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Clearing Away Past Wreckage

A Constructivist Grounded Theory of Identity and Mental Health Access by Female Veterans

CE 1.5 Contact Hours

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Women Veterans are the largest veteran population yet have significant mental health disparities, greater than both civilian women and veteran men. This article used constructivist grounded theory methods to explore the experiences of women Veterans that led to mental health outpatient service use. Twelve women Veterans revealed meaningful stories on their experiences of trauma and their use of mental health services. A broader grounded theory process model emerged, linking the categories of Trauma, Transitions, Identity, and Structure. This research provides key insight into how women Veterans make health care–related choices and process traumatic events such as military sexual trauma. **Key words:** *constructivist grounded theory*, *mental health*, *qualitative research*, *treatment decision-making*, *women Veterans*

WOMEN VETERANS tend to have a higher mental health morbidity rate than both civilian women and veteran men, with a lifetime depression rate of 29% for veteran women compared with 16% of veteran men and a posttraumatic stress disorder (PTSD) rate of 21% compared with 5% of civilian women.[1,2] Mental health care for women Veterans is a critical unmet need that must be met.

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The literature describes a host of factors and experiences associated with women Veterans' need for mental health care. Traumatic experiences, notably the types of trauma women Veterans uniquely experience, such as military sexual trauma (MST), make women more likely to be vulnerable to PTSD and comorbid depression,[3,4] more likely to experience a longer duration of PTSD symptoms, and, in general, have a more pronounced reaction to trauma.[2,4] Women who serve in the military are also increasingly exposed to both the physical and psychological traumas of combat and its aftermath, particularly as women serve in broader military roles and as the nature of warfare changes, with a lack of a demarcated "front line."[3,5] Furthermore, women Veterans endorse more trauma outside of the military than their civilian women and veteran male counterparts.[4,6] The literature suggests almost all female veterans experience a traumatic event at some point in their lives, with estimates as high as 93%.[3,7,8]

While a robust body of research describes the prevalence of and predisposing factors for

Statements of Significance

What is known or assumed to be true about this topic:

Currently, it is known that women Veterans are one of the fastest-growing populations of veterans and that trend is unlikely to change in the future, as policies have changed to allow women into expanded roles in the military, including combat. It is also known that women service members experience trauma, including MST, at rates higher than their male counterparts.

What this article adds:

This article adds to the body of knowledge by expanding upon the pervasive experiences of trauma that occur throughout the life span of a woman veteran, not just within the military. Furthermore, this article delves into the intimate aspects of their experiences and how their identity changes over time in response to trauma. The dynamic nature of these transitions over time is also described in detail in the process model.

women Veterans' mental health conditions, less is known about how women Veterans' experience these events and how these events shape their identity. Understanding women Veterans' identity is crucial to understanding their mental health needs and mental health decision making.[9,10] Therefore, the purpose of this study was to assess and understand the experiences and identities of women Veterans before, during, and after military service that ultimately led to the use of mental health outpatient services.

STUDY METHODS

Study design and setting

This is a qualitative study of community-dwelling women Veterans living in southern California. Online and in-person recruitment took place from August 2015 to March 2016. Participants consented to a demographic survey and 1-time interview, using a semistructured interview guide. All study materials were approved by the Office of the Human Research Protection Program at the University of California, Los Angeles (UCLA).

Sample

Participants eligible for this study were women Veterans aged 21 to 65 years who served in the regular armed forces. Participants must have attended at least 1 mental health outpatient visit in community-based and/or Veterans Affairs (VA) services within the past 12 months. Exclusion criteria included currently hospitalized for a mental health diagnosis, under the influence of drugs and alcohol, or evaluated by a clinician to be under psychological distress. This study also excluded current active duty military personnel, VA employees, including VA work study students, women Veterans who were mental health providers, and nursing home residents. In total, 12 women were included in this study; 6 recruited via posted flyers and 6 recruited online.

