ABSTRACT

Understanding the Mental Healthcare Needs of Female Veterans
and Access to Mental Health Care Services within a Veterans Health Care Facility:
A Phenomenological Case Study

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Access to mental health care has become a significant issue among female veterans who served during Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). These female veterans have a greater need for mental health services than male veterans. However, little research exists focusing on the mental health needs of OEF/OIF female veterans. When evaluated by mental health professionals, female veterans score higher on mental health screenings than males. With increases in the veteran female population, it is important to understand these veterans' experiences accessing mental health care. The purpose of this phenomenological case study was to understand the barriers and access experiences to mental health care in veterans' healthcare facilities for OEF/OIF female veterans.

Feminist theory (Bean Mayberry et al., 2011) and Andersen's (1995) behavioral model of health use provided the theoretical framework for this phenomenological case study. Little research focuses on female veterans and there is a need for current research on utilizing mental health care within a veterans' health care facility. Data were collected

using purposive criterion sampling of four female veterans who served during OEF/OIF, who self-identify as having a mental health illness, and who are eligible to receive mental healthcare at a hospital that serves veterans. The researcher conducted and recorded one 30–45-minute interview with each participant in this study via a virtual platform. The researcher examined all participants as a whole case before completing a thematic analysis to reveal common themes.

The results from this study revealed the mental health care needs of female veterans are different from the needs of males and female veterans experience barriers to accessing mental health care at veteran healthcare facilities. During the analysis of the data from this study, the following themes emerged as barriers to mental health care: providers do not review medical records, male-veteran centered care, predominantly male mental health support groups, lack of female providers, quick turnover of providers, issues navigating the veterans' healthcare system, and delays in scheduling appointments. Based on the results from this research study, the researcher provides implications and recommendations to improve access to mental health care for OEF/OIF female veterans.

Understanding the Mental Healthcare Needs of Female Veterans
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A Phenomenological Case Study

by

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A Dissertation

Approved by the Department of Curriculum and Instruction

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGMENTS

Your life is your journey. Live for YOU, live for your FAMILY, and live for your FAITH. Your journey is a collection of your memories. Remember where you started, remember your success, and remember your sorrows, as well as those who guided you along the way. As you journey across the paths of others, some people will pause their journey to help you, others will need your help. It's you and your journey, but you are not alone. Remember to follow your faith and your heart as you do what YOU CAN when YOU CAN and if YOU CAN. Enjoy your life's JOURNEY!

—SFC Acquanetta Pullins (U.S. ARMY Retired)

First and foremost, I want to honor my sisters-in-arms of all military branches past, present, and future. Your service matters, and your struggles matter. I pray this research gives a voice to all female veterans who suffer from mental health illnesses. Thank you for your sacrifice and service to this country.

I want to extend my sincere gratitude and special recognition to my advisor and dissertation committee chair, Dr. Sandi Cooper. I honestly believe that God puts the right people in your life at the right time, and he did that for me with Dr. Cooper. Thank you for your support and your genuine concern for my well-being when difficult life situations happened. Thank you for encouraging me to "just keep swimming."

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To my children, Ari'Shaun, Christopher, Michael, and Mason Jr., I want you to know you all are my motivation. You are the reasons why I work so hard and never quit. Always make your dreams and goals visual and remember you can do anything that you set your mind to. You were born for greatness!

To my husband, Mason Gayles, Sr., thank you for going on this journey with me. You encouraged me to keep going when I did not think I could. Thank you for listening when I needed an ear to vent to and a shoulder to cry on. Thank you for your unconditional love, support, and understanding during my pursuit of completing my dissertation. Thank you for being my person. I love you to the moon and back!

DEDICATION

To my daddy, Keith D. Pullins,
I know at times it seemed like I was not listening.
I know at times my future did not seem bright.
I know at times I did not make it easy for you and mommy.

I wish I could tell you; I was listening.
I wish I could tell you; everything I do, I do to make you proud.
I wish I could tell you; I thank you for never giving up on me.

I wish I could tell you in person one more time that I love you.

I take comfort knowing that you are smiling down on me from heaven
and that you are so proud of me. I love and miss you so much.

CHAPTER ONE

Introduction to the Problem of Practice

Introduction

Women in the military use the term "invisible veterans" due to the military being a predominantly male population (A. Goldstein, 2018, 2019). The 2017 National Center for Veterans Analysis and Statistics reported women represented 9.4% of the veteran population in 2015. Since 2017, there is an expected increase at an average rate of 18,000 women per year over the next 10 years for the veteran female population (U.S. Department of Veterans Affairs [VA], 2017b). Once females transition out of the military from active duty they will then be known as a veteran and receive benefits from the VA. They face issues with access, exclusion, and improper health care management (VA, 2017b). Female veterans have come a long way with the integration of serving in combat environments. However, female veteran's health care is still an ongoing issue with today's female veteran population. Studies have shown that male and female veterans have different needs when it comes to mental health care (Eichler, 2017; VA, 2015b). Researchers have determined a need for a focus on the mental health care of post 9/11 female veterans (Patten & Parker, 2011). However, there is little research to determine what the mental health needs are of female veterans.

Few studies have researched female veterans' needs when accessing mental health services at a veterans' healthcare facility (Eichler, 2017). Much research focuses on the needs and barriers of the male and female veteran population without distinguishing the different needs of each gender (Eichler, 2017). Females in the military are evolving,

leaving the need to research the differences between the male and female veteran populations. This phenomenological case study provides a deeper understanding of female veterans' issues when accessing mental healthcare at veterans' healthcare facilities.

Statement of the Problem

The veteran female population is rising at an average rate of 18,000 female veterans over the next 10 years (VA, 2017b). This veteran population will increase by 14% over all branches of service with every five females having served in OEF/OIF (VA, 2015b). Mental health care is a significant problem among female veterans, specifically those who served during the OEF/OIF era. Studies have shown that female veterans are more likely to have a mental health condition than male veterans (Frayne & Mattocks, 2012; Kimerling, Bastian et al., 2015; Kimberling, Pavao et al., 2015). The specific problem is female veterans who served during OEF/OIF have experienced barriers accessing mental health care at veterans' hospitals. Some of these barriers are perceived to be due to the veterans' hospitals providing treatment designed for male-veteran centered care. Previous studies indicated that the predominantly male environment in veterans' hospitals were unwelcoming to female veterans (Kehle-Forbes et al., 2017). Participants in the study conducted by Kehle-Forbes (2017) expressed suffering from military sexual traumas and being uncomfortable in a hospital of predominantly male veterans. The concerns expressed in previous studies show a need for veterans' healthcare facilities to acknowledge the needs of female veterans.

Female veterans have complex needs and require specialty mental health services designed for women. Mental health disorders are a wide range of conditions that affect

mood, thinking, and behavior. In a 2015 survey conducted by the Altarum Institute, 52% of female veterans felt they needed mental health care, and 35% of female veterans were hesitant to seek mental health services (VA, 2015b). The results of the study conducted by the VA concluded female veterans do experience barriers to mental health care that may contribute to underutilization of mental health services at veterans' healthcare facilities. Evaluation of female veterans' experiences accessing mental health care at a veterans' healthcare facility will shed light on barriers to care and ways to overcome them. Previous studies indicated understanding the barriers these female veterans face will guide hospital leadership in improving accessing mental healthcare in veterans' hospitals (VA, 2015b; Washington et al., 2011). Koo and Maguen (2014) indicated there is sparse research on the barriers female veterans face in receiving mental health treatment and even less research on the barriers of OEF/OIF veterans.

Purpose of the Study

The purpose of this phenomenological case study was to understand the barriers and access experiences to mental health care in veterans' healthcare facilities for OEF/OIF female veterans. Identifying the barriers to mental health care will help improve patient care quality to make mental health services more accessible for OEF/OIF female veterans (Kimerling, Bastian et al., 2015; Kimberling, Pavao et al., 2015). Data collection included four OEF/OIF female veterans who self-identified as having a mental health disorder who would participate in semi-structured interviews. The results from this phenomenological case study highlighted the barriers and access experiences to mental health care that these veterans have experienced as they transitioned into a veterans' healthcare facility.

The participants in this study were OEF/OIF female veterans with mental health issues who are eligible to receive services at a Texas veterans' health facility. I interviewed participants on their experiences accessing mental health care at a veterans' healthcare facility. Upon approval from the Baylor University Institutional Review Board, I conducted one-on-one semi-structured interviews with four OEF/OIF female veterans. The four female veterans were all veterans from the U.S. Army. The research questions guiding this study included,

1. What factors prevent OEF/OIF female veterans from accessing mental health services at a veterans' healthcare facility?

2. How has access to mental health services at a veterans' healthcare facility impacted OEF/OIF female veterans' transition into life as a civilian?

Theoretical Framework

In this study, I used two a priori theoretical framework to understand the barriers and access to care that female OEF/OIF veterans face within a veterans' healthcare facility. I used feminist theory (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017) and Andersen's (1995) behavioral model of health service use to increase the growing research on female veterans and mental health care access. I chose the feminist theory (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017) framework that focuses specifically on female veterans' needs as there is little research on the needs of these veterans. I chose Andersen's behavioral model of health service use to identify factors that affect the use of health care services at the VA hospital. Together these frameworks focus on the barriers that OEF/OIF female veterans face accessing mental health care services at a veterans' healthcare facility. I explored reasons why female veterans do not use veterans' healthcare facilities for mental health services.

I used a feminist theory approach to research mental health needs and access to care among OEF/OIF female veterans (Eichler, 2017). There is a new reality on gender-specific research on the needs and challenges of female veterans (Boyd et al., 2013) "due to female veterans being the fastest growing new users in the Department of Veterans Affairs (VA) Healthcare System" (Bean-Mayberry et al., 2011, p. 84). Eichler (2017) stated feminist theory helps identify and analyze the various approaches to gender found in veterans' research. Eichler (2017) found focusing on female veterans is the most common approach to addressing gender. Eichler (2017) explained,

> In scholarship on veterans, the most common approach to addressing gender is to focus on female veterans. This scholarship acknowledges that while women make up a significant portion of the contemporary population of veterans, we know little about them. This scholarship aims to produce knowledge that allows us to better understand and respond to the needs of female veterans. (p. 679)

I used a framework based on Andersen's behavioral model of health services use, I identified barriers female veterans face accessing mental health services at VA hospitals. Andersen (1995) developed the behavior model of health services use in the late 1960s. Anderson initially developed this model to assist in understanding why families use health services and to understand the "how's" and "why's" of health services' use (Andersen, 1995). This model has evolved several times over the years with the development of the phase three model in the 1980s. Andersen's phase three model was used to show how the population utilizes services at the local hospitals for preventive medicine.

The behavior model of health service use identifies factors contributing to the usage of or a lack of mental health services at a veterans' healthcare facility. Andersen's (1995) phase three model uses external factors to understand patient's usage of health

services. I adapted Andersen's phase three model to understand OEF/OIF female veterans' barriers utilizing mental health services at the VA hospitals. Andersen's model was a helpful framework in identifying any predisposing, clinical, and enabling characteristics that contributed to the barriers and access to mental health care for OEF/OIF female veterans. I used individual characteristics of the veterans, such as ease of access and disabilities. This model helped identify why these veterans have their current attitudes concerning using or not using mental health care services at a veterans' healthcare facility.

Research Design and Methods

A qualitative research design was an appropriate research design for this study because the purpose of this phenomenological case study was to understand the barriers and access to mental health care in veterans' healthcare facilities for OEF/OIF female veterans. Creswell and Poth (2018) explain, "qualitative research is appropriate when a problem or issue needs to be explored" (p. 47). I aimed to give a voice to female veterans who have had problems accessing mental health services at a veterans' healthcare facility. Female veterans shared their experiences through semi-structured interviews. Using a phenomenological case study design approach, I examined female veterans' lived experiences of possible barriers and access to mental health care at a veteran's healthcare facility.

Participants for this study included four OEF/OIF female veterans who live in the State of Texas and are eligible for services at a veterans' healthcare facility. Purposive criterion sampling informed the participant types. I conducted semi-structured interviews with each participant and followed the proper interview protocol by asking questions

aligned with the research questions. I recorded and analyzed the similarities and differences from the participants' interviews. The data collected was organized, reduced into themes, and informed the discussion in this study.

Definition of Key Terms

Definitions of the following key terms are crucial to understand and interpret the results of the study.

Military Sexual Trauma: Unsolicited sexual advances experienced by a veteran while serving in the military (VA, 2017a).

Operation Enduring Freedom: The Global War on Terrorism was officially named Operation Enduring Freedom on September 11, 2001, by the U.S. government (VA, 2019).

Operation Iraqi Freedom: The name of the attack between the United States and Iraq that led to the dismantling of Saddam Hussein's regime (VA, 2019).

Post 9/11: Any time after September 11, 2001, terrorist attacks on the United States (VA, 2019).

*Post-Traumatic Stress Disorder: "*A psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape, or other violent personal assaults" (American Psychiatric Association, 2021, para. 1).

Suicidal Ideation: An individual who has thought of ending their own life (WebMD, 2021).

Veterans' Healthcare Facility: In this study, a veterans' healthcare facility refers to a medical hospital or clinic that provides medical services for military veterans only.

Veteran: In this study, a veteran refers to any male or female who has served at any period in the United States Armed Forces and is no longer serving.

Conclusion

The U.S. military dates back as far as 1775 with the Army being the oldest branch of the military. At the time, only men could join the military and serve their country, making the veteran population mostly males. It was not until 1917, during WWI, that women officially joined the military (Toler, 2019). However, even though these women served their country, their service was not recognized. The role of women service members has drastically transformed over the years. Women went from serving in the military from the sideline to serving in the Women's Army Corps. As of 2016, women can choose any military occupation including ground combat units. The evolvement of women in the military has changed the veteran population and led to a unique need for female-centered health care. More female veterans have served during the OEF/OIF era than any other wartime era. The majority of health care research focuses on the needs of male veterans. Recent studies have shown female veterans have different needs than male veterans (Eichler, 2017; VA, 2015b). Although the veteran female population is continuously increasing, the veteran population is still predominantly male.

Limited research provides an understanding of the needs and access to mental health care for OEF/OIF female veterans. The veteran population continues to grow with female veterans who have served during the OEF/OIF era. Due to prolonged and frequent deployments, many veterans discharge from active duty with a mental health disorder. Studies have shown there are gaps in the literature concerning female veterans and their mental health needs (Eichler, 2017; VA, 2015b). This study aimed to fill those gaps by

providing a deeper understanding of female veterans' mental health needs from veterans' healthcare facilities. Chapter Two provides a detailed review of the literature on the veteran female population, gender-specific research, needs, and access to mental health care.

CHAPTER TWO

Literature Review

Introduction

Women have been serving unrestrictedly in combat units in the U.S. military since January 24, 2013, when the Pentagon lifted the ban on women serving in direct combat (Rosenberg & Phillipps, 2015). A little over eight years have passed since this historical event occurred. Female servicemembers are now serving in combat environments. Once female veterans are discharged from the military and enroll in the VA healthcare system, evidence shows women are receiving substandard care. In many cases, no treatment for combat-related stress and other psychological and physical issues unique to their situation. This literature review provides an overview highlighting female OEF/OIF veterans' issues when accessing mental health care services at a VA healthcare system.

The influx of female veterans into the VA healthcare system has resulted in a need to address the difference in female veterans' mental health care needs versus male veterans. "Military servicewomen live with coexisting identities that are dissonant with conventional gender roles"(A. Goldstein, 2018, para. 5). Female veterans are an underrepresented group due to a predominantly male military. According to the Women Health Evaluation Initiative of 2014, women diagnosed with a mental health condition use mental health services and have more mental health appointments (A. Goldstein, 2018). There is little research that focuses on the mental health needs of female veterans.

