2-7-2025

U.S. Operation Iraqi Freedom and Operation Enduring Freedom Female Veterans' Attitudes and Perceived Barriers to Mental Health Treatment

Elizabeth E. Kuntz
Walden University

Walden University

College of Social and Behavioral Health

This is to certify that the doctoral dissertation by

Elizabeth E. Kuntz

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Allison Spargo, Committee Chairperson, Counselor Education and Supervision Faculty
Dr. Marilyn Haight, Committee Member, Counselor Education and Supervision Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2025

Abstract

U.S. Operation Iraqi Freedom and Operation Enduring Freedom Female Veterans' Attitudes and Perceived Barriers to Mental Health Treatment

by

Elizabeth E. Kuntz

MA, Malone University, 2018

BS, Kent State University, 2016

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

February 2025

Abstract

The purpose of this nonexperimental, quantitative survey research study was to investigate the potential barriers to mental health care that female veterans who participated in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) experience. As the female veteran population continues to grow so does the need for gender-specific literature. Past researchers have indicated that there is limited research on female veterans. Data was collected during the fall of 2024 using an online survey method. This study consisted of one research question, which stated as follows: To what extent does stigma, attitudes, and combat exposure act as barriers for female OIF/OEF veterans seeking mental health help at the VA? This study hypothesized that stigma, attitudes, and combat exposure are significant barriers to female OIF/OEF veterans seeking mental health help at the VA. This study was grounded on the feminist and multicultural theories. A multiple regression was used to analyze the data. The results of the analysis indicated that the independent variables were not found to significantly predict whether female OIF/OEF veterans seek out mental health help at the VA's. The results of this study may not be statistically significant, but they add to the literature on female veterans and can potentially help medical and mental health providers understand a female veteran's needs and if any barriers are being experienced.

U.S. Operation Iraqi Freedom and Operation Enduring Freedom Female Veterans' Attitudes and Perceived Barriers to Mental Health Treatment

by

Elizabeth E. Kuntz

MA, Malone University, 2018

BS, Kent State University, 2016

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

February 2025

Dedication

This dissertation is inspired by my son, Braeden Ray Record. Braeden, this dissertation is dedicated to you. As a single mother, I have worked to instill in him that he should never give in to self-doubt, always have continued faith in his abilities, and know that anything is possible. I have worked hard to teach him from an early age that education is an integral part of life. I wanted to teach Braeden that having a strong work ethic will unlock the door to unlimited possibilities. I must thank my parents, family, and friends, whose support was and is a constant source of inspiration. The love and encouragement mean everything to me and will never be forgotten. To my friends who have stood by me throughout my educational journey, the love, support, and encouragement will always be remembered. To everyone in my life, I will be forever grateful for the love and grace you have given to me in my life.

Acknowledgments

This doctoral journey would not have been possible without the love, time, and patience of everyone in my life. I need to give my sincerest gratitude and appreciation to my dissertation committee, Drs. Allison Spargo and Marilyn Haight. The guidance, push, patience, and support you provided throughout this journey are beyond words. I am thankful for your direction, and I know that without you, I would not have completed this as I envisioned. You have made this possible and opened my eyes to future research opportunities.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

Females joining the military has been growing over the last 20 years, more than likely due to more job opportunities opening to females (Dodds & Kiernan, 2019). As the female population continues to rise so does female veterans utilizing services at the Department of Veteran Affairs (VA). Gender-specific research continues to be necessary to understand the specific needs of the female veterans. Dodds and Kiernan (2019) found that only 2% of the literature available mentions women veterans. This study could provide potential positive change by giving medical and mental health providers a better understanding to the unique needs of female veterans, what barriers they may be facing when utilizing services within the VA, and how all healthcare providers can provide better care for this population.

Background

Veterans roughly comprise about 7% of the U.S. population (Dichiara et al., 2021), females make up 10% of all veterans, and 21% of post-9/11 veterans are female (Wilson et al., 2021). Veterans coming home from wars, such as Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn, are seeing diagnoses such as posttraumatic stress disorder (PTSD), depression, and increased suicide rates for both female and male servicemembers (Dichiara et al., 2021). As more veterans come home and the wars end, the VA has trouble getting veterans to utilize VA health services due to the traditional masculinity ideology that one must be tough, emotionally in control, while not showing weakness or vulnerability (Neilson et al., 2020).

As soon as the veteran signs their name to become a part of the U.S. military, acculturation begins. McCaslin et al. (2021) defined acculturation as "the process by which members of one group culturally and psychologically adopt the beliefs and behaviors of another group" (p. 612). On the first day of training, servicemembers receive information regarding the history of their chosen military branch, how to use phonetic numerals, read military time, and say and utilize the military alphabet. Once training begins, service members learn the military lifestyle's values, beliefs, and culture. This lifestyle can change the veteran's attitude and beliefs (McCaslin et al., 2021).

During their service, veterans often feel they must be stoic, invincible, and self-reliant (Roscoe, 2021). These thoughts and feelings can lead them to feel embarrassed or weak when presented with challenges beyond their skill level. A veteran's stigma often affects whether mental health treatment is sought out. When researching barriers to treatment for veterans, I used keywords such as *veterans, female veterans, barriers to treatment, stigma, access to treatment*, and *military culture*.

The VA significantly serves more male veterans than female veterans (particularly due to the higher volume are male veterans), and it is unclear if female veterans perceive the same stigma and mental health barriers as their male counterparts (Godier-McBard et al., 2022). Military culture has been historically structured on male societal influences, which can lead to severe underserving and understanding of the needs of female veterans (Strong et al., 2018). In many studies I have researched, many limitations noted were the lack of female veteran participation and the lack of research focusing on the needs of female veterans (Wilson et al., 2021). Female OIF/OEF veterans

provide a different way to capture information because these wars were the first time in history that male and female veterans were deployed in combat settings with their male counterparts (Newins et al., 2019). Capturing this information provides a unique insight into various factors that affect stigma around mental health.