Recruitment and data collection

Recruitment sites included a Veterans Center in Southern California, Veterans Service Organization, and a Veterans Resource Office on a college campus. Women responded to the study flyer invitation by contacting the principal investigator (PI). If eligible, participants selected a place and time for the formal written consent and interview. Lasting 45 to 90 minutes, each interview started with demographic questions including rank at entry and discharge and then proceeded through the interview guide.

The interview guide consisted of questions about their upbringing during childhood and adolescence, military service history, their first entry into mental health services, and their experiences with their mental health provider. Women were encouraged throughout the interview to provide descriptions of specific experiences before, during, and after their military service. All interviews were

digitally recorded, transcribed verbatim by a professional transcription service, and checked for accuracy. The participant was given a $25 gift card as compensation at the end of the interview.

Data analysis

This data analysis followed a constructivist grounded theory approach; consequently, data collection and analysis occurred simultaneously.[11] Atlas.ti was used to organize and sort data.[12] Using methods described by Charmaz,[11] the PI initially coded early transcripts line-by-line to note actions, experiences, and feelings within interviews.

Second, the PI analyzed the initial codes and used focused coding to identify and cluster frequent and significant codes. These codes were then verified by a coresearcher. From these code clusters, the PI and coresearcher created broader categories to represent the data. As codes and categories emerged from the data analysis, the PI created memos to document analytic steps and insights. Furthermore, interview questions in subsequent interviews shifted slightly to explore and fulfill possible theoretical categories.

Analytical techniques, such as free writing and code clustering, revealed connections not initially apparent during analysis and consequently raised the level of abstraction and depth of category formation. Other analytical techniques, such as examining language and using various meanings of a word, were used to raise analysis to a theoretical, interpretive level that spanned between and within interview participants.[13] By reflecting on initial findings while coding subsequent interviews, the PI and the coresearcher applied the questions, concerns, and analytical hunches from previous memos into the transcript currently being coded and documented that analytical synthesis into a new memo. After coding each interview, codes and memos were shared with the coresearcher for verification of the analytical process.

Finally, the team used theoretical coding to connect categories and create structures from the data.[11] Trustworthiness was verified through credibility, transferability, dependability, and confirmability, according to criteria specified in Lincoln and Guba.[14] For credibility, a coresearcher reviewed the codes and analysis and resolved discrepancies with the PI. Transferability was enforced through set inclusion criteria and detailed demographic information. For dependability, the documentation of analytical techniques through memos served as documentation of analyses over time. Finally, confirmability was maintained by sharing the memos with the coresearcher at each phase of analysis. Per Corbin and Strauss,[13] qualitative theoretical saturation may be achieved with between 10 and 25 participants in developing a grounded theory. For this study, theoretical saturation was achieved with 12 participants.

STUDY FINDINGS

Sociodemographic, military service, and mental health service use is presented in the Table.

The average age of participants was 43 years (range, 25-65 years), which is slightly younger than the national average age of 48 years.[15] The majority (66%) of women used VA health care benefits as their primary form of health coverage. Seven women (58%) were in mental health treatment for greater than 1 year. Five women (41%) saw either a psychiatrist or a psychologist at the time of interview, 6 participants (50%) saw both a psychologist and a psychiatrist, and 1 woman used women Veterans support groups as a form of mental health treatment in the months immediately post–military service.

The research findings revealed 2 interrelated processes: one that describes significant experiences that change and develop the participants' identity over time; the other uncovered the pervasiveness and significance of trauma at multiple points in these women's lives and how women used mental health outpatient services to deal with pervasive trauma.