Understanding the mental health needs and access to care for female veterans will help improve access to care.

Mental Healthcare of OEF/OIF Veterans

Veterans who served during OEF/OIF have become the largest veteran group to have served in the military (Koo et al., 2015). With the veteran population's continuous growth, it is critical to address the mental health needs of veterans. Studies have shown that more veterans have survived the OEF/OIF era than any other military period. Many veterans served during the OEF/OIF era were redeployed more than once and for more extended periods due to fewer veterans killed in action. Frequent and prolonged deployments exposed these veterans to more trauma, resulting in multiple and complex health care needs (Waszak & Holmes, 2017). However, veterans who served during the OEF/OIF era have more negative attitudes toward mental health treatments than veterans from other war time eras (Garcia et al., 2014). The negative attitude toward mental health is a barrier contributing to veterans receiving mental health treatments at veterans' hospitals.

Mental health illnesses such as anxiety, depression, post-traumatic stress disorder (PTSD), traumatic brain injuries (TBI), and sleep disorders attribute to the stress experienced by veterans deployed while on active duty. Frayne and Mattocks (2012) reported mental health disorders had become a frequent diagnosis among male and female veterans upon discharge from the military. There are similarities in mental health issues among males and females. However, the new generation of female veterans face unique mental health threats (Street et al., 2009). Studies have shown female veterans are more likely to have a mental health condition than male veterans (Frayne & Mattocks,

2012; Kimerling, Bastian et al., 2015a). Studies have shown mental health illnesses affect genders differently. L. Goldstein et al. (2017) noted female veterans receive minimal attention for military traumas in the predominantly male environment. Past studies have demonstrated that military experiences impact a veteran's mental health by exposure to military stressors. The feelings felt by these veterans from military stressors are normal feelings as the veteran adjust to becoming a civilian. However, the intensity and duration of these behaviors highlight if the feelings of veterans are side-effects of coming back from war or if they have developed into more complex mental health issues, such as clinical depression, anxiety, bipolar, or PTSD (Calhoun et al., 2008). To make sure that such conditions of veterans do not go undiagnosed, the VA offers screening and diagnostic assessments services to identify if the veterans are facing any mental health problems. In the case of mental health issues, the VA then offers treatment and recovering programs to the veterans.

Veterans who served during OEF/OIF had more exposure to violence and human trauma and consumed more alcohol than veterans who had lesser exposure. The Veterans Health Administration has diagnosed 36.9% and 50.2% of post 9/11 veterans with a mental health illness or disorder (Substance Abuse and Mental Health Services Administration, 2012). When diagnosing PTSD, it is often associated with other mental health issues such as depression or traumatic brain injury. The data from National Survey on Drug Use and Health shows in the years 2004–2007, out of 312,000 people, 9.3% of them are U.S. veterans that experienced a major depressive episode. Out of these veterans, female veterans were twice as likely to have experienced a major depressive episode than males and more likely to screen positive for a military sexual trauma

(Substance Abuse and Mental Health Services Administration, 2012). Given the impact that mental health illnesses have on veterans, research shows that some mental health illnesses affect the female veteran population more than male veterans.

Post 9/11 Effects on Female Veterans

The role of female veterans in the military has evolved over the years to include positions in combat environments. In addition to women's roles in combat, Street et al. (2013) say, "the changing scope of women's roles in combat operations has led to a growing interest in women's deployment experiences and post-deployment adjustment" (Abstract). Patten and Parker (2011) found female veterans were less likely to have served in combat than men. However, in 2006, 10% of the veteran population deployed during OEF/OIF were females (Afari et al., 2015). In 2015, then-Secretary of Defense Ashton Carter ordered all combat positions be open to women (Kamarck, 2016). The exposure to more combat positions added to the military stressors female veterans were already experiencing. Females were more likely to have emotionally traumatic or distressing experiences while serving in the military (Patten & Parker, 2011). Before combat integration, females were still serving in direct and indirect fire environments. Females can currently serve in combat support units, exposing them to enemy fire and physical combat with the enemy. Patten and Parker (2011) noted, 42% of male war veterans faced traumatic experiences at war, and 47% of women faced such experiences making their reintegration into the society very distressing.

The evolvement of female roles in the military also meant more exposure to military stressors. Research has indicated military stressors have an impact on the mental health of service members. However, these stressors affect men and women differently.

These stressors contributed to prolonged deployments and exposure to combat environments (Maguen et al., 2012). Multiple deployments combined with combat exposure are associated with military stressors such as PTSD and military sexual traumas (MST). Women in the military have shown to have high positive ratings for PTSD and MST because of their deployment history. According to L. Goldstein et al. (2017), OEF/OIF female veterans have more mental health problems than female veterans from other wartime eras. Luxton et al. (2010) noted combat exposure increases PTSD and depressive symptoms in female veterans than in male veterans. However, Afari et al. (2015), Jacobson et al. (2015), and Vogt et al. (2011) would argue that regardless of gender, all veterans who experienced combat had increased mental health symptoms. PTSD, military sexual trauma (MST), and suicidal ideations (SI) are the primary mental health illnesses among OEF/OIF veterans. Research shows that even though all veterans experience mental health issues due to military stressors, female veterans experience trauma differently than male veterans making their needs for mental healthcare different from male veterans. Fontana et al. (2010) determined women veterans of the Iraq/Afghanistan war had greater exposure than male veterans to traumas experienced during military service. Fontana et al. noted the military stressors and trauma differences between male and female veterans should be taken into consideration when Veterans Health Administration designs mental health treatment programs for veterans by addressing female needs differently.

Common Mental Health Disorders and Barriers

In multiple studies, OEF/OIF female veterans, like their male counterparts, have suffered from such traumatic issues as “post-traumatic stress disorder (PTSD),

depression, alcohol-related problems, social and family problems, and suicidality" (Garcia et al., 2014, p. 273). These conditions require specific mental health care treatment be received as soon as possible following the traumatic incident. Some female OEF/OIF veterans put up roadblocks to their treatment by underreporting or trying to hide their need for mental health services. According to Brownstone et al. (2018), veterans are concerned about a lack of confidentiality in the VA healthcare system. Shiner et al. reported "OEF/OIF female veterans might be worried that treatment could delay their separation from the service" (as cited in Fiedler, 2019, p. 10). Female OEF/OIF veterans need more mental health assistance after a traumatic experience. Compared to men, they are more likely to utilize these services and are more likely to attend more sessions (Kimerling et al., 2015). However, studies of OEF/OIF female veterans in the 2010s demonstrate an underperforming VA mental health system. For example, a nationwide study of OEF/OIF veterans revealed fewer than 10% of those diagnosed with PTSD or other depression issues got the recommended mental health care program from the VA (Garcia et al., 2014). The dropout rate for VA mental health program participation also indicates dissatisfaction among OEF/OIF veterans with the care they received. According to Garcia et al. (2014), upwards of 68% of female OEF/OIF veterans enrolled in VA mental health treatment for PTSD and other depressive disorders never complete the treatment regimen.

Researchers have been studying the issues surrounding the underdiagnosis of female OEF/OIF veterans. In a study conducted by Pereira (2002), 57.1% of the men had symptoms of PTSD and 27.8% of the women had PTSD. From other studies such as Ghahramanlou-Holloway et al. (2014), the effects of excessive trauma in female veterans

who served during OEF/OIF have an array of symptoms such as elevated anxiety rates, depression, and PTSD. In extreme cases, this depressive state has caused women to commit suicide. Women who serve in the military are more at risk for suicide (Ghahramanlou-Holloway et al., 2014). Signs of trauma usually show in these women after being on active duty, especially one or more tours during OEF/OIF or any other exposure to traumatic stress.

According to mandates covering the dispensation of mental health care at the VA, the organization has a "strong commitment" to the treatment of PTSD. Every veteran who presents themselves for treatment at a VA healthcare facility receives screening for symptoms of PTSD and depression, and facilities are "required" to provide every service member who demonstrates the symptoms of PTSD with "evidence-based" treatment for this disorder (McGinn et al., 2017). However, this situation may not always play out strictly according to the rules. As a matter of practice, a significant portion of OEF/OIF female veterans are either deciding not to take advantage of the care provided or do not feel at ease in the male-dominated environment of most VA clinics or hospital settings.

Post-Traumatic Stress Disorder

Female veterans between 18 and 64 are prone to be diagnosed with the second most diagnosed mental health condition known as PTSD (Frayne & Mattocks, 2012). Veterans' healthcare facilities treat all mental health conditions, with PTSD being the most common (Carlson et al., 2013). PTSD often links to other mental health symptoms, such as sexual assault, anxiety, and TBI. Jacobson et al. (2015) researched those females were at a moderately higher risk for post-deployment PTSD than men. Female veterans experience military stressors that trigger PTSD, such as handling deceased service

members following a battle, long deployments, and extended family separations (Carlson et al., 2013). Street et al. (2009) found females are more likely than men to meet PTSD criteria, and there is limited literature regarding gender differences in trauma and PTSD. Studies on gender differences are mixed with a stronger negative impact on women than men, while other studies have not supported these results (Street et al., 2009, 2013).

According to Maguen et al. (2012), OEF/OIF women veterans diagnosed with PTSD and depression are at a significantly higher probability of requiring inpatient care for severe PTSD symptoms and have a substantially higher risk of suicidal ideation. Secondary issues of substance abuse can cause a misdiagnosis of PTSD (Nunnick et al., 2010). When it comes to PTSD and substance abuse, there is often a bi-directional relationship between the two conditions. This statement means that, especially in female OEF/OIF veterans, those who test positive for elements of PTSD will often have a substance abuse problem underlying their PTSD and vice versa (Nunnick et al., 2010). The two conditions cover for one another when clinicians attempt to diagnose female OEF/OIF veterans.

Suicidal Ideations and Military Sexual Trauma

SI has a connection with MST and various other mental health illnesses among female veterans (Blais & Monteith, 2019; Khan et al., 2019). Koo and Maguen (2014) reported sexual trauma to increase the risk of other mental health conditions. These researchers found that one-quarter of female veterans experienced sexual trauma during their military careers. The VA (2021b) defines MST as "sexual assault or sexual harassment experienced during military service" (para. 1). Hester (2017) found female veterans have a higher suicide rate than civilians at 35 for every 100,000-female veterans.

Female veterans are 250% more likely to commit suicide than women who have never served in the military (L. Goldstein et al., 2017). Research on SI has focused primarily on male veterans (Khan et al., 2019). It is essential to understand the effects mental health disorders have on female veterans with suicidal ideations and identify the needs and access to mental health care.

Also, female OEF/OIF veterans often report that the VA does not take their claims of trauma resulting from sexual assaults seriously. One example of this was an anonymous female Army veteran who served in Iraq in 2004. She noted that initially, the VA did not believe her claims until she became suicidal and started cutting herself. Her assault was committed by a superior in her chain of command, and after she fought him off, he began to assign her to duties where she was bound to get injured and did (Benedict, 2010). Sadly, this incident is just one of many that OEF/OIF female veterans and other females serving in the military have reported.

Traumatic Brain Injury

As with other post-deployment mental health research areas, there has been more data collected on the reaction of males to this condition than females. Specifically, the comparison of psychiatric diagnoses and neurobehavioral symptom severity among OEF/OIF VA male and female patients presenting with symptoms of TBI has been the subject of intense scrutiny since before the full deployment of women in combat (Iverson et al., 2011). Iverson et al. (2011) did some pioneering research in this domain and discovered some significant differences between men and women in TBI. Some of the statistics resulting from this research were that PTSD was more prevalent in males, however not unobserved in females. When comparing male and female combat-related

TBIs, females with PTSD reported being two times more likely to have symptoms of depression, 1.3 times more likely to have a non-PTSD-related anxiety disorder, and 1.5 times more likely to have a PTSD diagnosis along with a comorbid diagnosis of depression (Iverson et al., 2011). Therefore, clinicians must pay special attention to all types of psychiatric diagnoses related to PTSD when adjudicating the condition of female combat veterans with TBI. Clinicians and doctors treating female OEF/OIF veterans must also closely examine the blast severity related to TBI diagnosis because women are reportedly more susceptible to a wide array of after-effects resulting from this type of trauma (Iverson et al., 2011). Because of the relatively short history of U.S. females serving in direct combat roles, the effects females suffer from deployment related TBI are largely unknown. According to Hendricks et al. (2013), 21.6% of OEF/OIF female veterans screen positive for TBI.

Veterans' Healthcare Facility Eligibility and Mental Health Screening

The veteran can receive medical care at 1,255 veterans' healthcare facilities, including 170 medical centers and 1,074 outpatient sites, serving nine million enrolled veterans each year; however, not all veterans meet eligibility requirements to receive medical treatment at these facilities. Discharge status and disability ratings determine eligibility. According to VHA Directive 1601A.02 (VA, 2021a), veterans must meet basic eligibility criteria to receive healthcare at a veterans' healthcare facility. First, the veteran must have other than dishonorable character of discharge. Second, the veteran must have served at least 24 continuous months on active-duty military, naval, or air service. Third, the veteran is eligible if they enrolled in the 15-month service program.

However, all veterans, regardless of discharge status, are eligible for mental health services at a veterans' healthcare facility up to 1 year after separation from the military.

Even though women veterans who meet the eligibility criteria are authorized for services at a veterans' healthcare facility, some female veterans do not identify as veterans. More than two million female veterans do not self-identify as veterans (VA, 2017a). According to the Department of Veterans Affairs, "self-identify means considering oneself a veteran, actively claiming veteran status on employment forms, using veteran-associated benefits, and maintaining active affiliation with military and veteran-oriented community, social, and professional organizations" (A. Goldstein, 2019, p. 3). Many of these women veterans are unaware of their military benefits, and fewer than 30% of women veterans self-identify as veterans (U.S. Congress Senate, 2015). The lack of self-identifying attributes to the daily microaggressions that remind them that they are a part of an institution designed for men (A. Goldstein, 2019).

Murphy et al. (2014) found female veterans who served during OEF/OIF had higher rates of positive screening for PTSD symptoms than male veterans. Female veterans are among the fastest-growing group of veterans enrolling in veterans' healthcare facilities (Murphy et al., 2014). In 1988, the Women Veteran Health Program acknowledged the unique medical needs of female veterans (VA, 2020b). Mental health illnesses are the third most frequently diagnosed medical condition among veterans (Kimerling, Bastian et al., 2014; VA, 2015a). When veterans are released from active duty and enroll in a veterans health care system, their primary care provider screens them through an Afghan and Iraq Post Deployment Screen (Seal et al., 2008). This screening is to detect PTSD, depression, and high-risk alcohol use among the veteran.

Currently, there is a Transition Care Management Program formerly known as the OEF/OIF Program. According to Perla et al. (2013), "the transition care management program is designed to provide a holistic, patient and family-centered approach to managing care for veterans or service members that require integrated services or request case management services who are diagnosed with mental health needs" (p. 234). This program meets the vast growing veteran population's needs to rehabilitate and recover medical and psychosocial needs. Based on the veteran's needs, these services can be short or long-term (Perla et al., 2013).

In summary, to receive medical care at a veterans' healthcare facility, you must first be an eligible veteran. Eligible veterans served 24-months of continuous active duty and received a discharge status other than a dishonorable discharge. There are screening tools implemented for primary care providers to screen veterans for mental health conditions. However, many of these veterans are falling through the cracks for mental health screenings. Studies have shown OEF/OIF female veterans have a high rate of positive mental health screenings. It is important to continue researching female veterans' mental health needs and understand their utilization or lack of mental health service usage at veterans' healthcare facilities.