Problem Statement

The rate of veterans who return from combat with PTSD is between 11% to 45%, with about 2% to 17% reporting combat-related PTSD since the Vietnam War (Neilson et al., 2020; Richardson et al., 2010). Many veterans returning from war (such as OIF and OEF) do not seek treatment for mental health conditions such as PTSD or will prematurely drop out of treatment (Neilson et al., 2020). The dropout rate from outpatient treatment is as high as 30% (Amsalem et al., 2022). Veterans often do not seek treatment due to access to treatment or stigma that suggests that veterans are damaged, angry, and unstable (Caldwell & Laurderdale, 2021), and they have negative beliefs (Williston & Vogt, 2021).

The rate of female servicemembers has been growing over the last 20 years (Dodds & Kiernan, 2019), and there is little research regarding veteran female needs and whether the barriers they experience are different from their male counterparts (Godier-McBard et al., 2022). Godier-McBard et al. (2022) specifically indicated gaps in the literature based on gender-specific barriers to care. Female veterans also have a unique subset of reasons as to why services are not sought out, such as military sexual trauma, feeling as though they are not real veterans, and lack of female-specific services (Wilson et al., 2021).

The gap lies in the perceived barriers to mental health care within the VA and within the veteran female population. My study's specific research problem is that there is a lack of understanding in the perceived barriers to mental healthcare within the VA within the female veteran population. This is further proven by Dodds and Kiernan's (2019) findings that only 2% of veteran research is directed towards female veterans.

Purpose of the Study

This nonexperimental, quantitative survey research design aimed to investigate the potential barriers to mental health care that female veterans who participated in OIF and/or OEF. Female veterans who served during OIF and OEF were the identified participants for this study and the dependent variable is barriers to VA care. I utilized a multiple regression for this study. Results of this study may provide a better understanding of a female veteran's views on self-stigma and attitudes toward seeking professional mental health within the VA. Developing a better understanding of the factors that influence a female veteran's decision to seek treatment can help improve access to mental health care for female veterans.

Research Question and Hypotheses

I sought to answer the following research question (RQ) in this study:

RQ: To what extent does stigma, attitudes, and combat exposure act as barriers for female OIF/OEF veterans seeking mental health help at the VA?

H_0: Stigma, attitudes, and combat exposure are not significant barriers to female OIF/OEF veterans seeking mental health help at the VA.

H_1: Stigma, attitudes, and combat exposure are significant barriers to female OIF/OEF veterans seeking mental health help at the VA.

Framework

The theoretical basis for this study was a feminist and multicultural theoretical framework. According to Goodman et al. (2004), both frameworks grew out of the dissatisfaction with the lack of inclusion of the lived experiences of women and people of color in traditional theories and the lack of awareness of how these experiences can affect psychological development and functioning. These approaches provided details on the social inequality within the VA healthcare system and the effects on female veterans' perceptions of healthcare in a predominantly male system.

The feminist lens helped build the foundation to understand the perceived barriers that female veterans face when seeking out mental health care through the VA. The military being predominantly male-oriented has created a healthcare that has been prominently male-focused (Godier-McBard et al., 2022). The multicultural lens integrating the understanding of how each person's lived experience and how it intersects with each aspect of their life helped give a better understanding into the perceived barriers that female veterans face.

Nature of the Study

The nature of this quantitative nonexperimental design was to predict whether CES predicts the use of VA mental health services for female OIF and OEF veteran's use of VA mental health services and to what extent do attitudes and stigma affect whether female OIF and OEF veterans seek out mental health help at the VA. The rationale for

using a quantitative approach to this study was to determine what extent does the ISMI and MHSAS predicts attitudes toward female OIF and OEF veterans seeking psychological help and if the CES predict female OIF and OEF veteran's use of the VA mental health services.

Definitions

Combat exposure: Defined by the National Center for PTSD as service members who are exposed to traumatic events during war, this could be through experiencing life-threatening situations, seeing injury or death, or have been in a serious accident or handled human remains (U.S. Department of Veterans Affairs, 2024a).

Department of Veterans Affairs (VA): An independent agency created on July 21, 1930, to serve America's Veterans and their families. It offers medical care, benefits, social support, memorials promoting health, welfare, and dignity to all veterans. It is comprised of three major line organizations, Veterans Heald Administration, Veterans Benefits Administration, and National Cemetery Administration (U.S. Department of Veterans Affairs, 2024b).

Feminist theory: Defined by Anderson (2008) as the concern with questions of agency and power and then conflates an analysis of gender with feminist approaches.

Multicultural theory (MCT): A metaframework or approach for working with culturally diverse clients that is based on six propositions: MCT is a metatheory of psychotherapy that holds that both clients and counselors develop identities within multiple contexts and layers, and that the totality of these experiences and layers needs to be considered in a clinical encounter, clients and counselors, the development of cultural

identity influences attitudes for both the self and for other groups, including the dominant group, counselors the importance of using multiple forms of interventions, including group, community interventions, or work with larger systems, are more effective when using MCT when they are using multiple modalities in their work with clients, and the liberation of consciousness as the basic goal of MCT (Schwarzbaum & Thomas, 2008 pp. 8-9).

Operation Enduring Freedom (OEF): Refers to military personnel serving in Afghanistan from October 7, 2001, to the present (U.S. Department of Veterans Affairs, 2024c).

Operation Iraqi Freedom (OIF): Refers to military personnel serving in Iraq from March 19, 2003, to December 15, 2011 (U.S. Department of Veterans Affairs, 2024c).

Posttraumatic stress disorder (PTSD): A mental health disorder that develops after a person goes through or sees a life-threatening event. Symptoms will last longer than a month and causes great distress in a person's life (U.S. Department of Veterans Affairs, 2024a).

Veteran: Defined by 38 U.S.C. § 101(2) as a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable (U.S. Department of Veterans Affairs, 2024d).

Assumptions

The first assumption that I made in this study is that all the participants would answer each question truthfully in their veteran status and throughout the survey. The second assumption was that female veterans were still facing barriers to receiving

services throughout the VA. My third assumption was that I may not have obtained equal representation from all military branches.