Table. Characteristics of Women Veterans (N = 12)

	n	%
Demographic characteristics		
Age, y		
21-30	1	8
31-40	5	42
41-50	2	17
51-60	2	17
60+	2	17
Employment status		
Unemployed	4	33
Full-time	3	25
Retired	1	8
Student	4	33
Insurance/benefit provider		
VA	8	67
Private employer	2	17
Medi-Cal	1	8
Student health insurance	1	8
Relationship status		
Divorced	5	42
Married	3	25
Single	3	25
Widowed	1	8
Has children		
Yes	7	58
No	5	42
Military service characteristics		
Branch		
Army	3	25
Navy	4	33
Air Force	4	33
Coast Guard	1	8
Rank		
Enlisted	3	25
Enlisted (NCO)	8	67
Officer	1	8
National Guard/Reserve Following Service		
Yes	6	50
No	6	50
Period served (including multiple tours, Guard, Reserve)		
Vietnam War (Aug 1964-May 7, 1975)	1	8
Post-Vietnam (May 8, 1975-Sep 7, 1980)	1	8
Post-Vietnam to Persian Gulf (Sep 8, 1980-Aug 1, 1990)	3	25
Persian Gulf War (Aug 2, 1990-Feb 28, 1991)	3	25
Post-Persian Gulf to Sep 11, 2001 (Mar 1, 1991-Sep 11, 2011)	3	25
Sep 11, 2001, to present (war in Afghanistan)	3	25
Mental health outpatient service use characteristics		
Type of provider seen		
Psychologist	2	17
Psychiatrist	3	25
Support group	1	8
≥2 providers	6	50
Time in treatment		
0-3 mo	2	17
4-6 mo	2	17
6-9 mo	1	8
>1 y	7	58

Abbreviations: NCO, Non-Commissioned Officer; OEF/OIF/OND, Operations Iraqi Freedom/Enduring Freedom/New Dawn; VA, Veterans Affairs.

Identity development process

The Figure describes 4 major categories that represented women Veterans' experiences surrounding mental health service use: (1) Identity (2) Structure, (3) Transitions, and (4) Trauma. Together, these categories form a broad description of their experiences from childhood to becoming a veteran.

Shifting identity

Changes in identity were inherent in women Veterans' movement forward in their lives. Before joining the military, the participants discussed the challenges they faced during childhood and adolescence, including poverty and strained family relationships. Struggle, disadvantage, and uncertainty shaped their identity, which continued

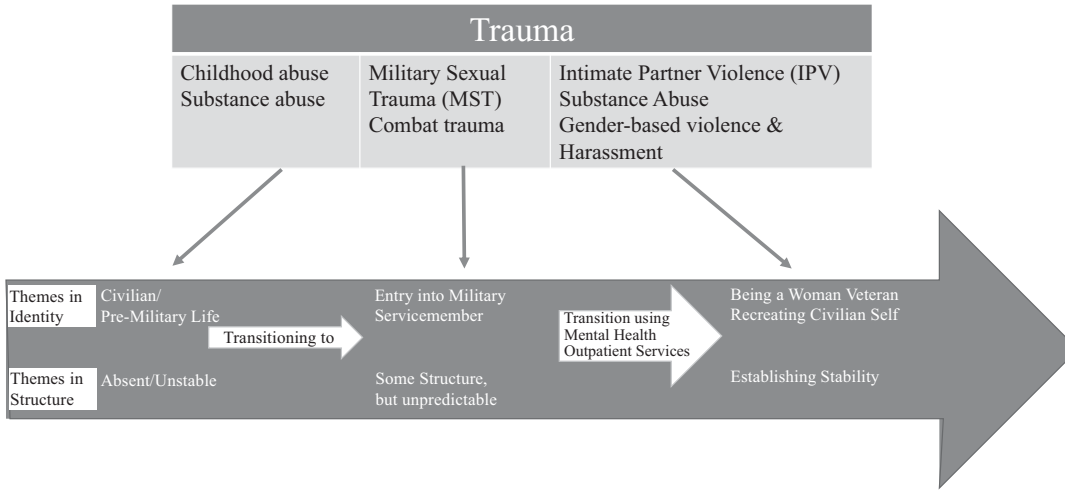

Figure. Williams model of women Veterans reconstructing self after trauma.

until joining the military. One woman described her upbringing in the following way, "[B]roken homes, abusive father, abusive mother, physically abusive, verbally abusive parents you know. It ain't happy families."