Accessing Mental Health Care in a Veterans' Healthcare Facility

The National Survey of Women Veterans found predictors of attrition from veterans' healthcare facilities were better overall health, higher income, having other forms of health insurance, and less favorable perceptions of quality of care and gender-specific features (Hamilton et al., 2013; Tsai et al., 2015). Kimerling, Bastian et al. (2014) argued it is significant to note that female veterans who served in the military

during the OEF/OIF era represent many veteran patients annually since 2003. This representation is more than the number of male veterans accessing mental health care. According to these analysts, the new generation of female veterans' health care requires more gender-specific attention. While examining the work of Kimerling, Bastian et al. (2014), this research carries vast significance for female veterans in understanding their mental health needs and access to mental health care. There is room for improvement in providing care to female veterans with mental health disorders due to military stressors. Although access to mental health care is available to female veterans through their veteran benefits, not all female veterans are accessing these mental health services making it essential to understand the needs and barriers to mental healthcare.

Veterans' hospitals are recognizably one of the largest integrated healthcare systems. These hospitals provide expertise in health care to all veterans. However, there is still a great need for veterans' hospitals to meet the primary mental health care needs of OEF/OIF female veterans. Female veterans who are eligible for mental health services may not be aware of their eligibility, have no access to the services provided by Veterans Affairs (VA), or there are certain barriers in place that make it difficult for them to access VA services. Research finds a few of the barriers that might influence a woman's access to VA mental health services are insufficient providers trained in women's health and care services which are specific to gender, inefficient referral and coordination with community providers, and psychosocial factors, for example, childcare (Marshall et al., 2021). In a study by Kimerling, Bastian et al. (2015), females reported they would be more inclined to receive care from veterans' hospitals if they were in women-only peer support groups with similar combat exposure experiences. Another possible concern that

female OEF/OIF veterans may have about seeking help in the VA system is the predominantly male-centric atmosphere of most VA mental health clinics. Some females feel uncomfortable discussing deeply personal thoughts and situations with someone of the opposite sex. This situation, combined with the principally male-dominated atmosphere at VA medical facilities regarding the numbers of male versus female patients also affects female participation. Additionally, satisfaction rates with mental health treatment at VA facilities showed only around 48% of female OEF/OIF veterans rated the VA as having met their mental health treatment needs (Kimerling, Bastian et al., 2015).

Gender bias is one of the many barriers for female veterans who need mental health services (Trobaugh, 2018). The assumption that male veterans are more likely to have mental health issues than female veterans is an example of the gender biases female veterans have encountered. Female service members have spent years earning their place in the military, proving women can serve their country equally as men do. According to Trobaugh (2018), even after discharge from the military, women still face gender bias as a veteran. Female veterans are in a dominant male environment, whether on active duty or as veterans. In a 2009 survey conducted by The National Survey of Women Veterans, female veterans reported they were not recognized as veterans when attending their appointments at veteran hospitals (National Academies of Sciences et al., 2018). There was an assumption that the female veteran was the wife accompanying her husband, the veteran. Female veterans report enrollment as non-combat veterans in the veteran's health system, assuming they did not deploy. In a female veteran study conducted by the Disabled American Veterans, many women reported feeling invisible and that their non-

combat role had less value than men who served (Murphy et al., 2014). In a study conducted by Turchik et al. (2013), female veterans associated a feeling of discomfort and not fitting in when going to veterans' healthcare facilities.

Research conducted by Cheney et al. (2018) found personal, financial, and legal issues are barriers these veterans face when accessing mental healthcare. Moreover, due to the lack of money, long-distance, lack of confidence in the clinical encounter, and the lack of privacy, these female veterans also fail to make regular visits to the veterans' hospitals, which devastatingly impacts their mental health (Cheney et al., 2018). Brunner et al. (2019) shared similar views with the authors mentioned previously as they also believe the lack of trust during clinical encounters serves as a basic need and a barrier for female veterans while accessing mental health services.

There are also practical barriers that female veterans of OEF/OIF deployments face in getting the PTSD care they need (Fiedler, 2019). Barriers to care affect female OEF/OIF veterans more than any other group and may influence female veterans' capacity to take advantage of available VA healthcare, like having the responsibility to care for a child and others such as not being able to get time off from work to attend VA mental health counseling appointments (Fiedler, 2019).

The discussion presented by Cheney et al. (2018) and Brunner et al. (2019) leads towards the evaluation that to meet the female veterans' primary mental health care needs, the veterans' hospitals should establish an environment that ensures the privacy of these women. These hospitals should also place importance on effectively training their mental health care providers on communication and compassion for the female veteran's mental health needs.

In summary, current literature suggests female veterans' mental health needs lack due to the lack of trained and proficient mental health care staff, lack of privacy, confidence, appointment issues, travel distance, and lack of health care insurance. While these hospitals should eliminate these barriers, Kimerling, Pavao et al. (2015) believe emphasis on gender bias will reduce most of the mental health care barriers that female veterans face. Eichler (2017) argues there is a need for broader integration of gender considerations while designing mental health care policies and programs by leadership in veterans' healthcare facilities.

Mental Health Care Needs for Female Veterans

Attention to gender-specific data is essential in the mental health needs of female veterans. The VA (2015b) conducted a study called the Study of Barriers for Women Veterans to VA Health Care. In this study, the VA focused on a random sample of 101,100 female veterans who were surveyed about their experiences accessing care at veterans' hospitals. The primary questions asked by the VA's survey consisted of "self-reported mental health conditions, hesitancy to seek care for these conditions, and reasons for their hesitancy to seek care" (p. 80). The VA's survey focused on mental health stigmas with 52% of these women self-reporting needing mental health care; however, "24% of [these] women indicated that they were hesitant to seek care for mental health issues" (p. 113). In the barriers for women veteran study, the VA (2015b) found female veterans reported being hesitant to seek mental health care services for reasons such as adverse effects of medication use, negatively labeled by friends and family, and not educated on how to obtain mental health services.

The VA's (2015b) study focused on the women veteran population and the various health care barriers within veterans' hospitals. As mentioned previously, the veteran population is increasing with female veterans from the OEF/OIF era. There is limited research on females and specifically the OEF/OIF era of female veterans. Washington et al. (2011) suggested OEF/OIF female veterans still experience barriers to health care access. Research suggests a lack of gender-specific mental health services is a barrier for female veterans accessing mental health care at veterans' hospitals. Washington et al. identified gender-sensitivity of health care personal is an area that has shown improvement; however, Hamilton et al. (2013) would argue gender-specific barriers are still an issue among female veterans' mental health care.

Kimerling, Bastian et al. (2015) found female veterans expressed women designated mental health services should be a priority. Kemerling, Pavao et al. (2015) suggest gender-specialized mental health services could improve the quality of care for female veterans. Recent studies are focusing on the need for gender-specific mental health care for female veterans. Fontana et al. (2010) found notable differences between male and female veterans of the OEF/OIF war. A study conducted by Fontana et al. discussed three differences between male and female veterans. First, female veterans have less support and money spent to support female veterans' needs. Second, female veterans experience more military traumas than men. Third, there is more diversity in the types of diseases for women than males.

Underutilization of Mental Health Services

Studies have shown a prevalence of veterans' mental health problems; evidence indicates OEF/OIF veterans are underutilizing mental health care services at the veterans'

healthcare facilities (Garcia et al., 2014). Studies have shown a need to research barriers to care by identifying factors that cause female veterans not to utilize their veteran health benefits for mental health care services. Studies have shown that regardless of veterans' mental health diagnoses, they do not use mental health services at the veterans' healthcare facilities. Underutilization of services has an independent effect on the veteran and jointly with the veterans' hospitals. Background characteristics such as age, gender, and ethnicity are possible barriers to accessing care. Stigmas related to mental health care are an ongoing barrier. For example, the belief that the veteran will look weak for seeking mental health services or the veteran feeling they are a burden to the system for needing mental health services.

The increase of females in the veteran population is a significant factor in ensuring an adequate number of female providers in veterans' healthcare facilities. Kimerling, Bastian et al. (2015) found female veterans faced gender disparities in primary care, preventive services, and mental health services. Kimerling, Pavao et al. (2015) conducted a study identifying gender-related indicators of perceived access to mental health care for female veterans. Kimerling, Pavao et al. (2015) noted,

> sampling 6,287 female veterans resulted in half of all women reporting perceived mental health needs; 84.3% of those women received care and nearly all mental health users (90.9%) used VA services, although only about half (48.8%) reported their mental health care needs were met completely or very well. (p. S99)

Research shows "OEF/OIF post-deployment (1–6-years window) depression rates were consistently higher among women than men" (Resnick et al., 2012, p. 897). Patients and staff at veterans' healthcare facilities are predominately male; therefore, the veterans' hospitals have limited female veterans' health care services. Data suggests that comfort is a factor in female veterans seeking mental health care due to a predominantly male

staffed health system. This factor identifies the need for specialty cares like mental health services to meet female veterans' unique needs. Pre- and post-9/11 female veterans reported not seeking help after a sexual assault during military service (Kintzle et al., 2015). Few studies focus on the utilization of mental health services within veterans' hospitals. Turchik et al. (2013) discussed avoidance of mental health issues, minimal knowledge of mental health issues, and the uncomfortable male environment as barriers for female veterans receiving mental health care. Another possible factor in female veterans not utilizing mental health services is a lack of knowledge of their veteran benefits. Some female veterans are unaware that they are entitled to use medical services at veterans' hospitals. This assumption may be due to the veteran serving less than four years in the military or having other than an honorable discharge status.

Most studies on mental health care come predominantly from the male veterans' point of view, leaving a lack of research to identify females' points of view. In 2019, VA researchers conducted a study to analyze reports from female veterans experiences obtaining timely access to mental health care in veterans' hospitals (Brunner et al., 2019). Timely access to mental health care is another barrier contributing to female veterans utilizing mental health services. Brunner et al. (2019) suggested more flexible clinic appointments may improve the timeliness of access to mental health care. Brunner et al. noted outside personal demands of women veterans affect them prioritizing their mental health care.

Some of the efforts made by the VHA are the inclusion of gender-specific and gender-sensitive primary care as well as specialty services. These services also include maternity care coordination (Mattocks et al., 2019) and separate health clinics for women

who are not comfortable in the general clinics. Despite these efforts, women continue to face barriers while accessing mental health care benefits provided by the VHA. There have been some national initiatives taken by VHA, such as the ChooseVA initiative that aims to include lesser waiting time, more availability, and prompt delivery of services (Office of Public and Intergovernmental Affairs, 2018). This initiative is acknowledged by researchers and is called to be one of the greatest efforts to improve community care access across the nation easier. However, there are no findings as to how it caters to women and their specific health needs. Therefore, to help make mental health services more accessible for women, it is important that VA implements programs that address female needs. There has been some research discussing the underutilization of care and identified some barriers to accessing mental health care, but there is a lack of research on female veterans (Harper et al., 2021). Data concerning the obstacles and needs have primarily been on male veterans and not focused on female veterans, specifically those who served during the OEF/OIF era. This research study discusses a need for more research on barriers that prevent female veterans from accessing and utilizing mental health services at veterans' hospitals. Up-to-date research will provide information to understand how to improve mental health services utilization.

The Need for this Phenomenological Case Study

There are currently gaps in the research literature on the needs and access to mental health care for OEF/OIF female veterans. Fontana et al. (2010) noted insufficient evidence suggesting mental health differences between female and male veterans and females of different war eras. Current literature suggests a need for more research to examine the comparative effectiveness of various mental health arrangements of female

veterans. Understanding the mental health needs and access to care for female veterans will identify the barriers that prevent them from accessing mental health services at veterans' hospital. Fox et al. (2015) identified a need for further researcher on female veteran mental health needs to understand their attitudes about mental health treatments and how the VA influences their mental health care decisions. Continuous research on the mental healthcare needs of female veterans is essential to provide high quality care for these veterans (Haskell et al., 2011). Veterans' hospitals are designed to provide healthcare to all eligible veterans; however, the veteran population is now made up of males and females. At one point in time only males were eligible to join the military leaving an all-male veteran population with healthcare and mental healthcare being designed to treat male veterans. Now that the veteran population consists of female veterans in addition to male veterans, treatment designed for females should be implemented into the VHA.

Kimerling, Bastian et al. (2015) acknowledged female veterans prefer gender-specialized services in a gender-integrated mental health setting. Maguen et al. (2012) explained there is little information about gender differences in this new generation of women. Evidence is lacking to treat the growing female veteran population (Rivera & Johnson, 2014). Due to the continuous increase in the veteran female population, it deems important to address female veterans' mental health needs. Sexton et al. (2017) agreed female veterans' clinical needs are vastly understudied, and one cannot assume females have the exact needs as male veterans. Eichler (2017) added studies on veterans should focus on gender disparities, gender norms, and inequality. Eichler noted analyzing gender specific needs of the veteran population aids in improving the transition of military to

civilian life. In addition, policies and programs for veterans can be improved with more research on gender specific topics.

This present study addresses the literature gaps by understanding the needs and access to mental health care through female veterans' perceptions. Existing literature focuses on the gender differences of mental health diagnoses, with females being at higher risk for mental health illnesses (Kimerling, Pavao et al., 2015; Kirk, 2018; VA, 2015b). There is a need to address how the veterans' healthcare facilities provide mental health care to female veterans, specifically those who served during OEF/OIF era. Limited studies discuss the barriers to mental healthcare, such as why some female veterans choose not to use veteran mental health care services or the issues they face when accessing mental health services (Kimerling, Pavao et al., 2015; Kirk, 2018; VA, 2015b). Barriers to mental health care could hinder the quality of care that veterans receive. The veteran female population continues to grow, and these veterans' needs are not the same as during other war times. Research on female veterans should be kept up to date so health care professionals can continue to improve mental health services in veterans' healthcare hospitals.

Conclusion

The phenomenological case study provides insight into the needs and access to mental health care of OEF/OIF female veterans within veterans' healthcare facilities. These needs and access to care examines the experiences of current OEF/OIF female veterans that are eligible to use veterans' healthcare facilities. As the literature review revealed, studies have shown mental health affects male and female veterans differently; therefore, females' mental health care needs are different. Females are growing in the

veteran population, with the most current veterans having served during the OEF/OIF era. With the increase in the veteran population, there is an increase in mental health diagnoses due to the experiences of more military traumas than any other wartime era. Previous research has focused on the needs of the male veteran population or the entire veteran population. Studies have shown females veterans are more likely to be diagnosed with a mental health condition than male veterans. Underutilization of mental health services is becoming a problem among female veterans. Identifying the possible barriers that prevent these veterans from seeking mental health services at veterans' hospitals will provide health care professionals with the most current information on improving the quality of care. I concluded this chapter by addressing the literature gaps related to the needs and access to mental health care in the VA hospitals for OEF/OIF female veterans.

CHAPTER THREE

Methodology

Introduction: Research Questions

The purpose of this phenomenological case study was to understand the barriers and access experiences to mental health care in veterans' healthcare facilities for OEF/OIF female veterans. McCaslin and Scott (2003) described phenomenology as "a study of the shared meaning of the experience of a phenomenon for several individuals" (p. 449). This chosen methodology fits my research because I want to capture my participants' personal experiences. To answer the research questions, participants had to meet the following criteria: OEF/OIF female veteran, self-identified mental health need, and be eligible to receive medical care at any veterans' healthcare facility. With this study, I sought to answer the following research questions:

1. What factors prevent OEF/OIF female veterans from accessing mental health services within veterans' healthcare facilities?

2. How has access to mental health services at the veterans' healthcare facilities impacted OEF/OIF female veterans' transition into life as a civilian?