Scope and Delimitations

The scope of this study was focused on investigating barriers that female OIF and OEF veterans may face when seeking mental health care at the VA. A delimitation of this study is that it is only focused on veterans of OIF and OEF. A second delimitation of this study is that I focused only on mental health treatment at the VA.

Limitations, Challenges, and/or Barriers

A barrier to collecting data includes recruiting female veteran participants and meeting saturation. I surveyed participants on veteran groups through social media sites such as Facebook pages aimed at veterans and Instagram. Utilizing this method, I drew enough participants or but not an equal number of participants from each branch of the military. Not recruiting enough participants leads to struggles in ensuring that my results are generalizable to all military branches. Due to utilizing an online survey, I was able to offer face-to-face debriefing if veterans were distressed due to the survey questions. Lastly, due to surveying potential participants from across the nation, contact information for mental health providers in their area would have been too complex but general numbers to the VA or suicide hotline were provided.

Significance

The information from this study was significant because it contributes to social change by providing more in-depth information to not only help the VA better assist female veterans through the various medical and access issues needs unique to this

population but also other practitioners, counselor educators, and family members who might want to better understand the needs and barriers to female veterans and their mental health. This study also aids in increasing female veteran engagement within the VA. Insights from this study is also able to contribute to social change by developing mental health programming that is more effective for the long-term engagement of the female population.

Summary

The military is inundated with masculine ideology (Neilson et al., 2020) that often leads veterans to feel that they must hold it together and be stoic and resilient (Roscoe, 2021). Over the last 20 years, the number of females joining the military has increased significantly (Dodds & Kiernan, 2019). As the female veteran population continues to increase, there is little research that include female veterans (Dodds & Kiernan, 2019). It was not until OIF and OEF that females deployed alongside male counterparts in combat settings (Newins et al., 2019). Understanding the perceived barriers to mental health care within the VA that female veterans face can help not only medical professionals but also family and friends gain a better understanding of a veteran's needs.

Chapter 2: Literature Review

Introduction

The purpose of this quantitative study was to examine differences in the perceived barriers to mental health care within the VA within the female veteran population of OIF and OEF. Many studies have addressed the perceived barriers that male veterans face, but little research focuses specifically on female needs. Dodds and Kiernan (2019) found that only 2% of the current research included female veterans. In Chapter 2, I discuss the following: my literature review strategy, the feminist theoretical framework as well as how multicultural theory can tie into the feminist conceptual framework, and how my literature review relates to my key variables and concepts.

As of 2021, the number of female servicemembers serving in active-duty positions during OIF and OEF was 231,741 members (U.S. Department of Defense, 2022) compared to the Vietnam conflict in which only 11,000 women served (U.S. Department of Veterans Affairs, 2024h). This new era of females having been deployed to combat areas and serving in combat positions has raised new questions of how to ensure that female veterans have proper access to care in a predominantly male-focused system. Godier-McBard et al. (2022) reviewed the literature for barriers and facilitators and found that female veterans have an increased risk of experiencing mental health problems and that mental health outcomes have worsened for female veterans over the past decades, but they are still more likely than their male counterparts to seek help for mental health.

According to Buckley and Thompson (2021), about 300,000 women have served in OIF and OEF from 2003 to 2011, and by the end of 2017, 166 females were killed in combat and over 1,000 were injured in combat. In 2000, females represented only 4% of approximately 26.4 million (Richardson & Waldrop, 2003) veteran population and is projected to grow to 18% by 2040 (U.S. Department of Veterans Affairs, 2024f). This could be largely due to the lifting of all restrictions on women serving in the front-line. Women can now serve in more roles than in previous years (Schuman et al., 2019).

The literature review had brought to light significant gaps in research regarding female veterans' barriers to mental health services within the VA healthcare system such as mental health outcomes and how gender affects this, what factors influence a female veteran's intention to access services, or how providing access to female providers, and female only groups may be a factor for female veterans seeking out services (Godier-McBard et al., 2022). There is a lack of understanding in the perceived barriers to mental health care within the VA within the veteran female population. Many studies that have been conducted have either only focused on male veterans or attempted to include females but were limited by female participation. Godier-McBard et al. (2022) focused on examining differences in the perceived barriers to mental healthcare within the U.S. Department of VA within the female veteran population.

This literature review focused on the perceived barriers that female veterans encounter and how it affects their utilization of the VA services. I reviewed the perceived barriers and oppression that females in society face (with respect to accessing medical services) and how females in the military often experience additional stressors from being

a minority in a male-dominated setting. Much of my review had brought up topics such as increased mental health risks, higher rates of exposure to trauma as a civilian, increased incidents of military sexual trauma (MST), intimate partner violence, higher rates of divorce or relationship problems, homelessness, social isolation, and feelings of invalidation or invisibility regarding their military service. In my review, I also addressed the feminist theory and multicultural theory as the conceptual/theoretical frameworks for this study, including how these theories provide a structural frame and lens for the examination of differences in the perceived barriers to mental health care within the VA within the female veteran population.

Literature Search Strategy

In this literature review, I gathered peer-reviewed articles from Walden University library's search engines through which I was able to access a variety of different databases such as ProQuest, EBSCOhost, SAGE, Military Medicine, and Military and Government Collection. I also utilized government websites such as Tricare and the VA to gather more recent statistics and other relevant information. I only utilized resources from the dates of 2019 to present, unless they were original articles.

Sources that I utilized included are peer-reviewed articles, reports from the VA's website, prior Walden University dissertations, scholarly books, and databases such as Military and Government Collection, Proquest Health and Medical, and SAGE Journals. My keyword search terms were *veterans, female veterans, barriers, mental health barriers, combat role, OIF/OEF veterans, gender inequity,* and *gender inequality*. During

my review of articles, I also reviewed relevant citations and references which helped expand my literature search.

Conceptual Framework

Feminist Theory

Feminism has historically been noted as a political movement and linked to women's activism which can be used as an umbrella term for the different injustices' women face (McAfee et al., 2023). Now, the feminist theory is not only is defined by seeking out equality between males and females (McAfee et al., 2023) but also includes a wide range of concepts of how gender is a social force (Cahill, 2022). Throughout history, women have struggled to find equality in various opportunities such as education, employment, and political representation, which is why the utilization of the feminist theory gives the ability to see through a lens and give construct to identify and understand gender inequality and injustices that women face (Folbre, 2023). In typical Western cultures, males are identified as being strong, independent, ambitious, authoritative, and rational, whereas women hold traits such as being caring, sensitive, dependent, and emotional (Neilson et al., 2020).