Upon joining the military, the woman assumed the identity of a service member, which was engrained during the arduous process of basic training. Notions of gender in the military were often reframed, as women are in the minority. Exposure to a male-dominated field and MST influenced how the women Veterans viewed themselves and interacted with other men:

> Because all the other girls were, I'm sorry, but they were sleeping around with all the guys on the ship and on the base because we were still in port. So when they see one that stands out, oh nobody's been with her, well that makes you a target. And I didn't want to be with anybody. I was in the military. I wanted to serve, not to be with all the guys in there.

Upon reentry to the civilian world, the status as a service member receded and the role as a wife, mother, or nurturer was assumed, often with difficulty. A participant described her postmilitary experiences as follows:

> So all these different aspects of my day just . . . . And I was a mother only. And I do value motherhood. I think it's very important for ourselves and our country and our world. But it was just hard letting go of all those other things.

As sense of self is reclaimed and restructured, participants over time created an identity that was separate and unique from military service.

Pursuing structure

The other foundational concept in this model is structure in that the participants sought out certain positive aspects: the stability and predictability inherent within social structures such as the military, where women saw the successful results of their efforts. A participant stated, "When I was in the military, for me it was the parenting that I never got. It was highly structured. It was organized. I could advance through my own merit. You did the work, you advanced."

Structure also refers to what happens when a sense of structure is absent. Structure seeking can happen as early as adolescence, where many women in this sample joined the military to get away from a traumatic household or maladaptive behavior, such as substance abuse and addiction. One woman shared her experience of actively joining the military to escape a negative situation and likened her circumstances to other women Veterans:

So there's three reasons why someone goes into the military—I was put on the street when I was 15 and you know I got caught doing stuff and you know I was headed to jail if I hadn't gotten into the military. But that's something that they're doing it to get away from—there's a lot of trauma in a lot of females that came out and joined the military, including sexual abuse, physical and verbal abuse.

One woman shared simply, "It's just, I joined getting away from crack. I said, I'll join the foreign legion." They sought systems such as the military to gain a sense of structure that was absent in their premilitary life.

Managing transitions

Changes in the structure of the environment and identity propelled these women forward toward the recognition of a need for assistance in reconstructing their sense of self. One of the first reported transitions was joining the military and the changes in environment that occurred with duty station assignment, military occupation, potential deployments, and the regimented structure of military life. These transitions were often wrought with tension and unease, as they represented a shift to unknown circumstances and the potential for their safety, both physical and emotional, to be compromised. This effect is compounded when considering a woman's upbringing since she may not have been prepared to experience change and transitions. One woman described her experience with changing duty stations in the following way:

Growing up where I grew up and being poor, I-I never really left the area that I was in and so a lot of the anxiety was from change, like major change. And so, um, so every time I would change duty stations, which I only did twice, um, I would have really bad anxiety problems. Um, and they would just say, "You know, you're-you're overreacting." You know, um, things like that.

The next major transition was out of the military and back into the civilian world, where women Veterans must transition into housing, employment, and in a larger sense, the role of a woman in larger society. Because of the overarching nature of trauma, this process is achieved with varying levels of success.

Transitions occurred within each of the components of the model. In addition to the larger transitions in physical location and occupation that occurred when joining and discharging from the military, identity, structure, and sense of self are transitioned as the woman veteran moved forward in the model. Women also reframed their military experiences for their positive aspects. One woman stated,

Like, I know the transition for student veterans to education is difficult. Especially if you come from disadvantaged backgrounds. Which a lot of us do. It's partly a lot of the reasons why we joined the military, you know, to-it's a social ladder, you know. Another commented, Um, I think it [the military] did help me a lot. It helped me learn how to be on my own. To grow up fast. To take on the world without fear. That's something I'm proud of. And there's nothing wrong with being a woman to do so. So that's what I believe. And if a woman wanted to go combat, she has every right to do so.