Researcher Perspective and Positionality

Creswell and Poth (2018) explained qualitative researchers make their value known in a study by positioning themselves and identifying their positionality in relation to the context and setting of the research. Creswell and Poth remind the researcher that their value, position, beliefs, and bias will reflect their personal experiences through their writing. As the researcher of this study, I have firsthand experience on some of the issues

female veterans face accessing mental health care at the VA hospital. I am an OEF/OIF female veteran who served 10 years in the U.S. Army. I live near Fort Hood, TX, one of the world's largest military bases, which is near several hospitals for veterans. After discharge from the military, I experienced the transition process of leaving the military and navigating myself into the veterans' health system to obtain health care. I was able to see how difficult it can be to access mental health care and the barriers that deterred me from receiving mental health care at the veterans' hospital. Being a veteran seeking mental health services, I found it challenging to navigate the veterans' health system and get the mental health services I felt I needed. Eventually, I saw a primary care doctor who prescribed medications for my mental health illnesses; however, there was no follow-up care or therapy establishment. As a veteran, I felt my needs were not that important, and it was best to seek services outside of the veterans' hospital. Going through this transition from active duty to veteran made me want to work closely with veterans to make their transition easier.

I obtained employment at one of the veterans' hospitals in my area and worked in the mental health and social work services departments. During my 4 years of employment at the hospital, I heard stories from veterans who came through the hospital and shared their experiences of receiving mental health care. Much of my interaction was with OEF/OIF veterans who served in the largest military group (Koo et al., 2015). I noticed a pattern with gaining access to be more difficult for female veterans than for male veterans—many of the mental health support groups that the VA hospital offered were majority male participants. When female veterans would come into my office to make an appointment with the Transition Care Management Case Managers, many would

complain about how long they have been waiting to get an appointment with a mental health provider or complain about having to go through obstacles that would prevent them from getting mental health services. I became intrigued by why more females did not attend these support groups or even receive mental health care. I now strive to bring awareness to female veterans' mental health needs in hopes that more policies and procedures directly address the health care of these veterans.

I understand that my close connection with the study because I am an OEF/OIF female veteran who self-identifies as having a mental health disability can present some preconceptions. I have enclosed my understanding of my bias, values, and experiences related to this qualitative research study (Hammersley & Atkinson, 1995; Merriam & Tisdell, 2015). As the researcher, I understand the importance of separating my personal experiences to ensure the interview responses reflect precisely how the participants state them. By acknowledging my own biases, I would have to separate my experiences of barriers accessing mental health care at veterans' hospitals. I can be more aware and more objective in how I approach my research study.

Theoretical Framework

In this study, I used two theoretical frameworks to understand the barriers and access to care that female OEF/OIF veterans face within the veterans' healthcare system. Feminist theory (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017) and the behavioral model of health service use (Andersen, 1995; Fasoli et al., 2010) are the frameworks utilized to collect and analyze data to answer the research questions. Feminist theory focuses on the need for research that is gender specific, recognizing the mental health needs of female veterans (Bean-Mayberry et al., 2011; Boyd et al., 2013;

Eichler, 2017). Using feminist theory offered a critical review of female veterans' mental health needs and the opportunity to understand the different approaches to gender-specific research. There is little gender-specific research on the mental health needs of female veterans. This framework puts the focus on the needs of female veterans. Eichler (2017) suggested, "examining veterans' issues in relation to gender norms, gender inequalities, and the intersections of gender with other categories of social difference such as race or sexuality" (p. 5). This framework shaped the data collection and analysis by identifying overarching themes that emerged from patterns that focused on gender norms and gender differences. By analyzing data using the feminist theory framework, I explored and expanded on research that focuses on female veterans' mental health barriers and needs.

The behavioral model of health service use focuses on patient usage of health services and access to health care (Andersen, 1995). Andersen (1995) suggested, "people's use of health services is a function of their predisposition to use services, factors that enable or impede use, and their need for care" (p. 1). The behavioral model of health service use shapes the data collection and analysis that explains why these veterans do not use the veterans' hospitals' mental health services as well as uncovers barriers to accessing mental health care. This framework uses predisposing characteristics, enabling resources, and determining the use of health services. This model was used as a framework to identify barriers that prevent OEF/OIF female veterans from utilizing veteran healthcare facilities for mental health care services. With this study, I identified patterns and themes from the participants' interviews and determined whether they have similar barriers to accessing mental health services at veterans' hospitals.

The feminist theory (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017) and behavioral model of health service use (Andersen, 1995) frameworks were used to shape the primary research questions. Feminist theory kept the focus of the research questions on female veterans (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017). Eichler (2017) noted "feminist theory helps identify and analyze the various approaches to gender found in research on veterans" (p. 675). Using feminist theory for gender-specific research brings awareness to the lack of research on female veterans. The behavioral model of health services use was foundational to developing the research questions to explain why these female veterans use or do not use mental health services at veterans' healthcare facilities. The frameworks used provided understanding to the readers on any barriers these veterans face, if any, accessing mental health services at veterans' healthcare facilities.

The theoretical frameworks helped inform my approach to collecting data through the recruitment of female veteran participants. These frameworks provided the foundation for collecting data from female veterans and identifying the need and access to mental health services. Understanding the purpose helped collect data from veteran females who served during the OEF/OIF era and eligible for mental health services at the veteran hospitals. Using semi-structured interviews, participants shared their personal experiences of accessing mental health services in veterans' hospitals.

Research Design and Rationale

The research method selected for this study was qualitative using a phenomenological case study research design. Creswell and Creswell (2018) suggest it is appropriate to use qualitative research when exploring a problem or issue. In the case of

this current study, I explored the barriers and access to mental health care in veterans' healthcare facilities for OEF/OIF female veterans. As Creswell and Creswell noted, conducting qualitative research allows the participants to voice and share their stories. With this study, I aimed to understand the issues female veterans face accessing mental health care at veterans' healthcare facilities. The four female veteran participants in this study had the opportunity to tell their own stories of their experiences navigating through the veterans' healthcare system to receive mental health care. I used case study research to analyze and compare the four female veterans' experiences.

Yin (2018) gives case study research methods a twofold definition. The first definition is considered the scope and describes "an empirical method that investigates a contemporary phenomenon (the 'case') in-depth and within its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident" (Yin, 2018, p. 15). Understanding the barriers and access to care of female veterans at veterans' hospitals is a current real-world case. The second definition is

> copes with the technically distinctive situation in which there will be many more variables of interest than data points, one and as one result, benefits from the prior development of theoretical propositions to guide design, data collection, and analysis, and as another result, relies on multiple sources of evidence, with data needing to converge in a triangulating fashion. (p. 15)

Since there is little research and evidence on female veterans' mental health needs (Maguen et al., 2012; Rivera & Johnson, 2014; Sexton et al., 2017), I aimed to understand those needs in a case study research design. Researchers who use a case study approach study real-life situations currently in progress to gather accurate information (Creswell & Poth, 2018).

With the need to bring out more studies on female veterans' needs, it is better first to understand the needs and barriers they have faced. A lack of research on female veterans' mental health needs makes quantitative research unsuitable for this study because there were no factors identified and predictors of outcomes were not understood (Creswell & Creswell, 2018). A quantitative approach would be a postpositivist worldview consisting of experimental design and pretest and posttest (Creswell & Creswell, 2018). A qualitative approach is more suitable for my study because I approached it with a transformative worldview. I used open-ended interview questions to examine further the issues my participants face accessing mental health care at veterans' healthcare facilities. Creswell and Creswell (2018) noted a qualitative approach is using a transformative world view in a study that collects the stories of individual's oppression with a narrative approach. I interviewed my participants to learn how they have personally experienced accessing care at veterans' healthcare facilities.

Site Selection and Participant Sampling

The study's site was Texas and participants who live in Texas and are eligible for care at a Texas veterans' healthcare facility. I live in Texas, which gives me access to the large population of veterans who live in this area. Texas is one of the largest active-duty military and veteran site locations and has given me a more comprehensive range to recruit female veterans for this study. There are many Veteran Service Organizations in Texas that serve veterans.

Fort Hood, TX, is the largest and most populated U.S. military installation in the world (Military.com, n.d.). The base's service member population consists of OEF and OIF service members. Fort Hood is roughly 30 miles from the nearest veterans hospital

which serves a veteran population of more than 252,000 (VA, 2020a). This site location was ideal for my research study because I had a more comprehensive range of female veterans to reach out to for this study.

Case studies can open up many possibilities with purposeful sampling (Stake, 1995; Yin, 2009). According to Creswell and Poth (2018), "criterion sampling works well when all individuals studied represent people who have experienced the phenomenon" (p. 157). The participants selected have a shared phenomenon of accessing mental health care at the VA hospital. The sampling was purposeful criterion sampling of four participants who met the following criteria: female veterans who have served in various branches of the military, who self-identify as veterans who served during the OEF/OIF era, self-identify as having a mental health illness, and who are eligible to receive care at veterans' healthcare facilities.

The study was conducted over a 3-month period and involved four participants of varying ages, military time in service, and self-identified mental health illnesses. Due to COVID-19 restrictions, I interviewed participants using a video-conferencing platform. Participants signed a consent form permitting the interviews to be audio and video recorded (see Appendix A). Pseudonyms replaced the names of the participants to protect their privacy. These four participants have firsthand experience in the phenomenon of accessing mental health care at a veterans' hospital. The participants gave their own experiences on how they transitioned into the veterans' health system after discharge from the military and accessing mental health services.

Data Collection Procedures

The data collection process gathers information to answer emerging research questions (Creswell & Poth, 2018). Creswell and Plano-Clark (2018) stated qualitative data emerge in new forms: "grouped into four basic types of information: interviews (ranging from one-on-one, in-person interactions to group, web-based interactions), observations (ranging from nonparticipant to participant), documents (ranging from private to public), and audiovisual materials (ranging from photographs to participant-created artifacts)" (p. 160). For this study, the data collection protocol used was semi-structured interviews allowing for guided conversation, observation, and field notes (Yin, 2009). According to Yin (2009), interviews in case studies explain key events and give insight into participants' perspectives. The interviews conducted for this study provided insight into the experiences these participants have accessing mental health care at veterans' healthcare facilities.

Procedures to collect and organize data was done in the following five key steps: sampling procedures, obtain permissions and recruit participants, identify data sources, record data, and administer the procedures (Creswell & Plano Clark, 2018). Figure 1 illustrates the data collection procedures for this case study.

Creswell and Poth (2018) stated, "to operationalize these new terms; they propose techniques such as prolonged engagement in the field and the triangulation of data sources, methods, and investigators to establish credibility" (p. 255). Yin (2018) noted a case study "relies on multiple sources of evidence, with data needing to converge in a triangulating fashion" (p. 15). I used semi-structured interviews, observation, and field notes as a data source for triangulation. These data sources established data triangulation and developed the validity of the findings (Creswell & Poth 2018; Yin, 2018). To

confirm the validity of the findings, participants reviewed transcribed interviews for accuracy.

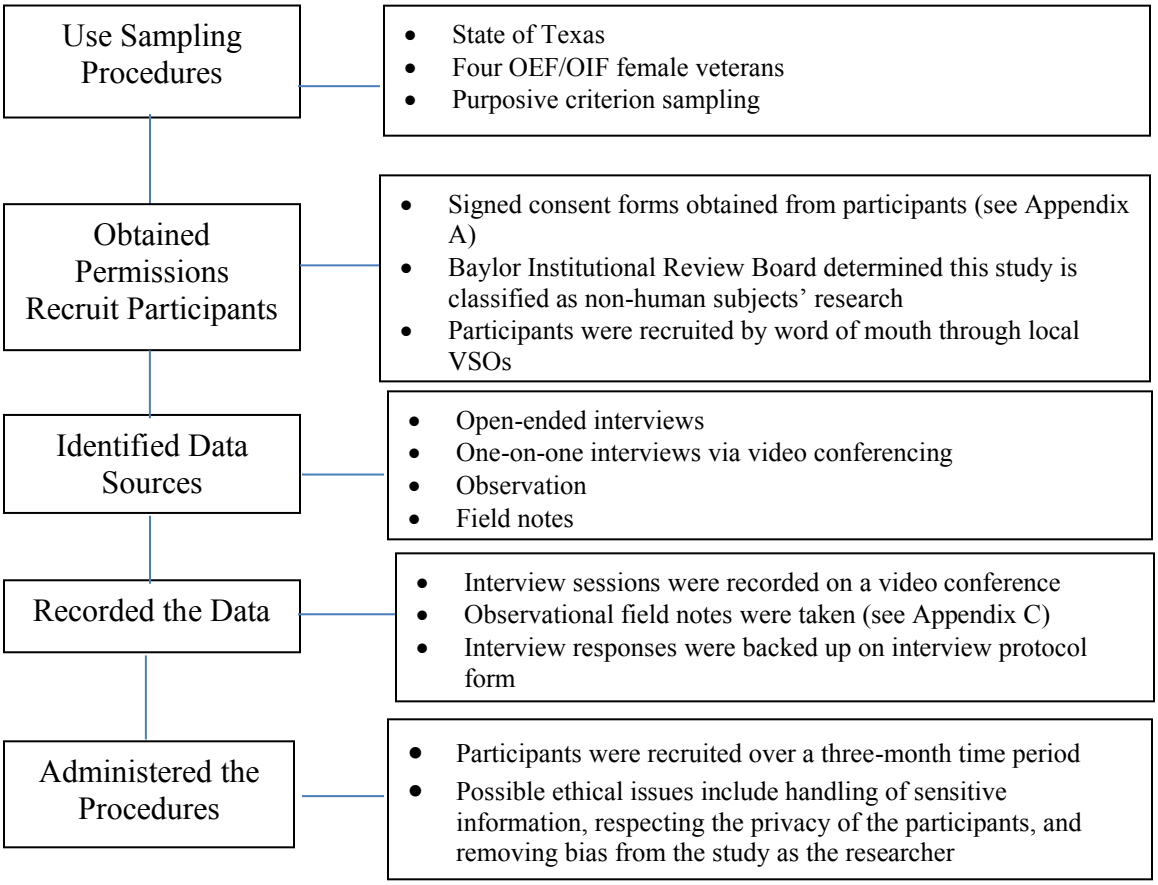

Figure 1. Steps in data collection.

Four female OEF/OIF veterans were interviewed for 45 minutes each using questions from the interview protocol (see Appendix B). To understand the participant's experiences of the phenomenon, I used interview questions—also known as the interview protocol (Creswell & Poth, 2018). I developed interview questions that would address the primary research questions based on the theoretical framework for this study. The interview questions are broken down into two groups, with the first group being about demographics and the second group being about experiences. The first group of interview

questions on demographics gave the background of the participants' eligibility to participate in this research study. On the second group of interview questions on experiences, I used open-ended questions that explained the participants' experiences accessing mental healthcare. The second group of interview questions connected to the theoretical frameworks of feminist theory (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017) and the behavioral model of health service use (Andersen, 1995; Fasoli et al., 2010). The second group of interview questions connected to the needs of female veterans and understanding the reason for their utilization or lack of utilization of mental health services at veteran healthcare hospitals.

The video conferencing platform interviews were video and voice recorded. The video conferencing platform transcribed the interview. During the interviews, I took field notes on observational data (see Appendix C) of the participants' facial expressions and body language. Due to the nature of the topic participants would recall situations they experienced that lead them to have a mental health illness. I observed the participants and took field notes to indicate if the participant may need a break or if I needed to stop the interview to prevent causing a mental breakdown. A digitally transcribed voice recording was reviewed and manually transcribed for accuracy as needed. The credibility of the transcribed interviews was established by sending participants the transcribed interviews for their review of accuracy (Creswell & Poth, 2018). The data collection process captured the participants' viewpoints and experiences, understanding the barrier to accessing mental healthcare.