However, feminism is not only a western concept. As the feminist movement could be seen in three phases in the western culture so was the same for the United Kingdom and the Australian colonies (Chakraborty, 2021). In India, there was a fight against the patriarchal society which considers a girl child a "burden" (Chakraborty, 2021, p.1611), and stands against child marriage, and a woman's right to inherit property

(Chakraborty, 2021). Notable leaders of this movement are Raja Ram, Mohan Roy, Vidyasagar, and Mahatma Ghandi (Chakraborty, 2021).

The females known for the first wave of feminism are Mary Wollstonecraft, Elizabeth Stanton, and Lucretia Mott (Biscontini, 2023). Wollstonecraft had strong views on marriage and education which opened the door to the first wave of feminism. The first wave started in the late 1890s when women such as Stanton and Mott took a stance on giving women equal opportunities. In 1920, women were granted the right to vote in U.S. federal elections, which paved the way for the second and third wave. However, winning the right to vote did not stop the inequality that women faced. The Supreme Court continued to govern a woman's right to work and hours they can work due to concerns of women being "weaker" and needing to preserve reproduction for the human race (Roosevelt & Tootell, 2021, p. 269).

Another key figure during this time was Eleanor Roosevelt who focused on women's reform and is known as the "prominent leader in social justice feminist movement" (McGuire, 2014, p. 925). During her time, Roosevelt established the monthly journal of Women's Democratic News, directorship of the women's section of the Democratic National Campaign Committee (DNCC) and strategically partnered women and the New York Democratic party to continue to expand the boundaries of women within the political scene (McGuire, 2014). Eleanor Roosevelt was a constant advocator for human rights. She constantly supported women and other minorities for civil rights and pushed to get women in the war effort through access of childcare and fair pay as well helping President Roosevelt create the Fair Employment Practices Commission to

deter racial discrimination in industries who contract with the federal government (Iodice, 2023). Following President Roosevelt's death, President Truman appointed her as a delegate to the United Nations where she served to gain the passage of the Universal Declaration of Human Rights, which is described as a "benchmark as to how nations should behave towards their people" (Iodice, 2023, p. 8).

The second wave began in the 1960s and focused on de-objectifying the women's body. During this movement, the main objectives were to bring to light the typical patriarchal roles that permeated the workplace as well as women's body rights in terms of proper sexual education and reproductive rights (Herring, 2023). The third wave began in the 1990s and is described as more "radical" and a "rebellion against second-wave mothers" (Finneman & Volz, 2020, p. 664). The main differences between the first and second waves compared to the third wave is the ability to utilize the internet and the lack of unified goals, which lead to an obscure understanding of what this social movement encompasses (Finneman & Volz, 2020).

Feminist theory is grounded in understanding and examining the power difference between men and women, confronting injustices based on gender, and ending oppression through social change (Hirudavarai et al., 2019). Feminist theory is an appropriate framework as current research focused predominantly on male veterans and the applicability to female veterans is unclear (Godier-McBard et al., 2022). The feminist theory provides a foundation to understanding the barriers and needs of female veterans when receiving care at the VA where many healthcare needs have been male-focused (Godier-McBard et al., 2022).

The military being inundated by patriarchy and hypermasculinity can be seen throughout its inception of allowing females into its ranks. Examples can be seen in the implementation of The Women's Armed Services Integration Act of 1948 allowed women to have permanent membership in the military outside of a wartime conflict but still barred them from serving in combat roles and needing to be discharged if they were to get pregnant, the adoptions of the "risk rule" that allowed women to serve in noncombat unit whose risk of exposure to combat was less than that of an all-male combat unit, to the Department of Defense (DOD) changing the risk rule to the Direct Ground Combat Definition and Assignment Rule (DCGCAR) that allowed women to serve if they were qualified but as long as the units primary mission was not ground combat (Pham, 2023). Allowing women into combat roles was an integral part of women's rights movement to help achieve equal rights. In January 2016, it was announced that all military occupations and positions were open to women if they meet the standards to hold those occupations/positions (Pellerin, 2015). Although women have been allowed to serve in these combat roles since 2016, women are still struggling to fully integrate, examples being the Marine Corps requesting an exemption to the 2016 change and as of 2020 Special Operations components such as Green Berets and Navy Seals has been unsuccessful at integrating females (Mercadel, 2023).

Multiculturalism

Sue et al. (1996) developed multicultural theory as an approach for working with culturally diverse clients (as cited in Vance, 2021). The term multiculturalism can appear to be an umbrella term, but overall means the lens in how people's identities are shaped

and intertwined within the world around them (Vance, 2021). The military is a melting pot of cultures that naturally forms its own culture that creates its own values and traditions that many civilian providers may struggle to understand (Tkachuck et al., 2022). The diversity of race, ethnicity, gender, age, sexual orientation, or how socioeconomic status intersects within a larger cultural context of how the military engrains their social norms on their servicemembers (Singh et al., 2020; Zwiebach et al., 2019).

Being culturally aware includes not only developing one's awareness of their identity but also how their power, privilege, oppression, and social justice affect those around them (Singh et al., 2020). The dichotomous thinking, such as males versus females, enlisted versus officers, servicemembers versus civilians, or active versus reserve/guard that the military provides can easily allow for the marginalization and victimization of minority members. Each entity provides a unique outlook that should not be pitted as one versus the other (Zwiebach et al., 2019).