Surviving trauma

Trauma emerged as a major substantive category in the formation of mental health needs and need for mental health outpatient services. Each of the women in this study reported some sort of trauma throughout the course of her life, from her childhood to the present. This trauma took different forms and had differing levels of intensity, but all events created instability for the woman in terms of her security, trust, sense of worth, and view of the world. For this sample of women, trauma included rape or assault, as well as harassment, threatened assault and/or harassment, and unwanted sexual advances. Types of trauma varied and included combat trauma ($n = 3$), childhood abuse ($n = 9$), domestic abuse ($n = 5$), MST ($n = 7$), and repeated instances of rape and harassment ($n = 7$). Nine women disclosed more than 1 instance of trauma throughout their lifetime. These powerful stories demonstrate the devastating nature of the

trauma they experienced and must work to overcome:

> One guy came in and-and I mean you know I was kind of like the triage nurse and I kind of look and he has like a hole where his nose is but the whole head of his, back of his head's blown out and like he has no brains you know what I mean? Another woman shared, [S]omebody beat my head in with a pipe and the cement on the ground to carry the front load and rape me for 16 hours . . . and I had three other rapes that happened when I was in the military that was undiagnosed . . . .

The pervasiveness of these trauma experiences infiltrates all parts of the conceptual model (Figure); hence, its placement at the top of the model and its connection across the life span from premilitary life to recreating civilian self. Trauma is the context in which each phase of identity formation takes place. The trauma that took place in their lives created disruption in their self-identity coupled with the identity formation inherent in becoming a service member. Trust was destroyed and is never fully regained after.

"From shame to pride": Renegotiating trauma

The other process that emerged from the data focused on the experience of pervasive trauma from the point of childhood through the present day as a veteran, with the military experience adding to the complexity of experiencing and creating meaning from trauma. As a result, the participants could incorporate military experiences into their reformed identity. They could reframe their trauma in terms of the example they could set for others and their pride in what they had been able to overcome. This process model incorporates each of the major concepts in some way and emerges along with the overall transition from civilian to service member to veteran.

Traumatic event

This refers to the traumatic incident or incidents in their lives that shattered their views of the world and personal identity. Some women had 1 instance of sexual assault or rape, whereas others unfortunately suffered multiple incidents. Combined with this, 9 women experienced childhood trauma as verbal, emotional, or physical abuse within their families, along with poverty and low socioeconomic viability in their neighborhoods.

Instability

Because of trauma and their diagnosis women Veterans spoke of entering a period of instability, which lasted from months up to 10 years. The participants who reported having PTSD and other mental health symptoms indicated that their ability to form meaningful relationships, stable housing, and maintaining sobriety was impaired. Some women become involved in multiple abusive relationships, substance abuse, and experienced homelessness. A notable component of this model of trying to recreate stability reported by the women was the encapsulation of trauma. As a means of survival, women reported emotionally locking away their trauma and their reactions to it. This phenomenon, which we refer to as "soldiering on," is a means of managing stress by regaining some stability to be able to continue to move forward and perform even with significant trauma.[16] These women reported doing this to maintain a household, job, or sense of sanity as they moved through the world and threatening spaces, "Because it-it . . . . And I think I don't really realize how I felt when I was in the military 'cause I just put up this strong front and I kind of just block everything out when I'm walking through there."

However, as these women told their stories it became evident that this encapsulation, combined with the hypervigilance, emotional numbing, and triggering that are symptoms of PTSD, became increasingly difficult to manage over time and eventually degraded the woman's ability to maintain the life she had established postmilitary.

Tipping point

Over time, women reported reaching a tipping point, where they exhausted their

coping resources and reached a point where they realized they needed resources to help them reestablish a postmilitary, posttrauma identity in order to move forward with their civilian lives. The participants reported incidents that included conflict with a work supervisor or spouse, incarceration, or a perceived overload of responsibilities. Some tipping points were expressed as internal realizations, whereas others were triggered by additional trauma or violence:

> [I]t was a situation where I was kind of backed in the corner.... And it was the fight ... the flee or fight type syndrome you know and I had just started [OCCUPATION] the year before, And I had not gotten past my probation yet and it was like okay, one of us ... you know something's gotta give.... You know and so I decided to go into treatment and I've been in treatment ever since.