Data Analysis Procedures

The data analysis procedures consist of four steps to provide insight into the barriers to mental healthcare that female veterans experience accessing care at veteran hospitals. First, I organized the data from the interview responses by creating a filing system to locate information (Creswell & Poth, 2018) easily. Second, reading and memoing emergent ideas give a complete overview of the data without getting caught up in coding too soon. Third, I classified codes into themes developed from the descriptive detail of the second step. Fourth, discuss results in a narrative format to give meaning to significant statements through textural and structural descriptions (Creswell & Poth, 2018). Data analysis prioritized what to analyze and why by searching for patterns, insights, and concepts (Yin, 2018). Coding was the analysis, a deep reflection, and the interpretation of the meaning of the data collected (Miles et al., 2020). Table 1 shows the data collection method used to provide evidence for the research questions.

Table 1

Data Analysis Methods Used to Answer Research Questions

Research Questions	Data Collection Method
1. What factors prevent OEF/OIF female veterans from accessing mental health services within the veterans' healthcare facilities?	Interviews Field notes
2. How has access to mental health services at veterans' healthcare facilities impacted OEF/OIF female veterans' transition into life as a civilian?	Interview Observation Fieldnotes

The first step in the data analysis procedure was organizing the data. I organized the data by grouping the four interviews into two sections based on experiences. I created

a digital filing system labeled “positive experience” and “bad experience” and filed each transcribed interview according to the participant's experience. I created a filing system so data could be easily located (Creswell & Poth, 2018). Subfolders in each file contained individual folders of each participant using pseudonyms, the video recording, audio recording, and interview transcription.

The second step in the data analysis procedure was reading and memoing emergent ideas. I listened to the interviews and read through the interview transcripts multiple times. While reviewing the data multiple times, I took intensive notes on the participants’ interview protocol responses. I included notes on the participants’ facial expressions and body language as they recounted stories of their experiences that led them to need mental health services. Notetaking validates the study by leaving an audit trail to clarify understanding of the data (Creswell & Poth, 2018). Notes from the data were written down manually and scanned into the participants’ files to easily access. Note-taking was strategically done to identify code categories for themes by comparing data.

The third step in the data analysis procedure was classifying codes into themes. This step in the data analysis procedure was coding the data to understand the transcripts and observations from the interviews (Creswell & Poth, 2018). Data coding was done through digital documentation and filed in the appropriate folder. I first listed possible codes that may emerge while identifying codes from the data. Data from the interviews were reduced into small categories, and each category was coded with a label (Creswell & Poth, 2018). Moustakas (1994) said to identify significant statements from the interviews and group the statements into broader information units. Along with coding

the data, I took significant statements from the participants and categorized them on a separate document under positive or negative experiences. The codes identified were grouped by similarities, and themes were developed from the groups.

Additionally, I identified emergent themes using thematic and framework analysis. I analyzed the data collected as a whole case study to identify those themes for a thematic analysis that would provide a rich and detailed account of the data (Braun & Clark, 2006). Themes were identified that connected with the theoretical frameworks. These themes were identified and included in the framework analysis.

The fourth step in the data analysis procedure was discussing results in a narrative format. I created individual textural descriptions of the participants' interview responses by describing what the participants experienced (Creswell & Poth, 2018). Quotes from the participants are used and I give examples of what the participants experienced. In the narrative, structural description is used to explain what led to the participants' experiences and I created individual textural descriptions of the participants' interview responses (Creswell & Poth, 2018). A combination of textural descriptions and structural descriptions revealed themes and conveyed the overall essence of the participants' experiences (Creswell & Poth, 2018). A combination of both descriptions gives an overview of the participants' experiences of the phenomenon.

The participants' lens is a validation strategy used to ensure the accuracy of the results in this study. The participants' lens is seeking feedback from the participants for their approval on the transcribed interview. I reviewed the digitally transcribed interview with the voice recording of the interview to ensure the transcription matched what was said in the interview. Edits of the transcript were completed as needed to correct any

errors initially presented. The participants' transcripts were emailed to them to be judged for the accuracy and credibility of the interview (Creswell & Poth, 2018). Participants responded with confirmation that transcripts accurately represented their experiences.

Ethical Considerations

Due to the nature of this study and the female veteran participants, it was important to consider ethical issues that could arise. Yin (2018) noted, "the study of a contemporary phenomenon within its real-world context obligates you to important ethical practices" (p. 88). In October 2020, I submitted the Institutional Review Board application to the Office of the Vice Provost for Research at Baylor University for approval to collect data for this study. The Institutional Review Board helped to ensure this study protected the rights and welfare of all voluntary participants. The Office of the Vice Provost for Research approved this study and classified it as non-human subject research. The participants' trustworthiness was established by gaining informed consent, avoiding deception in the study, and protecting privacy and confidentiality (Yin, 2018).

The participants were provided with a detailed email explaining the study's purpose and an informed consent form was attached to include my contact information for any questions or concerns. I informed participants this study was voluntary, and they were under no obligation to participate in the interviews. To avoid identifiable information in the analysis files, the participants' names were masked and replaced with pseudonyms (Creswell & Poth, 2018). To prevent deception in the study, the participants' experiences were accurate and unadulterated as the participants gave them in the interview. During the individual interviews, each participant shared personal information on their mental health issues and access to mental health care at veterans' healthcare

facilities. Participants shared sensitive experiences making it important to protect their privacy and confidentiality by keeping their names confidential. Additionally, given that I am a female veteran, personal bias was removed to not affect the study participants' responses. To create honest and trustworthy reporting, I included ethical considerations in the writing of this study.

Limitations

Three limitations were identified in this research study. The first limitation of this study was the small sample size. Due to time, I was unable to pull a larger sample size. A larger sample size would give a greater representation of the veteran female population on their experiences accessing mental health care. The second limitation of this study was the participants self-identified as female veterans with a mental health illness. There is no way to check the participants' veteran or mental health status. The third limitation of this study was the participants may be hesitant to discuss their mental health needs as this is a vulnerable topic. I addressed this limitation by establishing a relationship with the participants to gain their trust and using a pseudonym for their names to maintain privacy.

Delimitations

One delimitation for this study was that participants live in Texas. I selected participants from this area because I live in this area, and Texas is the largest area in the world for the military and veteran population. The second delimitation was all the participants served in the Army. The third delimitation was all the participants were minority female veterans. Selecting a larger sample size would potentially bring forth a wider range of participants from various military branches and ethnic groups.

Conclusion

In this chapter, I described the research design, the research perspective, the participant and site selection process, the data collection method, the analysis methodologies, ethical considerations, and the limitations and delimitations. The purpose of this phenomenological case study was to understand the barriers and access to mental health care in veterans' healthcare facilities for OEF/OIF female veterans. This study's analytical process began with collecting the responses to the interview questions from the participants and then analyzing them for patterns and themes.

CHAPTER FOUR

Results and Implications

Introduction

In the current study, I utilized a phenomenological case study design to understand the mental health needs of female veterans and their access to mental health care services within a veterans' healthcare facility. With this study, I provided details and insight into the barriers OEF/OIF female veterans face accessing mental health care and what can improve access to mental health care at veterans' healthcare facilities. This study will add to the current research on the needs of female veterans. Four participants conveyed their perspectives through interviews using open-ended semi-structured interview questions that I collected and analyzed to assist in answering the research questions.

Research Questions

1. What factors prevent OEF/OIF female veterans from accessing mental health services at a veterans' healthcare facility?
2. How has access to mental health services at a veterans' healthcare facility impacted OEF/OIF female veterans transitioning into life as a civilian?

As discussed in Chapter Two, the research design uses feminist theory (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017) and behavioral model of health service use (Andersen, 1995; Fasoli et al., 2010). Data were analyzed from the perspective of both theoretical frameworks. The first framework, feminist theory (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017), focused on the need for

continuous research that is gender-specific to recognize the mental health needs of female veterans. The second framework, the behavioral model of health service use (Andersen, 1995), focused on understanding the underutilization of mental healthcare services at a veterans' healthcare facility. The frameworks aligned to answer the identified research questions by recognizing patterns and themes on female veteran needs and understanding why these veterans may not use mental healthcare services at veterans' hospitals.

For this qualitative study, a phenomenological case study was an appropriate research design. Data were collected and analyzed using semi-structured interviews. The data from the interviews revealed a phenomenon of the participants' direct experiences accessing mental healthcare at veterans' hospitals. Using the data collected from the interviews, I was able to pull themes from the research questions and themes that derived from the theoretical frameworks.

This chapter begins with the demographics of each veteran participant and an overview of each veteran's unique experiences as expressed in the interviews on mental healthcare access at veterans' healthcare facilities. Following the interview descriptions, this chapter unfolds by identifying overarching themes that emerged from patterns identified through thematic analysis related to each research question. A discussion on the framework analysis results will explain the *a priori* theoretical frameworks, feminist theory (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017), and behavioral model of health service use (Andersen, 1995; Fasoli et al., 2010) applied to analyze and interpret the interview data as guided by the frameworks. Following the framework analysis, I bring the results and findings together to discuss key themes, literature, and theoretical frameworks. Implications of the study are presented along with discussing the

significance of the study to include support from previous research studies. The implications section consists of recommendations to improve mental healthcare access for the veteran female population within the veterans' healthcare system. This chapter concludes with a summary and conclusion of the study findings and a discussion as to where these findings will make the most impact.

Participants

Participants for this phenomenological case study are female veterans, who live in the State of Texas, self-identify as having a mental health illness, are eligible for health care at a veterans' healthcare facility, and served during OEF/OIF. The participants' demographics are shown in Table 2. I used data from the interviews of four participants to identify key themes, patterns, and explore the relationship among those themes through cross-case thematic analysis (Bergin, 2018). In the next section of this chapter, gives an overview of the interviews of each participant to include their experiences and thoughts.

Table 2

Participant Demographics

Pseudonym	Time in Service in Years	Self-Identified Mental Health Illnesses
Veteran One	30	PTSD
Veteran Two	9	Depression, PTSD
Veteran Three	15	Major Depression, Anxiety, PTSD
Veteran Four	3	Bipolar, Depression, Anxiety

Note. All four of the veteran participants served in the U.S. Army.

Veteran One

Veteran One is a female combat veteran who served 30-years in the U.S. Army. Her service includes three years in the U.S. Army Reserves and 27 years on active duty. During Veteran One's time in service, she deployed multiple times to include deployments to Iraq and Afghanistan. She self-identified herself as having PTSD due to her experiences while deployed. She also briefly shared that she was in a situation where she was sexually harassed and assaulted while on active duty. Veteran One stated she is eligible for mental health services at VHA; however, she does not use those services at the time of the interview.

Veteran One explained once she was discharged from the military, navigating through the VA system was difficult. During her last deployment, she was in a plane crash where she was the only survivor. The Army had her listed on the manifest as one of the soldiers who died during the plane crash. Being declared deceased when she was not caused a horrific experience for her and her family. While she was in transit back to the states, her family was planning her funeral because the U.S. Army notified them that she died in the plane crash. Once she had arrived back in the states, she reached out to her family; however, her family had already experienced emotional trauma after thinking she was gone.

On top of everything else she experienced while on active duty, this incident caused many emotional and mental scars. The U.S. Army marked Veteran One's medical record as deceased, making it challenging for her to enroll in the VHA system and even to receive a disability rating. Her transition into being a civilian was challenging as she needed mental health services. The lack of mental health care deeply affected she and her family. She experienced anger and outburst that she could not control at times. She later

learned that she suffered from PTSD. Once the Army and the VA hospital cleared up her discharge status to show she was not deceased, she still did not receive mental health care right away. Eventually, the VA made appointments for her, but she had no idea what they were for or where they were. When describing her first appointment, she stated, "Nobody told us anything, just be at this building, this is your appointment time." When trying to receive mental health care, she described a lack of communication between her, the provider, and the mental health treatment teams.

Interacting with males is a trigger for this participant due to past experiences on active duty. During the interview, she mentioned her sexual assault experiences were in her medical records; however, providers did not always read her medical records thoroughly or communicate her problems with the mental health treatment staff. Veteran One explained her provider recommended that she start attending mental health group sessions; Veteran One gave details of her first experience in a group session:

> I'm sitting in this room, and the door opens on the other side of the room, and in walks, six males and the last one coming in shut the door. I freeze; I'm just frozen there. I was unaware that I was signed up for a group and was the only female. So, it's like they didn't even read your record [referring to the provider]. I was like, oh no, and I just I couldn't believe that they put me in that situation. I left the VA that day, left phone, and everything.

It took a long time for Veteran One to come back to the VA; she felt as though the VA dangled her disability rating over her head to make her come back and receive treatments.

During our interview, Veteran One said she did have good providers who were female. However, they did not stay employed long at the hospital. Veteran One described the last incident that made her decide to start receiving mental health care outside of the VA:

> She [referring to a new provider she was assigned] called me by the last four digits of my social security number. I thought, and I said, excuse me. I just

> remembered that so because it made me furious. I was just insulted, and I said, when I become a number, I don't want to be a number in your program.

Eventually, Veteran One decided to start seeking mental health care outside of the VA hospital. She felt like her needs were not addressed; if there was a good female provider she liked, they did not stay her provider long, and providers were not reading her medical records before giving referred treatments. When asked what she felt the VHA should do to make access to mental health care better for female veterans, Veteran One responded that females should make the decisions. She felt that male hospital staff members make many decisions on female overall health care. She also feels that the female voice is not heard nor acknowledged.

Veteran Two

Veteran Two is a female combat veteran who served nine years in the U.S. Army, with three years in the U.S. Army Reserves. While on active duty, she was deployed to Iraq and suffered from depression and PTSD. When asked if her transition as a civilian into the VHA system was easy, she described it as fast-paced. Veteran Two stated, "there were talks about, okay you do this, you do that, you go here, you go there for that, no one kind of like showed you the ropes or no one in." Veteran Two described having to figure many things out independently when enrolling in the VHA and getting mental health care. When reflecting on her experience first establishing care at the VHA compared to now, she describes it as being much better. She says the VHA has more resources available now to help you navigate the healthcare system. She mentioned that now when she needs assistance, it is easier for her to get the help she needs from the VHA. Veteran Two's experience of access to mental health care at the VHA differs from that of Veteran One. Veteran Two shared that even though it was a rough start, the care she receives now

from the VHA is exceptional. She did say she never attended mental health group sessions as she was not interested in that type of treatment and preferred one-on-one sessions with a provider. When reflecting on her feelings about group therapy, Veteran Two explained:

> I didn't feel comfortable doing it, and I believe it's like the go-to for most of the VA mental health programs for the veterans is group therapy. I didn't agree with that because they kind of just throw you in a group, you know, full of strangers.

She said if the mental health groups were all female, it would have made a difference in her attending group sessions, especially if the groups of females had deployment and mental health issues. Regarding the difference in mental health care given to male veterans compared to female veterans, she expressed that she did not feel there was a difference. She did believe there is not enough focus on the different needs female veterans have from male veterans.

Veteran Three

Veteran Three is a female combat veteran who served 15 years in the U.S. Army. She deployed to Iraq and Kuwait. She stated she suffers from major depression, anxiety, and PTSD. Veteran Three described her experiences obtaining mental health care at the VHA as a terrible experience. She was medically discharged from the U.S. Army due to various mental health issues. She had to attend different classes when discharging from the military that were supposed to help her transition to become a civilian and enroll into the VHA system. Still, there was too much information at one time. She expressed when trying to make appointments for mental health treatments, there would be delays in getting seen, and the appointments were scheduled very far out. When discussing her

current mental health treatment, she states her appointments with her psychiatrist are very quick and were not helpful. She explained:

> You talk to a psychiatrist for 5–10 minutes a day; they talk about medications, but they don't give you the tools that you need to kind of rebuild your life and start, you know, fixing some of your unhealthy behaviors.

She feels it is just a quick meet to justify getting a prescription filled.