Grzanka (2020) defined intersectionality as conceptualizing human experience, understanding their social identities, and how they function in multiple systems. In the military, service members must conform to unified ways of thinking, dressing, and speaking as part of the military culture. They are taught how to march and run in unison, utilize the military alphabet and time, learn specific military lingo and terms, and abide by a particular moral code set by each branch of the service. For example, the Army has the Warrior Ethos, which is set on seven core values, loyalty, duty, respect, selfless service, honor, integrity, and personal courage, the Navy embraces integrity and respect,

with core values of honor, courage, and commitment, and the Air Force rests their core values on integrity, service before self, and providing excellence in all they do. Kysar-Moon and Mustillo (2019) described this phenomenon as being "socialized into a warrior culture" (p. 158). However, the overarching military culture does not consider how each member's culture integrates and intersects with the military culture they belong to. The military, a predominantly white, male-dominated workforce, can perpetuate an unhealthy system of disparities within marginalized groups (Portillo et al., 2022). Shields et al. (2020) conducted a study to examine service branch differences in the diagnoses of and treatments for self-reported poor mental health conditions. Although the authors noted that continued research is needed, the authors findings indicated that mental health is impacted by a females branch of service, which could be impacted due to the different cultures each branch entails, the different resiliency programs and how it is delivered to their personnel, as well as their own personal experiences within their unit, trauma, and support system in place (Shields et al., 2020).

Literature Review Related to Key Variables and/or Concepts

Women and Military Service

The U.S. military is known as the largest male-dominated organization that has a long history of discriminating against females in terms of job opportunities, workspaces, and overall equality (Portillo et al., 2022). Although women have been serving by the side of their male counterparts since the start of the Revolutionary War, it was not until The Women’s Armed Services Integration Act of 1948 was enacted that women could finally legally serve in the military (Boros & Erolin, 2021).

As of 2018, only 18 million of the adult American population could identify as veterans of the U.S. Armed Forces (Vespa, 2020). This makes veterans a small subculture within the U.S. population. Of that 18 million, only 1.7 million identify as a female veteran (Boros & Erolin, 2021; Vespa, 2020). Due to being a male-dominated society, women often had to conform to the hypermasculinity and traditional male traits while avoiding any sense of femineity to fit in with their male counterparts (Boros & Erolin, 2021). Conforming to such standards to not be seen as a sex symbol or objects of romance as well as avoiding being seen as weak or subservient has been a controversy since women could legally serve in the military (Boros & Erolin, 2021).

On average, women are the fastest growing population of the U.S. military. Despite these increasing numbers, there are still gaps in resources within the VA that are gender specific for women veterans (Schuman et al., 2019). In January 2016, The Women in the Service Implementation Plan lifted all restrictions for women serving in front-line combat roles (Schuman et al., 2019). Allowing females to serve in front-line combat roles can help females continue to work on breaking the glass ceiling and reach the same heights as their male counterparts. Another breakthrough for female veterans is the implementation of Johnny Isakson and David P. Roe M.D., Veterans Health Care and Benefits Improvement Act of 2020 (2021), which grants females care related to fertility, newborn care, childcare, sexual assault and trauma, and homelessness (U.S. Department of Veterans Affairs, 2024g). This shows a forward movement in the understanding that females do have specific needs separate from males not only in their personal lives, but also in the eyes of the military for authorized veterans' health care services.

Access to Services

The VA utilizes the Rural-Urban Commuting Areas (RUCA) system to define whether an area is rural or urban. Certain factors such as population density, proximity to larger urban centers, and how the U.S. Census Bureau counts citizens are included in this complex algorithm (U.S. Department of Veterans Affairs, 2024e). According to the VA, there are 4.4 million veterans who live in rural or highly rural communities, and within the 4.4 million, there are 2.7 million veterans (61.36%) who are enrolled in VA services, which leads to question as to why only 32% of the VA healthcare budget is allocated to rural veteran care (U.S. Department of Veterans Affairs, 2024e).

Access to mental health care can be difficult for veterans and nonveterans due to various factors regarding where an individual resides. When recruiting men and women to join the service, more servicemembers are recruited from rural areas than urban (Bommersbach et al., 2021). Maley and Hawkins (2018) noted that this could be due to several factors such as younger people from a rural area having few opportunities, to other sociodemographic factors such as populations with greater youth and minorities, religious base, military presence, or the historical/cultural/family tradition that joining the military could hold. Once a member separates from the military, returning to their hometown may be a priority due to proximity to friends, family, and cost of living (U.S. Department of Veterans Affairs, 2024e). The lack of mental health providers in rural localities can be a cause of concern. For veterans and civilians, suicide rates are higher for those who reside in rural areas (Bommersbach et al., 2021). Compared to urbanites, veterans who reside in rural areas have higher rates of poverty, limited housing resources,

poorer access to mental health services due to greater distances to Veteran Health Administration (VHA) facilities, and limited access to transportation to access these services (Bommersbach et al., 2021). Along with limited access, veterans who reside in rural areas have been found to have lower physical and mental health quality of life, which could limit how often they could go to a VA clinic. Both limited access to transportation and lower quality of life can indicate why rural veterans have fewer visits per calendar year.

Urban areas often have more programs that can be implemented, more specialty services, as well as more mental health professions to meet the needs of the population being served such as case management, vocational rehabilitation programs, homeless outreach, subspeciality mental health services, and housing assistance (Bommersbach et al., 2021). The limitation of providers and specialties leads researchers to question how many providers provide services aimed at female mental health needs, such as struggles as a single parent, divorce, children, etc.

Rural veterans are more likely to be non-White compared to urbanites. Past studies noted that rural veterans utilize fewer therapy services but will enroll in more VHA services than their urban counterparts (Bommersbach et al., 2021). It was found from these studies that rural veterans would commonly utilize emergency medicine as a form of mental health treatment versus outpatient services due to various factors such as low community-based programs due to low density of patients, travel distances, lack of public transportation, and shortages in mental health professionals (Bommersbach et al., 2021).

