Professor, Auburn University, Department of Special Education, Rehabilitation, and Counselor