Veteran Three discussed a big issue she is having with keeping the same provider. She said she has had great providers at times, but they never stay long at the VHA, and she is assigned a new provider and must explain her mental health history and establish trust with the new provider. She is not sure about the differences between the treatment that male veterans receive compared to female veterans; however, she does feel the mental health needs of female veterans is much different from male veterans. She described female veterans facing mental health issues that society would see as male issues. She elaborates,

> Because I've just realized recently, you know a lot of the behaviors and stuff of females in the Army are like masculine traits and masculine behaviors. At the end of the day, you are still a woman, and you're still feminine. You have to deal with trying to be masculine on this side of the world [referring to the military] and then coming home and feeling like a failure as a female.

She discussed it was challenging to balance being a woman outside of the military when you have experienced so much trauma while on active duty that many would not think a woman would have gone through. She felt many of the mental health issues female veterans suffer are being perceived as male veterans' issues.

Veteran Three shared that she faced barriers accessing mental health care at the VHA. One issue she faced was being able to afford gas to drive back and forth to her appointments. She lives over 30 miles from the nearest veterans' hospital, and she would have multiple appointments throughout the month, and at times she could not afford to

drive to the appointments. She stated shuttle buses would meet at different locations to drive veterans to the hospital for their appointments, which was helpful.

When asked what, if any, improvements the VHA could make to mental health care and accessibility to care for female veterans, she stated they could take ideas from non-VA mental health facilities. She mentioned facilities outside of the VHA have a better atmosphere that is more inviting and calming for someone who has mental health issues. Veteran Three described the hospital where she is assigned as a gloomy and depressing place.

Veteran Four

Veteran Four is a female veteran who served three years in the military. Her mental health illnesses include bipolar disorder, depression, and anxiety. Veteran Four described her experience transitioning out of the military as a smooth process. She did receive a lot of information; however, she was able to navigate through the VHA system easily with the help of the staff at the VHA where she is receiving mental health care. She stated she was in a program the U.S. Army had when servicemembers were discharging out of the military.

She has had issues with delays in appointments which has interfered with her getting her medications filled. When scheduling appointments, they were usually far out, which was a hindrance when she needed assistance right away. If she was not able to be seen by a provider when she needed it, she had the option of being seen at the emergency room. However, that would have been an all-day wait. Veteran Four is also a mother, and at times childcare was an issue when trying to attend appointments.

These four OEF/OIF female veterans identified a variety of common experiences from their interview responses. Understanding the experiences that each of these veterans had to access mental healthcare at the VHA provides insight into barriers female veterans face accessing mental healthcare and the need to focus more on female veterans mental health care. Some of the participants experienced traumatic events, which could have caused difficulties with them to share their experiences. Each veteran participant was observed during the interview for any signs of distress in their voice and facial expressions during their interview. In the next section of this chapter, research questions are answered from themes generated from the thematic analysis results.

Thematic Analysis

Braun and Clark (2006) described thematic analysis as a method of identifying, analyzing, and reporting patterns and themes within the data. To conduct a thematic analysis for my study, I followed Braun and Clark's (2006) step-by-step process to pull themes from the data to provide evidence for my research questions: (a) familiarized myself with my data by transcribing the data from the interviews and jotting down initial ideas, (b) coding relevant data, (c) organizing coded data into potential themes and combine to form overarching themes, (d) reviewing themes by removing themes that do not have enough data to support and identifying the themes that support my research, (e) defining themes by giving a detailed descriptive analysis of the theme as it fits in the research, and (f) producing the report by answering each research question through the thematic analysis results. Data collected from each interview were examined as a whole case, and themes emerged from the thematic analysis results. Table 3 outlines the

emergent themes that answer the research questions as revealed from the participant's interview responses.

Table 3

Emergent Themes

Research Questions	Emergent Themes from the Research Questions
1. What factors prevent OEF/OIF female veterans from accessing mental health services at a veterans' healthcare facility*?*	Quick turnover of providers Difficulties navigating the VHA system Delays in scheduling appointments Male-veteran centered care Predominantly male mental health groups
2. How has access to mental health services at a veterans' healthcare facility impacted OEF/OIF female veterans transitioning into life as a civilian?	Providers do not review medical records A feeling of not being heard Ineffective treatment plan

Research Question 1: What factors prevent OEF/OIF female veterans from accessing mental health services at a veterans' healthcare facility?

The purpose of this research question was to identify themes from the interview responses that relate to factors that prevent these veterans from accessing mental health services at veteran healthcare facilities. The themes identified include quick turnover of providers, difficulties navigating the VHA system, delays in scheduling appointments, male-veteran centered care, and predominantly male mental health groups. The themes assisted in understanding the challenges these veterans face accessing mental healthcare.

Quick turnover of providers. Two veterans spoke about the being a quick turnover of providers. They felt this affected the quality of care they received because when they started to get used to a provider the provider would leave the VA. The

veterans expressed they would then receive a new provider and must explain their mental health issues all over again and reestablish trust with the new provider. One participant reflected on her experience with a provider that she felt went above and beyond to help her with her mental health issues. She felt this provider cared about her well-being. Referring to the provider she stated,

> She called me and said, I just want to pray with you. I just want to pray with you because I am so sorry for the treatment you received. That is the first experience that, let me know there are real people in the VA system in that health care system and I told them if they would allow me to work with her, I would be able to at least move forward.

Unfortunately, this provider did not stay at the VHA long. Veteran One alleges that the provider left, because her morals and patient-care values did not align with that of the VHA. This then led to her receiving a new provider that looked at the participant as more of a number by referring to her by the last four digits of her social security rather than by her name. This theme also supports the literature in that the lack of trust in providers creates a barrier for female veterans wanting to receive mental health care at the VHA (Brunner et al., 2019). Veteran Two mentioned she started seeking mental health care services outside of the VHA, because she did not trust the providers at the VHA. She expressed she was tired of getting a new provider every time she went in for an appointment.

Difficulties navigating the VHA system. Three of the veterans expressed similar difficulties navigating the VHA system. This became more of an issue as they were transitioning out of the military. Several of the veterans expressed there being a lot of information thrown at them at one time and no one to walk them through enrolling into the VHA system. Veteran One mentioned appointments being scheduled for her and she

did not know what they were for or where to go for her appointment. Issues navigating the VHA system is a theme that leads to underutilization of mental health services at the VHA (Garcia et al., 2014). This theme is a barrier that female veterans face accessing mental health care. During the time of transition, the veterans shared there is a lot to process to include accepting that your military career is ending.

Delays in scheduling appointments. All veterans in this study shared they experienced delays in scheduling mental health appointments. This issue has increased due to COVID-19; however, pre-pandemic female veterans experienced delays in scheduling mental health appointments. Several veterans experienced waiting up to a month to be seen by a provider for mental health issues. Veteran One stated she was constantly being canceled by the clinic when it came close to her appointment time. This was due to a provider not being available the day of her appointment. Availability of appointments became an issue for some of the veterans. This relates to the literature in that appointment flexibility would improve access to mental health care (Brunner et al., 2019). These veterans expressed that not being able to attend appointments due to work or childcare put a delay on scheduling appointments.

Male-veteran centered care. Two veterans shared they felt the mental health care treatments were male veteran centered. The veteran population is made up of 24% male and 2% women (Newport, 2012). During the interview Veteran One reflected on how she felt being a female veteran seeking mental health care in a male-centered healthcare system at the VHA:

> The VA, they got some issues, females are not important… I think that there was some disparity between treatment of the males to females, you can tell the

> programs are male driven [referring to her experience attending group therapy sessions] … And there was more availability for the males.

Veteran One shared that she has a son who is an officer in the U.S. Army and that when he was injured and seeking care from the VHA his appointments were setup for him by the VHA staff. After witnessing the treatment her son was receiving from the VA, she decided to seek care outside of the VA and stated, "I was worthy of the attention and needed the same thing that my male counterparts did." Veteran Two felt female veterans are group together with the male veterans concerning mental health care and other issues such as postpartum depression and MST toward females is not considered to be a focus on the needs of female veterans.

Predominantly male mental health groups. This theme supports the common theme of male-veteran centered care found in the literature, specifically how mental health support groups are male dominant (A. Goldstein, 2018, 2019; Kimerling, Bastian et al., 2015; Koo & Maguen, 2014). A recent research study showed the VHA provided general health care and gender specific services geared toward men, because the veteran population was predominantly male (Sussman, 2021). Veteran Two shared she would be more inclined to attend mental health support groups if there were only female veterans in attendance. Veteran One shared stories of how she was put into mental health groups where she was the only female. Another veteran discussed how "it is hard enough to open up when you are one-on-one with a provider, it will be even harder in a room of all men when you are the only female."

Research Question 2: How has access to mental health services at a veterans' healthcare facility impacted OEF/OIF female veterans transitioning into life as a civilian?

The purpose of this research question is to identify themes from the interview responses that have impacted these veterans transitioning into life as a civilian. The themes identified included providers do not review medical records, a feeling of not being heard, and ineffective treatment plan. The themes assisted in understanding how the lives of these veterans have been impacted while accessing mental healthcare.

Providers do not review medical records. Two female veteran participants felt some providers do not thoroughly read the patients' medical records to go over problem lists and previous treatments. For example, Veteran One identifies as having PTSD and has experienced military sexual trauma that she stated is annotated in her medical record. When attending a group session that her provider referred her to, she stated,

> I'm sitting in this room and the door opens, on the other side of the room and in walks six males and the last one coming in shuts the door. I freeze I am just frozen there. I was unaware that I was signed up for a group and was the only female. So, it's like they didn't even read your record [referring to the provider].

Further discussion with Veteran Three revealed having to constantly repeat issues she was having that was affecting her mental health. During one-on-one sessions with her psychiatrist, she expressed her sessions felt more like a vent session where she just complained on what her issue was at the time. She expressed feeling the psychiatrist she was seeing at the VA was not giving her the tools she needed to handle the mental health issues that were listed in her medical record.

Feeling of not being heard. Two participants that had negative experiences accessing mental health care felt when they expressed their concerns on their mental state, they did not feel like they were being heard. Veteran One spent a significant

amount of her interview expressing her strong frustration of not receiving the mental healthcare that she needed. Veteran Two recalled a time when she asks for a referral from her psychiatrist for therapy she stated:

> When I told my psychiatrist, I need you to put a referral in for a therapist, she was just kind of like, well, you can go to veteran's resources and talk to somebody up there, but yeah that's not really. I need a therapist that's going to help me work on my CBT stuff [referring to cognitive behavioral therapy]. None of the VA doctors ever mentioned that term to me [referring to cognitive behavioral therapy], but when I started working with the civilians…They were the ones that are teaching me how to rebuild my life.

She expressed that at one point she sought mental health care assistance outside of the veterans' hospital. She heard through word of mouth of a private organization that serviced veterans in need of mental health services. She stated when she got there, she felt comfortable and that her needs were being heard.

Veteran One mentioned several times in her interview that she experienced sexual assault while in the military. For a long time, this experience affected her interactions with males. Even though her and her family expressed these concerns with her providers, the concerns seemed to fall on deaf ears. Numerous times she was put in situations at the veterans' hospital where she would have an encounter with a male. These encounters would be her being put in a mental health support group where she was the only female or sending a male provider to her home. Before receiving mental health care at the veterans' hospital facility, the hospital would send providers to her home for home visits. These home visits were meant to establish trust so she would come into the facility for care. Veteran One recalled a time when a male provider came to her home:

> I was at home and they [referring to the veteran hospital] were sending people [referring to providers] to come see me to try to talk to me and work through my anger issues. If you have a male issue where you were attacked and stuff you don't send a male to do a one-on-one and they sent this person [referring to a male

> provider] to my house and I shut the door in his face. I just remember that so vividly because he was saying I'm here to help you. No, you're not.

Both participants expressed concerns with their mental health or issues with how they were receiving treatment; however, the providers at the veterans' hospital failed to adhere to their concerns. These participants did acknowledge at times there were providers that did listen to their concerns, but due to the quick turnover of providers they were not able to continue care with those providers.

Ineffective treatment plan. These veterans felt the way the providers treated them for mental health issues was ineffective. Veteran Two referred to her sessions with her psychiatrist as a session for her to complain. She did not receive any effective tools on how to deal with her anger and that the session was just a way for her to continue to get medication. As stated in a previous section, this veteran felt she would come in for 5 to 10 minutes complain and receive medication. She never would receive the tools she needed to really rebuild her life. It was not until she sought care at the private organization, but the care at that organization was temporary. The organization provided 6-month long programs. In that program she learned to deal with cognitive behavior disorder issues. When reflecting on what she learned in the program she stated, "You learned making better routines and making better changes, and you know not falling into thinking traps and stuff, but I've never really gotten those skills from the VA." She continued to discuss that when she was hospitalized for mental health issues, even then she did receive the necessary treatment needed. Since all her other appointments with her psychiatrist did not show any major issues based on the notes the psychiatrist wrote in her medical record, the hospital determined there was not a real need for her to have a mental

break to need to be hospitalized. She was released without a new treatment plan, but to continue what she had been doing.

Veterans One and Three also expressed feeling that the treatment they were receiving was standard and did not meet their specific needs. They would have monthly sessions and would be referred to mental health groups. Veteran Three expressed she was not interested in attending mental health support groups as it was triggering for her to hear bad experiences other veterans went through.

Framework Analysis Results

As described in previous chapters, I used two *a priori* theoretical frameworks to analyze data. The first framework was a feminist theory (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017). The second framework was the behavioral model of health service use (Andersen, 1995; Fasoli et al., 2010). The feminist theory framework added to the increase in gender research on veterans, focusing on female veterans (Eichler, 2017). The behavioral model of health service use framework was used to understand the predispositions female veterans have to use mental health care services at veterans' healthcare facilities (Andersen, 1995). Figure 2 portrays the framework and thematic analysis themes for this research study.

Feminist Theory

Feminist theory brings focus on the need for gender-specific research with a focus on the needs of female veterans (Bean-Mayberry et al., 2011; Boyd et al., 2013; Eichler, 2017). Eichler (2017) discusses in her article that gender is becoming a relevant category in research. Eichler expressed it is important to expand on research that focuses on female veterans as there is little literature on this veteran population. The application of

the feminist theory for this research study data on female veteran needs and gender differences adds to the scholarship of female veterans.

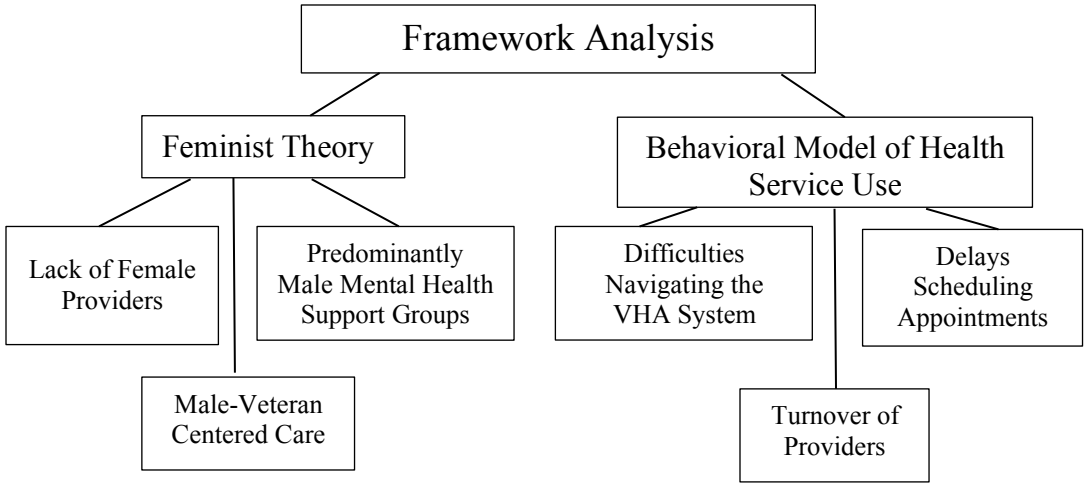

Figure 2. Theme correspondence with frameworks.