Once this point was reached, these women Veterans reported seeking and willingly entering mental health treatment. This decision to enter mental health was described as an individual choice that was not generally discussed with the woman's social network. When deciding to enter mental health services, the women Veterans interviewed remarked they felt isolated and had difficultly establishing trust with others.

Reestablishing identity with mental health treatment

The women Veterans told stories of confronting painful traumas from childhood to their present situations. Women spoke of being unable at first to approach their trauma, having kept it locked away for so long, "But, you know, twenty years later. This is inside of me. So, I-I finally dis, discussed it with her." Some of the women reported that it was difficult to separate the trauma from the context in which the trauma occurred: "Yeah, it still haunts me a little bit today, but I think about it when I have to. I don't think about it anymore because I know it will make me mad sometimes."

Over time, women expressed being able to process their trauma through significant and meaningful partnerships with mental health treatment providers. They felt that they became aware and conscious of their symptoms, triggers, and the relationship between their traumatic histories and their distressing behaviors. Continued use of mental health outpatient services led to more confidence in managing their mental health symptoms, enhanced ability to form relationships, and determination to reintegrate into large systems such as health care, employment, and education. One woman described a time where she had to rely on her provider to help her with her education:

> I check in and I know that I can call my psychologist if I'm having a really bad time, which I did last quarter. I had a really, really bad time. I almost quit school. And I called her and we had a couple of appointments. She helped me to get reprocessed and she did an outstanding job.

Regaining stability and moving forward

At this stage, the women Veterans interviewed were taking active steps to move their lives and goals forward, such as finding and maintaining employment, starting postbaccalaureate education, and securing stable, safe, housing, and entering substance abuse treatment. The participants reported still experiencing symptoms and encountering triggers but felt better able to handle their symptoms because of a rebuilt sense of identity.

Some women Veterans expressed that the natural process of aging brought perspective and scope to their experiences in that they could separate their trauma from the other experiences in their lives. One participant valued her travel and worthwhile connections:

> Yeah so you could get 30 days a year vacation you know, so I'd take a week here and a week there. And I made a lot of friends. I have four friends who had restaurants, two Germans and two Italians that have restaurants. We'd go there and eat all the time. They're sweet, sweet people. They're good people. They're aggressive but sweet. They're from the heart. But it was just a great experience, and a lot of it I brushed it off. Finally, women Veterans told of forming stronger ties with women

Veteran peers, and a small group of friends and family members. Ties to other women Veterans provided an outlet for experiences to be easily understood, without explaining oneself. The ties are a crucial social aspect of women Veterans' lives.

Although these women took significant steps forward in confronting their trauma, restructuring their lives, and reestablishing an identity, some women Veterans reported still feeling isolated during this time. Trusting relationships can be formed, but it is a slow, deliberate, conscious process on behalf of the woman veteran. For that to happen, the relationship must be nurturing to her and lack any reciprocal expectations as a result of forming the relationship whether social, monetary, or romantic. The women Veterans interviewed wanted an environment in which they can feel safe and understood rather than one that is overly expressive or focused on emotional sharing, "I have my friend (name) who, she doesn't judge me. She listens to me. She's had a couple kids removed from her so she knows. And we just we grieve a little bit together."

Reestablishing identity, owning experiences

In this culminating stage, the women Veterans interviewed reclaimed their identity and reframed their traumatic experiences. They could separate themselves from the shame they experienced and realize they were not to blame for their trauma and separate the traumatic experience from the other positive experiences within that context. Women Veterans in this sample at this stage talked about their MST and about the positive experiences in the military, such as socioeconomic stability, international travel, and opportunity to learn a skill. Finally, they "owned" their experiences in that they saw the potential to educate other women Veterans and share their stories. They framed their stories of MST and past traumas as a story of survival and ability to maintain a positive outlook:

> And then be able to talk about it and-and realize that, yeah, this-this happened, but I'm not gonna allow you to take my life away from me just because you d-, you caught me. You know, it's the same as, you know, even if someone cut me with a knife. The scar's always gonna be there. And it's gonna be a reminder of, but I'm not gonna allow that cut take away my arm, you know? So, and that's just one of my analogies, and it works for me.