External Barriers (Females)

In 2000, females made up four percent of the veteran population and are expected to grow to 18% by the year 2040 (U.S. Department of Veterans Affairs, 2024e). Differences between male and female veterans and access to services have been quite notable. Godier-McBard et al. (2022) found that female veterans express more concerns regarding cost, have more difficulty scheduling appointments due to not being able to be excused from work or school, not knowing the different methods to scheduling appointments and where to go for help, or not being able to obtain childcare. Scheduling appointments can be a barrier to female veterans due to needing a particular VA site that offers female care, such as clinics that are only directed for women and knowing which particular service they will need to ensure scheduling with the correct type of medical caregiver, for instance primary care or gynecology (Godier-McBart et al., 2022). Female veterans often wear many hats and are the breadwinners as well as the primary caregivers in their families. Female veterans are often parents, workers, and/or students themselves (Schuman et al., 2019). Juggling these multiple roles can leave very little room to obtain services for themselves. Often VA services are unavailable for those who work a typical nine-to-five job (Schuman et al., 2019).

Female veterans experience higher rates of intimate partner violence and may feel uncomfortable attending services at the VA due to past trauma and not wanting to experience unwanted sexual attention (Schuman et al., 2019). Females are more likely to have little support and struggle with the transition to civilian life (Boros & Erolin, 2021) and struggle with feelings of invalidation, disconnectedness, and invisibility when

discussing their service (Shuman et al., 2019). Compared to their civilian counterparts, female veterans experience higher unemployment rates, less pay, decreased job stability, are more likely to experience homelessness, and have higher divorce rates at 23% compared to 12% of female civilians (Boros & Erolin, 2021).

Known Barriers

Over the years, many studies have been completed regarding veterans' barriers to treatment, although many studies either did not include female veterans or could not recruit enough female participants. The stigma surrounding veterans and their time in service can be a significant factor in whether a veteran will seek out service. Less than 50% of all veterans diagnosed with a mental health condition receive mental health services, 22% out of the 50% receive therapy services, and 46% of the 22% attend more than two sessions (Johnson & Possemato, 2021, p.11). Those who experience combat-related PTSD can endure the stigma of being seen as dangerous, angry, unstable, mentally, and physically damaged, or weak for having a mental illness (Caldwell & Laurderdale, 2021). Culturally, the military is inundated with constructs that masculinity and mental toughness are expected, and the thought of needing help will be seen as weak or less than their counterparts (Silvestrini & Chen, 2023).

Another known barrier is the treatment that a veteran might receive. Kysar-Moon and Mustillo (2019) found evidence of racial/ethnic disparities in treatment, such as receiving care, diagnosis, or the strength of diagnoses. An example would be non-White patients receiving differential care in emergency rooms, less likely to be discharged to a rehabilitation center, or Hispanic service members being diagnosed with higher levels of

traumatic brain injuries (TBI; Kysar-Moon & Mustillo, 2019). Kysar-Moon and Mustillo (2019) found that even though a person of color self-reported the same number of symptoms of a TBI as a White service member, they are still less likely to receive a TBI diagnosis.

Provider Shortage

Not having a unified education and licensure program across the United States creates great difficulty for an entity as large as the VHA to ensure they are employing well-qualified mental health professionals. According to the American Counseling Association (ACA; 2023), as a nation the United States faces a shortage of mental health professionals due to lack of funding, poor reimbursement rates, low retention, increased demand for providers but limited access to care, and providers aging out of the workforce. The average age of mental health counselors is 41.2 years old with 77.1% being women and 22.9% being men (DataUSA, 2024). Counselors are experiencing higher caseloads with little pay, compounding the shortage crisis. In the past, Medicare has also added to the counselor shortage by not allowing licensed professional counselors (LPC) to treat Medicare patients (Morgan et al., 2022; Wiley et al., 2019), but due to the recent passage of the Mental Health Access Improvement Act, LPCs can now treat Medicare patients (Todd et al., 2023). Clinical psychologists and licensed clinical social workers (LCSWs) are the only mental health professionals currently deemed eligible to treat Medicare patients as determined by the Centers for Medicare and Medicaid Services (Morgan et al., 2022; Wiley et al., 2019).

Access to care may also be a barrier for servicemembers due to a counselor shortage within the VA. The VHA noted that shortages are partly due to mental health professionals experiencing burnout, which the coronavirus pandemic has exasperated, the hiring standards within the VHA, and the fact that not all graduate programs are a part of the Council for Accreditation of Counseling and Related Educational Programs (CACREP), which is a requirement of being hired as a licensed professional mental health counselor (LPMHC) within the VHA (Government Accountability Office, 2022).

Mental Health and Tricare

TRICARE is a military health system that is serviced by different military hospitals, clinics, and a network of civilian health care professionals that serves active-duty service members, National Guard and Reserve members, retired service members, beneficiaries who are eligible, survivors, and a servicemember's family (Tricare 101, 2024).There are several plans to choose from depending on eligibility, location, age, and Medicare status (Tricare 101, 2024). Having TRICARE allows the beneficiary to choose a mental health professional within or out of the network, which can be beneficial if the individual is looking for a specialized provider or if there is a lack of providers within their area. One barrier identified is the lack of providers willing to accept new TRICARE patients compared to Medicare patients, even though the reimbursement rates are comparable (Anand et al., 2020). Mental health providers are less likely to know if they accept TRICARE and are more likely not to be aware of TRICARE, which can limit access to mental health providers for veterans (Anand et al., 2020). Lastly, as of January 1, 2021, to be a TRICARE certified mental health counselor, a counselor must have

passed the National Clinical Mental Health Counselor Examination (NCMHCE) or an equal exam, possess a master's degree or higher from a CACREP program, and have a minimum of 2 years post-master's degree of supervised mental health counseling practice, which includes 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision (Mental Health Counselor Provider Requirements, 2024). As mentioned previously, the requirement of graduating from a CACREP program or being supervised for 2 years is not mandatory nationwide. This policy could exclude valuable counselors and counselor trainees who have not yet met the 2-year requirement or professionals who reside in states that do not require this. This disparity in licensure requirements is one of the reasons it took so long for LPCs to be considered a Tricare and Medicare provider.

Licensure Portability

According to ACA, 47% of the population in the United States lives in a mental health workforce shortage area, and some states need at least 700 more practitioners to remove that designation (Phillips, 2023). The hope is that increased licensure portability can help fill the gaps in areas where counselors are needed.