Literature by Bean-Mayberry et al. (2011) and Boyd et al. (2013) supports this framework by adding to the research on female veterans' mental health needs and provides their thoughts on the need for more female veteran research. To add to the growing need for female veteran research, Eichler (2017) suggested, "examining veterans' issues in relation to gender norms, gender inequalities, and the intersections of gender with other categories of social difference such as race or sexuality" (p. 5) The themes identified in the thematic analysis results related to feminist theory include lack of female providers, predominantly male mental health support groups, and male-veteran centered care.

Lack of female providers. Until 1917, males were the only people eligible to serve in the military thus making the veterans' healthcare facilities serviceable for the needs of male servicemen turned veterans (Toler, 2019). Now that female veterans are a

contributing part of the veteran population female veterans' health care needs require further research. Literature by Boyd et al. (2013), supports the need for further research by stating, "As more women warriors return from active duty in Iraq and Afghanistan, their deployment struggles and their mental health challenges are becoming more visible" (p. 11). Interviews from two participants revealed there is a lack of female providers that service the veterans' healthcare facility. Feminist theory supports the theme lack of female providers through the gender norms categories. Eichler (2017) refers to gender norms as,

> For instance, expectations about what it means to be a man or woman in a particular social and historical context can shape the ability of veterans to readjust to civilian life as well as how society and health practitioners will treat veterans. (p. 683)

Veteran One stated she had issues with sexual assault in the military and as a result did not feel comfortable around males. In her interview she stated, "I do not want to be in a male driven program" [referring to receiving care from a male provider]. Both veterans mentioned that if more female providers were available, they would be more comfortable receiving mental health care at the veterans' hospital.

Kimerling, Pavao et al. (2015) conducted a study identifying gender-related indicators of access to mental health care for female veterans. The study conducted by these authors suggested female veterans faced gender disparities in mental health services (Kimerling, Pavao et al., 2015), which supports the theme of the lack of female providers at veterans' hospitals. The veterans interviewed for this study felt more female providers should be employed at the VA hospitals to support the needs of the female veterans. Veteran Four was fortunate to have only had female providers treat her mental health

illness. During our interview she expressed how grateful she was to have a female provider and if she had a male provider, she would not have felt comfortable.

Predominantly male mental health support groups. Mental health support groups are a treatment used for veterans to be among their peers to share their experiences suffering from mental health illnesses and sharing and learning of ways to cope with these illnesses. Three of the veterans interviewed in this study agreed this type of treatment is helpful, but female and male veterans should have separate groups. This theme aligns with feminist theory as mental health support groups that are co-ed insinuates a gender norm that female and male veterans share the same mental health experiences. During my interview with Veteran Two, who did not have any issues accessing mental healthcare, she mentioned she only does one-on-one sessions with a psychiatrist. She declined mental health support group treatments. She explained, "I would not want to be in group sessions with males and have to take on their experiences." After further explanation she felt as if those experiences would have been a trigger for her negatively impacting her own mental health treatment. Two of the veterans interviewed, who have experienced military sexual traumas would also be triggered attending mental health groups with males. Veteran One experienced trauma when she attended a mental health group where she was unaware male veterans would be in attendance. She recalled, "I'm sitting in this room and the door opens, on the other side of the room and in walk six males… I freeze, I'm just frozen there." This experience added to the mental health issues of military sexual trauma that this veteran was already experiencing.

In a study conducted by Kehle-Forbes et al. (2017), female veterans reported mental health groups were limited to male veterans, making these female veterans feel uncomfortable. Kehle-Forbes et al.'s (2017) study results support the theme and framework that predominantly male mental health support group is an issue for OEF/OIF female veterans seeking mental health care. In a study by Kimerling, Bastian et al. (2015), females reported they would be more inclined to receive care from veterans' hospitals if they were in women-only peer support groups with similar combat exposure experiences. Hamilton et al. (2013) argued gender-specific barriers are still an issue among female veterans' mental health care. The same concerns were expressed by the participants in this study showing a need for mental health care treatment to be further evaluated to treat each gender separately.

Male-veteran centered care. Male-veteran centered care is the final theme analyzed using the feminist theory framework. This theme is one of the main issues the female veterans experienced as expressed in their interviews. Male veteran centered-care directly aligns with feminist theory as it is associated with gender variables in that female veterans feel both genders are combined as one when it comes to treatment (Eichler, 2017). In actuality, the treatment is centered around male needs with the assumption that the same treatment will work for female veterans. Kimerling, Bastian et al. (2015) acknowledged female veterans prefer gender-specialized services in a gender-integrated mental health setting. All the participants in this study agreed more focus should be on the mental health needs of female veterans. Female veterans reported that a lack of access to designated women's mental health treatment settings was a barrier to accessing mental healthcare (Kimerling, Bastian et al., 2015). Throughout this study these participants

expressed being put in situations that triggered their mental state such as being subjected to male mental health groups when having a MST diagnosis, not being able to have female providers when uncomfortable with males, feelings of not being heard, and having generalized treatment plans. Veteran One had the most troubling experience when she recalled sitting in a room for a mental health support group and being the only female in attendance. Veteran One expressed the encounter being a horrific experience as she suffered from MST. Her experience shows mental health treatment is generalized for all veterans regardless of gender.

Feminist theory and current literature helped to analyze emergent themes from this study. These findings assist in filling the gaps on female veterans' mental health research. As I analyzed the data from the interviews, it was evident that the themes identified were barriers revealed in past literature. These themes stood out as they related to feminist theory such as gender norm issues and the assumption that mental health care should be the same across the board regardless of gender. The women in this study and past studies have voiced the need to expand research on female veterans needs and provide mental health care services that cater to female veterans only.

Behavioral Model of Health Service Use

The behavioral model of health service use framework brings focus on the lack of mental healthcare use at the VHA. This framework is used to identify reasons female veterans may choose not to receive mental health care at the VHA. Themes identified using this theory were difficulties navigating the VHA system, delays in scheduling appointments, and turnover of providers. There were two themes that emerged that were initially not considered barriers: transportation and childcare. The two themes were

factors that affected veterans using the VHA for mental health services. The themes identified from the interview responses were analyzed using Andersen's (1995) behavioral model of health service use framework. This framework uses predisposing characteristics, enabling resources, and determining the use of health services.

Female veterans who served during OEF/OIF are considered demographics for the predisposing characteristics. Using Andersen's model, difficulties navigating the VHA system, turnover of providers, and delays in scheduling appointments are enabling resources identified as barriers that prevent female veterans from wanting to utilize veterans' hospitals for mental health care access. The needs component of the framework is used to understand the perceived need for female veterans to want to use veterans' hospitals for mental health care.

Difficulties navigating the VHA system. Several participants in this study expressed difficulty navigating the VHA when they discharged the military. Veterans One and Three stated they did not know where any of the buildings were or who to speak to about scheduling appointments. Veteran Two referred to the information received on enrolling into the VHA system as "face paced." Locating the buildings where the appointments were located was another issue brought up in the interviews with Veterans One and Three. Veteran One stated she was late to an appointment because the appointment slip had the wrong clinic location and she had difficulty locating the correct clinic. This resulted in her appointment being canceled and added to the frustration she was already experiencing obtaining mental health care at the hospital. There are transitioning programs at veterans' healthcare facilities that assist the veterans in rehabilitation and recovery medical and psychosocial needs (Perla et al., 2013). However,

some of the veterans are falling through the cracks and have not been enrolled in these programs. Andersen's (1995) behavioral model of health service use determines difficulties navigating the VHA system to be an enabling resource to why female veterans choose not to utilize veterans' hospitals.

Delays scheduling appointments. Participants expressed delays in scheduling mental health appointments. Veteran One expressed that when she would try to schedule an appointment and the appointment availability would be as far out as "3 to 4 months." Veteran Three stated appointment delays would affect her getting the help she needed. She stated, "I would have to schedule my appointment so far out. It's kind of impossible" [referring to managing her mental health]. This theme is an enabling resource identified though the behavioral model of health service use that is also a perceived need to improve access to mental health care. In their study, Bean-Mayberry et al. (2011) determined timely access to healthcare to be a predisposing characteristic that affects female veterans access to mental healthcare. Delays in scheduling appointments is a theme identified using Andersen's (1995) behavioral model of health service use. This theme is considered an enabling resource as it is a characteristic that affects hospital utilization and can be addressed through hospital intervention (Fasoli et. al., 2010). The mental health state of female veterans is impacted when they are not able to be seen in a timely manner to address their mental health issues coincidently affecting the quality of health care these veterans are receiving.

Turnover of providers. Turnover of providers is an enabling resource that two of the participants expressed being a factor to causing them to seek mental health care

outside of the veterans' healthcare system. Kimerling, Bastian et al. (2015) found a lack of providers, including female providers, to be a significant factor in accessing mental healthcare. Veteran One and Three expressed frustration in their interviews of constantly receiving a new provider. Veteran One stated, "I would lose the provider and have to meet somebody and get the trust established." Veteran Three explained further that when she would finally get to know a provider and establish enough trust to open up, they would leave, and she would have to establish trust all over again with another provider. Veteran One provided a similar experience as Veteran Three in mentioning receiving a new provider and not only establishing trust but being comfortable with the way the new provider treated her for her mental health disabilities. Turnover of providers is a theme identified using Andersen's (1995) behavioral model of health service use that affects female veterans' hospital utilization. Using Andersen's model, turnover of providers is a predisposing enabling characteristic of veterans' healthcare hospitals that affect access to mental healthcare.

Andersen's (1995) behavioral model of health service use and current literature helped to analyze emergent themes from this study. As I analyzed the data from the interviews the framework assisted in pulling themes that may be responsible for some female veterans choosing to seek mental health care outside of the VHA. The themes identified were enabling resources that are barriers for the participants in this study and are perceived needs that will require attention to improve access to mental health care. Identifying barriers that affect veteran healthcare hospital utilization gives a

Discussion

Female veterans are underrepresented in the predominantly male veteran population. The purpose of this phenomenological case study was to understand the barriers and access to mental health care in veterans' healthcare facilities for OEF/OIF female veterans. In this research study four OEF/OIF female veterans were interviewed on their experiences accessing mental health care at veterans' hospitals. This study utilized current literature to include past research studies, feminist theory (Eichler, 2017) framework, and behavioral model of health service use (Andersen, 1995) to analyze data from the interviews and identify emerging themes. Findings from each research question revealed several overarching themes that emerged from the data.

- Veterans' healthcare facilities should put more focus on the needs of female veterans' mental health care.
- Female veterans' mental health care needs are different from the needs of male veterans.
- Mental health care for female veterans at veterans' hospitals need improvement to cater to female veterans' needs.

Based on the data collected from the interviews, these participants all agreed female veterans' mental health care could be improved and treatments for care could be designed to treat the individual needs of female veterans. Additionally, even though females served alongside males in the military, their needs are not the same as their counterparts. The findings from this study are confirmed from past studies and theoretical frameworks used for this research study.

Finding 1: Veterans' healthcare facilities should put more focused on the needs of female veteran mental healthcare.

Findings from this study confirm a need for continuous research on female veterans' mental health care. Kimerling, Bastian et al. (2014), analyzed female veterans' access to mental health care and determined this population of veterans require more research to determine their needs and barriers accessing mental health care. One of the theoretical frameworks used for this study was Eichler's (2017) feminist theory. Eichler (2017) suggested there is a need for broader integration of gender considerations when designing mental health care policies and programs by leadership in veterans' healthcare facilities. The literature findings and theoretical framework identified confirm a need for more research on female veteran mental health care needs. With this study, I aimed to add to current literature on female veterans' mental health care needs and encourage future studies.

Finding 2: Female veterans' mental health care needs are different from the needs of male veterans.

Eichler (2017) noted there is little research that distinguishes the difference between female veterans and male veterans' mental health needs. This framework supports the finding that relate to recognizing that female mental health needs are different from male veterans. L. Goldstein et al. (2017) noted female veterans receive minimal attention for military traumas in the predominantly male environment. The experiences the participants expressed in the interviews confirm the findings of past studies that female veterans' needs are different from male veterans. Veteran One strongly expressed that she is unable to attend mental health groups with male veterans.

Interactions with males is a mental health trigger that she expressed numerous times as she attempted to receive mental health care.

Finding 3: Mental healthcare for female veterans at veterans' hospitals need improvement to cater to female veterans' needs.

Kimerling, Bastian et al. (2014) noted the need for improving in mental health treatment for female veterans. Studies show some female veterans feel their mental health treatment needs are not being met (Kimerling, Bastian et al., 2015). This finding connects the theoretical framework on behavioral model of health service use as the study results showed various enabling resources that caused female veterans to seek mental health services outside of the veterans' healthcare hospitals (Andersen, 1995; Fasoli et al., 2010). Cheney et al. (2018) and Brunner et al. (2018) noted to meet the female veterans' primary mental health care needs, the veterans' hospitals should establish an environment that ensures the privacy of these women. Providing privacy and a protected space for all female veterans could greatly increase the utilization of veterans' healthcare hospitals for female veterans.

Reflection of my findings in connection with past studies and theoretical frameworks used, determined there are barriers female veterans face accessing mental health care at veterans' healthcare hospitals. This problem of practice study adds to current research on female veterans' mental health care; however, there is a need for further studies evaluating the needs of this veteran population. In the subsequent section, I provide further information on how these findings can be addressed.

Implications

Evidence from this study provided several implications to support the need for further research to address barriers OEF/OIF female veterans face accessing mental health care at the VHA. The four female veterans provided their own stories on what they experienced transitioning out of the military, transitioning into the VHA system, and accessing mental health care at the VHA. Although each veteran had different experiences, some positive and some negative, accessing mental health care at the VHA; they all agree the needs of female veterans' mental health are different from male veterans, mental health treatment in the hospital needs improvement, and there should be continuous research of the mental health needs of female veterans.

The implications identified show there should be more gender specific research on the needs of female veterans (Eichler, 2017; Maguen et al., 2012; Turchik et al., 2013). As the female veterans in this study shared their experiences, a confirmation was given that female mental health needs are different from males. As mentioned in previous studies, not all female veterans feel comfortable attending mental health groups with male veterans, female veterans feel female providers may be more understanding of their issues, and mental health issues for female veterans can be MST and post-partum depression (Kimerling, Bastian et al., 2015; Koo & Maguen, 2014; Resnick et al., 2012). The issues mentioned are just a few of the mental health concerns female veterans feel differ from those of males.

It will take time to address all the findings in this study; however, acknowledgement from veterans' healthcare hospital leadership would be a start. There cannot be a solution to the issues presented in this study and past studies without hospital leadership acknowledging that female veterans do experience barriers accessing

treatment in their hospitals. Additionally, this issue needs to be known throughout the veteran community through presentations at conferences that discuss veterans, veterans' health care, and veterans' mental health care. This will bring the issue to light among people that can assist in making necessary changes.

As shown in the finding of this study, veterans' healthcare hospitals should update their way of treating the veteran population. Instead of looking at mental health care among the veteran population, individual focus should be placed on each gender. As mentioned, the military was once only open to males, thus making veterans' hospitals a treatment facility that served only the male population at one point. It is time for hospital officials to look at the female veterans and understand that some of their mental health issues cannot be treated the same way as male veterans. Policies need to be changed to address female mental health specifically. Mental health screens should not be generalized. These screens should ask questions that are specific for female veterans and male veterans.

All veteran hospitals should have clinics for female veterans only that service all health care needs of the female veteran to include mental health care. These clinics should also include female providers only. Creating a place for female veterans' health care will give these veterans privacy and make them feel comfortable when they walk into the hospital to receive the mental healthcare they need.