This positive outlook extended to themselves, as participants acknowledged their own needs and understood the benefits in addressing these needs, instead of encapsulating them. One woman stated:

> I would say it's time to start loving you and taking care of you instead of always doing for others, but if you don't take care of you first you're no good to anyone else. And address your issues whether it's physical or mental, emotional whatever, head on. And clear away your wreckage that you've had in your past . . . .

DISCUSSION

This constructivist grounded theory study provides an in-depth description of what women Veterans experience before, during, and after military service and what brought them to mental health outpatient services and how they benefitted. The categories of shifting identity, seeking structure, managing transitions, and surviving trauma emerged as major themes related to the identity development process. Identity, structure, and transitions emerged from the data as major themes that described how the identity process, including renegotiating identity, occurred. The cumulative experiences of trauma over time contributed to the majority of women's entry into the military, that is, to escape a traumatic and unstructured home life; heightened the potential threats inherent in military service, such as combat violence during her military service; and created an arduous process of reintegration back into the civilian world. Over time and with mental health intervention, study participants established a sense of stability by renegotiating the place of trauma in their lives and reshaping their identity. This process facilitated participants' abilities to move forward into education, employment, and meaningful relationships.

This study contributes to the body of existing knowledge regarding how women Veterans reconcile/renegotiate trauma experienced before, during, and after military service. These findings not only demonstrate the hardships and strains that can result from military service but also highlight the additional challenges of being a woman in the military, where a woman might also face internal safety threats from her fellow service members. Despite these challenges, these women exhibited admirable tenacity and strength to cope with trauma and its consequences and survive under stressful situations. This drive for survival, which was reinforced by military training, also led to trauma encapsulation to the point where the effects sometimes manifested in the woman's life without her conscious knowledge. However, once these issues were uncovered, the woman veteran successfully engaged with mental health outpatient services to reconcile trauma and reestablish identity.

In a grounded theory qualitative study, Burkhart and Hogan[17] also discovered that coping with transitions was a significant experience for women Veterans as they moved from civilian to service member and then reintegrated back into the civilian world. These researchers found similar themes of joining the military to seek safety, experiencing combat trauma and MST and continued harassment once in the military, and feeling unprepared for civilian life as they straddled 2 social worlds between military and civilian life experiences.[17] An added stressor during this transition was a PTSD diagnosis and the associated symptoms of emotional lability and hypervigilance. Ultimately, women Veterans used camaraderie and connections with other veterans to take pride in their service and contribution to public safety and well-bring.[17]

Study results revealed some striking difference and similarities about sexual trauma. Seven of the 12 women (58%) reported MST, which is higher than general estimates (30%-45%) in the literature.[2,18] However, the prevalence of MST in this sample (58%) is similar compared with samples of women veteran VA users who access mental health services (55%)[19] or have a substance use disorder (64%).[20] This suggests traumatic experiences, in part, lead to the subsequent use of mental health services as one method of coping.

This sample of women Veterans is far more diverse than other studies of women Veterans. Half (50%) of the women in this study were women of color compared with estimates that range from 50% to 80% white/Caucasian in the literature.[7,21,22] The average age of women in this study (43 years) is close to the national average age of women Veterans (48 years).[15] In terms of service use, the women Veterans in this study have higher usage of VA health care (66%) than the overall prevalence.[23,24] Considering veterans of all genders who use VA services are more likely to have more severe medical and mental illness, this reflects in the high reports of trauma in this sample.[19]

Limitations

The study sample can constitute a potential bias, as participants had to opt into the study rather than refuse to participate. The small sample size and trauma experiences may not be representative of women Veterans' experiences as a whole. Also, considering 80% were VA users and 58% were in treatment for greater than 1 year, it is also possible that this group of women have experienced significantly more trauma and are more likely to have a mental health condition than women who are not in the VA system.