The American Association of State Counseling Boards (AASCB) and the ACA pushed states to adopt a more unified movement known as 20/20: A Vision for the Future of Counseling. This movement pushes for standardization, professional unity, and licensure portability. There is a shortage of mental health professionals, and the demand continues to increase (Bayne & Doyle, 2019). Although adopting a licensure standard in 1976 was a big step forward for the counseling profession in strengthening the counseling

identity, more standardization and clarity is needed on licensure portability. Currently, each state oversees its own licensing procedures, and the requirements greatly vary (Bayne & Doyle, 2019). Along with different requirements, the title of a professional counselor also varies greatly. For example, in Ohio, an LPC can practice counseling, and work will need to be supervised, but in other states, an LPC may be able to practice independently.

Counseling Compact

The Counseling Compact (National Center for Interstate Compacts, 2022b) was created to allow counselors to practice in another state, creating nationwide portability (Moorhead et al., 2023). Currently, 37 states have moved forward to bring the Counseling Compact to legislation (ACA, 2024). The inconsistent regulations and difficulty for counselors to relocate or become licensed in other states adds to the growing problem of a need for more available licensed counselors. These inconsistencies hinder how individuals seek out competent mental health professionals.

Summary and Conclusion

In this literature review, I discussed barriers the gaps in research regarding female veteran's barriers to mental health services within the VA healthcare system. Using the framework of feminism and multiculturalism, I highlighted how, historically, females have been fighting the battle for equality and how it is happening in Eastern cultures. The battle of feminism is a continuous battle with the same basic concept in both cultures: equal and fair treatment. Although the military, the largest male-dominated organization, has made strides to close some equality gaps, more work must continue to break the glass

ceiling. As this movement continues and more female veterans emerge, continued research on their specific needs and barriers to access care must continue to ensure quality care.

Chapter 3: Research Method

Introduction

Previous studies have examined barriers faced by veterans receiving mental health care through the VHA but very few are specific to only female veterans. I used a nonexperimental survey research design to examine perceived barriers to mental health care within the VA within the veteran female population. Furthermore, data from this survey may stimulate social change in how the VHA can better serve the female population as well as provide enhancement in the field of Counselor Education and Supervision and Counseling (CES) in how counselors and future counselors may attend to the needs of female veterans.

The need to examine the perceived variables to accessing mental health services is due to the possibility that the results may fill a gap in understanding specific barriers that female veterans face in accessing and subsequently receiving mental health treatment within the VA. It is important to address barriers that are unique to females due to needing to improve gender inequality, address social roles through a lens of a male dominated field, advocate for resources that may be lacking or not available in a predominantly male system, and bring awareness of how female centered experiences can affect psychological development and functioning. The results of this study could aid the VA in identifying and meeting the needs of female veterans. It is my hope that future VA policymakers, mental health counselors, and other health care providers will consider the intricate needs of the growing female veteran population.

This study can also be significant to the field of Counselor Education and Supervision and counseling due to the barriers that licensed professional counselors face when seeking employment within the VA health care system. The National Board of Certified Counselors (NBCC) has been advocating for licensed counselors and the barriers they face when seeking employment within the VA as early as 2006 when a law was passed to include LPMHCs as eligible for VA employment (National Board for Certified Counselors, 2024) Under the recent passage of the Mental Health Access Improvement Act (S.828/H.R. 432), LPCs will be allowed to enroll as a provider as a Medicare provider (Todd et al., 2023). As a step forward in legislation, TRICARE will now allow LPCs to be a TRICARE network provider (TRICARE, 2024). Having uniformed standards for education, licensure application, and endorsements can help the VA establish a hiring system that allows more ease of employment for licensed professional counselors can help bring in more mental health professions to meet the needs of veterans (Bayne & Doyle, 2019). This study surveyed female veterans of OIF and OEF.

In this chapter, I will describe my research design and justification the selection of participants and instruments. I will explain the methodology that I used in this study so that it may be replicable in the future. Lastly, I will include a discussion of threats to the validity of the study and any ethical concerns that may arise.

Research Design and Rationale

In this study, I examined potential differences in the perceived barriers to mental health care within the VA and the female veteran population. The primary independent

variables (IV) were stigma, mental health seeking attitudes, and combat exposure, and the dependent variables (DV) were barriers to VA care. I included age, branch of service, number of deployments, current duty status, type of discharge from military service, and in which conflict they served (OFI or OEF).

Although researchers have investigated barriers that veterans face when receiving mental health treatment within the VA, there is very little or no literature on the development of perceived barriers to mental health care within the VA among the veteran female population. The number of women in the military is vastly growing, and they often wear many hats simultaneously once they leave the service such as parents, workers, and students (Schuman et al., 2019). Inherent barriers that are unique to female veterans are how gender intersects with the different dimensions of the veteran's life within and outside of the service. Veterans are often surrounded by stigma suggesting that they are damaged, angry, or unstable (Caldwell & Laurderdale, 2021). The military falls under an umbrella of a masculine ideology with norms such as being tough, strong, resilient, not showing weakness, and emotional control. Historically, women are often seen as being sensitive, emotional, and caring (Neilson et al., 2020). How a female veteran's identity intersects may cause distressful experiences during and after their service and inhibit the care they receive (Tkachuck et al., 2021).

This study is significant in that it can help fill a gap in understanding barriers that female veterans face in accessing and subsequently receiving mental health treatment within the VA. The results of this study can aid the VA in identifying and meeting the needs of female veterans. Entities such as the ACA, AASCB, and the NBCC have been

advocating for licensed counselors since the start of the counseling compact and the barriers that licensed professional counselors face when seeking employment within the VA (Bayne & Doyle, 2019). By establishing employment eligibility parity within the VA system, licensed professional counselors can help provide expanded access to mental health services to meet the rising needs of veterans.

Research Methodology

Population

The target population for this study was cis-gendered female veterans of OIF and OEF. Sampling for my study only focused on female veterans of OIF and OEF to generate data from the latest era of war veterans. Female veterans were exclusively recruited for this study due to this group's growing numbers and lack of research that focuses solely on the needs of female veterans (see Wilson et al., 2021).