Summary and Conclusion

In summary, the purpose of this phenomenological case study was to understand the barriers and access to mental health care in veterans' healthcare facilities for OEF/OIF female veterans. The focus of this study was the mental health needs of female

veterans are different from those of male veterans (Brunner et al., 2019; Kimerling, Pavao et al., 2015). Literature shows a rise in the veteran population and an increase in the female veteran population (Kimerling, Bastian et al., 2015; Rivera & Johnson, 2014). With an increase in the female veteran population, there is a demand for the needs of females in the military to be addressed (Eichler, 2017). Lack of research on female veterans and majority research studies on predominantly male veterans mental health needs prompted a necessity for this research study (Eichler, 2017; Luxton et al., 2010; Maguen et al., 2012; Turchik et al., 2013).

The methodology used for this study was a data collection protocol of semi-structured interviews allowing for guided conversation. Sampling for this study was purposeful criterion sampling of four female veterans who served during OEF/OIF, enrolled in a VHA in Texas, and self-identify as having a mental health disability. Participants were interviewed and recorded using a virtual platform. Interviews were transcribed by hand and themes were identified and highlighted. The key findings of this study revealed a need for further research on barriers female veterans face accessing mental healthcare at the VHA. Additionally, the study results showed the mental health needs of female veterans differ from the needs of male veterans.

The findings of this study will directly impact future and current female veterans with mental health needs. The study results suggest continuous research needs to be focused on the needs of female veterans to stay up-to date with this veteran population as more females join and discharge from the military. Leaders at veterans' hospitals will have access to this study to be informed of these barriers and the recommendations to improve access to mental health care. Findings from this study will be shared at female

veteran conferences and mental health conferences. Addressing the implications associated with this study will bring more female veterans into the VHA for mental health care. Leaders in these hospitals will be informed on how implications such as all-male mental health groups, lack of female providers, and male-veterans centered care affect female veterans and ways to address them.

CHAPTER FIVE

Distribution of Findings

Executive Summary

The findings for this study identified that the mental healthcare needs of OEF/OIF female veterans are different from male veterans. With the OEF/OIF female veteran population growing, continuous research is needed to understand the barriers faced when accessing mental health care at a VHA. While services exist in the VHA that provide mental health care to female veterans, some female veterans feel these services are not easily accessible. These veterans expressed seeking mental healthcare outside of the VHA due to what their experiences accessing mental health care at the VHA.

Female veterans who served during the OEF/OIF era suffer from mental health issues such as PTSD and MST (Garcia et al., 2014; Kimerling, Bastian, et al., 2015). Accessibility for treatment for these mental health issues has become difficult due to barriers such as lack of female providers, male-centered healthcare, turnover of providers, and male mental health groups. However, in this study, not all female veterans experienced barriers to mental healthcare. Half of the veterans in this study had no issues accessing mental healthcare at the VHA. All the veterans in this study agreed there needs to be more attention on the mental health needs of the female veterans as their needs are different from the needs of male veterans.

In this phenomenological case study, four female veterans who served during OEF/OIF were interviewed. Each veteran was interviewed individually in a semi-structured interview setting using a virtual platform. The responses to the interview

questions were analyzed and compared for cross-case analysis. These results were detailed in Chapter Four of this study. Chapter Five provides a summary of the data collection and analysis, a summary of key findings, and informed recommendations.

Overview of Data Collection and Analysis Procedures

Capturing the shared experiences of each veteran that was interviewed made a qualitative phenomenological case study an appropriate methodology for my research study (Creswell & Poth, 2018; McCaslin & Scott, 2003; Stake, 1995). Qualitative research involves data that is non-numerical and provides a deeper understanding of the data collected (Creswell & Poth, 2018).

The purpose of this phenomenological case study was to understand the barriers and access to mental health care in veterans' healthcare facilities for OEF/OIF female veterans. Four participants volunteered to participate in the study. These participants were OEF/OIF female veterans enrolled in a hospital for veterans, live in Texas, and identify as having a mental health illness. These veterans were asked questions from the interview protocol (see Appendix B) on their experiences accessing mental health care at a healthcare hospital for veterans. The questions from the interview protocol were designed to answer the research questions:

1. What factors prevent OEF/OIF female veterans from accessing mental health services at a veterans' healthcare facility?
2. How has access to mental health services at a veterans' healthcare facility impacted OEF/OIF female veterans' transition into life as a civilian?

During the semi-structured interviews, participants could elaborate on their responses and share stories of their experiences. I used the transcribed data from the video conferencing platform and coded the data to develop patterns and themes (Miles et

al., 2020). Each participants interview was examined as a whole case study. The responses were combined as a whole case and analyzed for common themes that emerged.

Summary of Key Findings

In this study, I discovered not all female veterans experienced barriers to mental healthcare. All four participants in this study gave their experiences receiving mental health care at a hospital for veterans. Half of the participants shared they did not face any barriers to accessing mental health care services, while the other participants did experience barriers. After reviewing the answers to the research questions, several overarching findings emerged from this case study's focus. Even though not all participants had the same experiences, several findings highlight the issues that all participants identified as important for female veterans. Those findings are female-centered mental health care, the need for female mental health groups, and more female providers.

The first finding, female-centered mental healthcare, highlights the lack of research that focuses on the mental health care of female veterans. Some of the participants expressed current treatments to mental health care are centered around the needs of male veterans. Females were not even allowed in the military until 1917 (Toler, 2019), and even though this has changed, males are still dominant in the veteran population (A. Goldstein, 2018, 2019). Being that the VA was initially designed to care for males, these participants feel there has not been much of a change to address the needs of female veterans.

The second finding, a need for female mental health groups, focuses on most of the participants in mental health support groups being male veterans and the provider leading the groups. This finding is significant as some women have experienced MST, making it difficult for them to be around males, especially in a room filled with men. One participant shared her experience attending a mental health group that she was not aware had male participants. As the participant shared her experience, I observed her emotions, and it was evident that it was a traumatic experience for her, and she is still affected by it today.

The third finding, lack of female providers, is an issue all participants agreed on. These veterans felt having a female provider makes it easier to open up concerning their mental health issues. Female providers may be able to relate more to these veterans regarding postpartum depression or MST issues. One participant shared that she felt her needs were not as important to the provider when she had a male provider.

Informed Recommendations

This study's data analysis and findings show OEF/OIF female veterans experience barriers to accessing mental health care at hospitals for veterans. To improve access to mental health care for female veterans, barriers to mental health care need to be addressed according to the needs of female veterans. To improve access to mental health care, I recommend mental health care services be available in the women's clinics, mental health support groups for female veterans are formed, and duplicate the current study with a larger sample size.

The VHA currently services women's health care needs. However, not all VHA has a designated area where women can go to receive care. Those VHA that do have a

women's clinic do not provide services for mental health care. I recommend that all VHA's have a women's clinic where female veterans can receive treatment for all healthcare needs, including mental healthcare. Female veterans who suffer from mental health issues need a place designated for women only. Women clinics for female veterans with mental health services will address other barriers to care, such as women who suffer from MST who are uncomfortable around men, and female veterans will see providers who are females.

Veterans in this study expressed issues attending mental health groups with male veterans. Veteran Two described that she would consider attending mental health groups if there were mental health groups with only female veterans. The VHA could separate female and male veterans into separate support groups. Female providers should lead the support groups for female veterans. Female mental health groups will allow these veterans to engage with other female veterans who may have similar experiences. These veterans may also feel more comfortable opening up about their mental health illness with other females.

Finally, I recommend further research studies on female veterans barriers to mental health care to be conducted on a larger sample size. Two female veterans interviewed served during multiple wartime areas leaving reason to research access to care barriers for all female veterans. In addition to larger sample sizes, the research methodology should include questionnaires to reach a broader range of female veterans. Further research will bring awareness to female veterans' mental health needs and identify other barriers female veterans face to access mental health care.

Findings Distribution Proposal

Target Audience

In this section, I describe the findings and distribution proposal to include plans to disseminate the findings. Additionally, the target audience that will benefit from the findings of this study are Veteran Integrated Service Network (VISN) directors and female veterans. Each target audience is identified with a brief description of the distribution method.

Veteran Integrated Service Network (VISN) directors. Veterans' healthcare hospitals are divided into 18 regional systems across the United States which are called VISNs. VISN directors would benefit from reviewing these findings because they are in positions to make the necessary changes to improve access to mental health care within the hospitals. VISN directors have the ability to reach officials in Congress to advocate for female veterans' needs so policies and laws can be changed from a higher level. The conclusions of this study will give VISN directors insight into some of the barriers female veterans face accessing mental health care at the veterans' healthcare hospitals. Based on the findings and recommendations, VISN directors can make informed decisions and begin to implement a plan to improve access to mental health care for female veterans.

Female veterans. Further research is needed to add to ongoing research for female veterans and their mental health care needs. It was not easy for me to obtain participants for this study as many of the veterans felt uncomfortable telling their stories and reliving their past experiences. Female veterans will benefit from the findings from this study because they can add to future research studies on this problem of practice. Sharing the result of this study may encourage other future female veterans to come

forward and participate in future studies. These results will also benefit the female veteran audience as they will see that awareness is being made on access to mental health care for this veteran group.

Proposed Distribution Method and Venue

The most appropriate way to distribute my findings is by speaking at conferences that cover veterans' health care issues. Specifically, speaking at the VA Healthcare 2022 summit would be an ideal conference to distribute results from this study. Many healthcare officials who want to provide veterans with world-class quality health care will attend this summit. Some of the attendees include VA officials, government officials, private health care officials, academia, and consultant communities (Institute for Defense and Government Advancement, 2021). Distributing the research results at this conference would help me to reach VA officials, to include VISN directors, and other government and civilian officials that are able to improve mental health care access for female veterans. In the next section, I provide details on what I will discuss at the conferences and the distributing materials I would use.

Distribution Materials

I will present these finding at a professional presentation to reach key stakeholders. As mentioned above these finding will be presented at the VA Healthcare Summit 2022. I will apply to become a 2022 summit speaker. The presentation format will be through an electronic visual aid such as PowerPoint that will consist of 20 to 30 slides. The PowerPoint presentation will include quotes from the participants in this study, literature to support the purpose and findings of the study, and tables and figures of the themes identified in this study. The presentation will be 30 minutes long with an

additional 10-minutes of time for questions and answers. The presentation will include an overview of this problem of practice. The overview will cover the purpose for this study and the problem statement. Each section of this problem of practice will be discussed and presented visually using PowerPoint. The research will go in-depth on the themes that emerged from the data analysis and the literature and frameworks that confirm these findings. The presentation will conclude with me sharing recommendations to address the findings and a summary on why there is a need for continuous research on female veteran mental health care needs to the audience at the conference.

Conclusion

In this qualitative, phenomenological case study, four OEF/OIF female veterans shared their experiences accessing mental health care at veteran hospitals. An analysis of these experiences identified barriers they faced accessing mental healthcare. Findings from this study indicate not all female veterans are using mental health care services provided by the VHA. The study results identified some of these barriers to accessing mental health care. In addition to current literature, this study aids in research on the mental health care of female veterans and the need for future research to be conducted.

APPENDICES

APPENDIX A

Informed Consent

Baylor University
Curriculum & Instruction

Participant Consent Form for Research

PROTOCOL TITLE: **Understand the Mental Healthcare Needs of Female Veterans and Access to Mental Healthcare Services within the Veterans Health Administration: A Phenomenological Case Study**

PRINCIPAL INVESTIGATOR: **Andrietta Gayles**

SUPPORTED BY: **Baylor University**

Invitation to be Part of a Research Study

You are invited to be part of a research study. This consent form will help you choose whether to participate in the study. If you decide to participate in this research study, you will be asked to sign this consent form. Feel free to ask if anything is not clear in this consent form.

The person in charge of this study is Andrietta Gayles, under the supervision of Dr. Sandi Cooper.

Important Information about this Research Study

Purpose of the research: This study aims to understand the mental health needs and barriers that OEF/OIF female veterans experience when accessing veteran hospitals' mental health services. The researcher asks you to participate in this study because you are a female veteran who served in the military during OEF/OIF and identifies with having a mental health illness.

Eligibility to participate: To participate in this research study, you must be

- Female military veteran
- Self-identify as having a mental health illness
- Be eligible for healthcare services at any veteran hospital

Study activities: If you choose to participate, you will be interviewed on your experiences accessing mental health services at a veteran hospital and any possible barriers you may have faced. Interviews will be one-on-one via a virtual platform. The interview will take 45 to 60 minutes.

This information learned from this study may be beneficial to others in the future.

Risk and confidentiality: A risk of taking part in this study is the possibility of losing confidentiality. Loss of confidentiality includes having your personal information shared with someone who is not on the study team and was not supposed to see or know about your information. The researcher plans to protect your confidentiality.

You are required to be video recorded to participate in this study. A transcript of the interview will be provided to you for your review. We will keep the records of this study confidential by **using pseudonyms to replace your real name.** We will make every effort to keep your records confidential. However, there are times when federal or state law requires the disclosure of your records.

The following people or groups may review your study records for purposes such as quality control or safety:

- Representatives of Baylor University and the BU Institutional Review Board
- Federal and state agencies that oversee or review research

This study's results may be used for teaching, publications, or presentations at professional meetings. If your results are discussed, your identity will be protected using a code number or pseudonym rather than your name or other identifying information.

Your Participation in this Study is Voluntary

Taking part in this study is your choice. You are free not to take part or to withdraw at any time for any reason. No matter what you decide, there will be no penalty or loss of benefit to which you are entitled. If you choose to withdraw from this study, the information you have already provided will be kept confidential. You cannot withdraw the information collected before your withdrawal.

Contact Information for the Study Team and Questions about the Research

If you have any questions about this research, you may contact:
Researcher: Andrietta Gayles
Phone: [redacted]
Email: Andrietta_gayles1@baylor.edu

Contact Information for Questions about Your Rights as a Research Participant

If you have questions about your rights as a research participant or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the following:

Baylor University Institutional Review Board
Office of the Vice Provost for Research
Phone: [redacted]
Email: irb@baylor.edu

Your Consent

SIGNATURE OF SUBJECT:

By signing this document, you agree to be in this study. We will give you a copy of this document for your records. We will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I understand what the study is about, and my questions so far have been answered. I agree to take part in this study.

_____ _____

Signature of Subject Date

APPENDIX B

Interview Protocol

Date/Time of Interview: _____

Location of Interview: _____

Interviewer: _____

Interviewee: _____

Demographic Information

1. What years did you serve in the military?
2. What branch of service did you serve?
3. Are you a combat veteran?
4. What was the highest rank you held while on active duty?
5. Do you consider yourself to be a veteran?
6. Do you have a mental health illness? If so, what type?
7. Are you eligible to receive medical care at a veterans' healthcare facility?
8. Are you currently receiving care for your mental health illness?
    a. If so, is it at a veterans' healthcare facility?

Experiences

9. Describe your experience transitioning into the veteran health system to obtain medical care.

10. Have you experienced delays making appointments to be seen for your mental health illness?
11. Describe your experience receiving treatment for mental health services at a veterans' healthcare facility.
12. How would you describe the differences in mental health treatment at a veterans' healthcare facility for female veterans compared to male veterans?
13. Describe any barriers you have faced accessing mental health services at a veterans' healthcare facility.
14. Do you feel mental health services for female veterans could be improved at veterans' hospitals? If so, how?
15. Is there anything else you would like to share about your experiences accessing mental health services at a veterans' healthcare facility?

APPENDIX C

Observational Field Notes

NAME OF PARTICIPANT_____

DATE AND TIME _____

	DESCRIPTIVE NOTES
General	_____ _____ _____
Facial Expression	_____ _____ _____
Body Language	_____ _____ _____

	REFLECTIVE NOTES
General	_____ _____ _____
Facial Expression	_____ _____ _____
Body Language	_____ _____ _____

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