Implications

The women in this study came to a "tipping point," or point of realization that their current situation was not sustainable and they needed assistance. For some women, it was a sudden act of abuse, but for most others, moving toward the tipping point was a process that escalated over a period of time. This offers opportunities for proactive intervention and research, which could mitigate or even prevent the tipping point. Supplementary services such as housing, transportation,

and other services to ease transition out of the military can be provided before women reach the tipping point.

In addition, for the women who experience trauma, services should be readily available, gender-appropriate, and trauma-specific. Refining these areas of intervention has implications for practice and policy, insofar as both individual practice and structural policy are influenced and changed.

Implications for practice

These study findings combined with the current literature strengthen the need for evidence-based programs to address the specific needs of women Veterans. For example, gender-specific medical services in both VA and civilian settings seem essential. This extends to mental health services, which should address gender-based violence and its repercussions. Services should also extend to trauma throughout the life span, since women Veterans are more likely to report a lifetime history of trauma than male veterans.[2,3] In the VA setting, systemic changes to improve women Veterans' activation and engagement with care often lead to positive outcomes for women Veterans and are closely linked to the provision of gender-specific services.[25] Women Veterans who positively rate VA mental health services are more likely to perceive gender-related comfort in the health care setting and receive care from a female provider and in women-only settings as often as they wished compared with women Veterans with negative ratings.[25]

Less is known about how women Veterans experience care in civilian settings, but the literature demonstrates developing military cultural competency among mental health providers can improve the "fit" between veterans and providers.[26] Military cultural competency is defined by a level of familiarity with military and veteran culture practices, prior training or proficiency in veteran-specific spaces, and a comfort level and past experiences with veterans and their families.[26] This also requires the use of evidenced-based assessments, treatments, and therapeutic approaches for PTSD and depression. However, considerations of military cultural competency should be expanded to echo the particular experiences women have before, during, and after military service, such as MST, being pregnant, and being a caregiver during and after being in the military.

Implications for policy

Traumatic events that women Veterans experience before, during, and after military are also correlated with higher levels of unemployment.[27] In total, 11.2% of a nationally representative sample of women Veterans was unemployed compared with 9.4% for male veterans and 8.3% for civilian women. Women who reported having a mental health condition, those who reported joining the military to leave a negative home environment, and those who felt their military service was misunderstood were more likely to be unemployed.[27] Conversely, women Veterans who felt their employer respected their military service had the greatest level of satisfaction with their care.[28] The women in this study have a range of experiences across this spectrum, which demands focused programs that prepare women Veterans for successful, steady employment and employers to adapt to the needs of women Veterans who have experienced trauma. Workforce development programs sponsored by the VA and local city and county services can prepare the woman veteran for success by translating her skills from military service into tangible skills that appeal to civilian businesses. Businesses that utilize federal, county, or municipal funds should be incentivized to hire women Veterans, educated on their needs, and given adequate resources to ensure the transitioning women Veterans can thrive in a civilian workplace.

CONCLUSION

The findings of this study, combined with the pertinent literature, indicate the pervasive presence of traumatizing events throughout

the life of women Veterans, the mental health burdens these women experience, and the importance and centrality of their military experience in molding their identity and sense of self. Despite the male-centered military and veteran culture, women Veterans are joining and transitioning out of the military more than any other time in history. Their presence demands recognition of their experiences and treatment that respects their backgrounds, service history, gender, and mental health needs. The development of the major concepts of "trauma", "transitions", "identity", and "structure" offer another aspect of understanding the social worlds and significant interactions that shape the lives of women Veterans. These concepts give voice to their powerful and impactful stories have been silenced or ignored and lay the basis for further research, practice, and policy change that can positively impact the lives of women Veterans and their families.

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