Sampling and Sampling Procedures

The sampling strategy used was both convenience and purposive sampling. Utilizing female veterans who had been deployed to either Iraq (OIF) or Afghanistan (OEF)was a specific characteristic that I looked for in my participants. This type of sampling also falls under convenience sampling due to female veterans' population being conveniently accessible yet may not be generalized to other populations (Andrade, 2021), such as veterans who participated in other conflicts or male veterans. Utilizing a convenience/purposive sampling method had the advantage in being cost effective and not needing to list the population elements but limited the ability to control variability and bias as well as not being able to be generalize beyond the female veteran population

who participate in OIF and OEF (see Acharya et al., 2013.) Interested participants were able to scan a QR code on the flyer or click on the link that was provided. Each interested participant that volunteers was used in this study. The goal of this study was to generate at least 200 participants.

Power Analysis

I conducted a G*Power (Version 3.1.9.2) *a priori* analysis for an *F* test for a linear multiple regression to calculate the minimum required sample size. I used 2% margin of error and a 98% confidence level with a large effect size, which resulted in sample size of $N = 64$.

Procedures for Recruitment, Participation, and Data Collection

Recruitment

Recruitment was completed using various internet platforms. The primary source of participants was collected from veteran-based Facebook sites, such as finding Facebook groups relating to veterans and military posts and bases, and Walden University's veteran group, Salute. Using social media platforms was cost-effective and gave me the ability to reach a broad number of potential participants (see Salvy et al., 2020).

Participation

The inclusion criteria and initial questions of the survey included that all participants identified as cis-gendered female veterans of OIF and OEF of the United States Armed Forces. If the participant met this requirement, then the participant would

continue to answer the rest of the survey questions. If a participant indicated no, then the survey ended, and it thanked them for their time.

Data Collection

As part of the recruitment and advertisement process, a link and a QR code to the Qualitrics site was included on each flyer that was disseminated to various social media groups. Informed consent was included as the first step in the survey, followed by inclusion criteria questions. Those who met the inclusion criteria were then be permitted to respond to the survey questions that align with the RQ.

Instrumentation and Operationalization of Constructs

In this section, I will discuss the four survey instruments that I used to collect data from participants and why I chose these instruments. Each of these instruments was approved by the author for use in this study or was free to public use.

The CES scale was created by Lund et al. in 1984 and is a 7-item self-report measure that measures combat experiences that have been found to have "favourable psychometric properties and be strongly predictive of mental health outcomes among Iraq and Afghanistan veterans" (as cited in Sudom et al., 2019, p. 11). The CES was created to measure wartime stressors experienced by soldiers due to the assumption that combat exposure was the central development of PTSD (Keane et al., 1989). The CES was found to have a high degree of reliability that was tested using two different methods as well as a positive outcome for test-retest reliability (Keane et al., 1989). This self-report assessment contains items based on a 5-point frequency in which the participants are asked to reply based on their exposure to various combat situations (U.S. Department of

Veterans Affairs, 2024a.). A sample question is "Were you ever surrounded by the enemy?" and the respondent would reply with a 1 to 5, 1 = *no* or *never*, 2 = *1 to 3 times*, 3 = *4 to 12 times,* 4 = *13 to 50 times,* and 5 = *51 or more times*, 1 = *none*, 2 = *1-25%*, 3 = *26 to 50%*, 4 = *51-75%,* and 5 = *76% or more*, or 1 = *never*, 2 = < *1 month*, 3 = *1-3 months*, 4 = *4-6 months*, and 5 = *7 or more months* (Keane et al., 1989).). The test-retest reliability showed excellent stability with a total score being *r* (29)- .97, $p < .0001$ (Keane et al., 1989).

The ISMI was developed by Dr. Hammer and Dr. Toland in 2017 to measure the internalized self-stigma among people who have a psychiatric disorder (Hammer & Toland, 2017). There is an ISMI-29, ISMI-24, ISMI0-10, and ISMI-9. For this study, I used the ISMI-9 due to the condensed nature and the overall ability to accomplish the same task (see Hammer & Toland, 2017). The ISMI-9 was found to have a stronger internal consistency and cleaner measurement of the general internalized stigma of mental illness construct compared to the ISMI-10 total score (Hammer & Toland, 2017). The unidimensional model of the ISMI-9 demonstrated good fit, S-B^2(27) 70.35, *p* .001, RMSEA .046 [90% CI of .033, .059], CFI .976, TLI .967, SRMR .027. ISMI-9 total score (α = .86, 95% CI [.85, .88], *M* 2.13, *SD* .58) demonstrated slightly stronger internal consistency estimates than did the ISMI-10 total score (α =.82, 95% CI [.80, .84]). According to Hammer and Toland (2017), the ISMI-9 total score showed a "slightly cleaner unidimensional structure and stronger reliability than the ISMI-10 score" but will benefit from additional research to delineate whether these findings are "idiosyncratic or generalizable" (p. 159). An example question from the ISMI-9 is "Stereotypes about the

mentally ill apply to me" and "People without illness could not possible understand me" (Hammer & Toland, 2017, p. 174). The ISMI 9 is a 4-point Likert rating scale ranging from 1 (*strongly disagree*), 2 (*disagree*), 3 (*agree*) and 4 (*strongly agree*).

The Mental Health Seeking Attitudes (MHSAS) is a 9-item instrument that was developed by Hammer et al. (2019) to measure a respondents' overall evaluation of their seeking help from a mental health professional. The MHSAS has been found to have met criteria for generalizability, validity, and reliability. The MHSAS uses a 7-point semantic differential scale. Examples from the instrument is useless to useful or satisfying to unsatisfying and the participant will rate it at a 3, 2, 1, 0, 1, 2, or 3. Hammer et al. found compared to the Attitudes Toward Seeking Professional Psychological Help scale (ATSPPH-SF) or Psychological Openness subscale of the Inventory of Attitudes Toward Seeking Mental Health Services (IAMSMHS-PO) the MHSAS achieves a stronger internal consistency, uses items less likely to measure construct-irrelevant variance or underrepresent the construct of interest, and has a cleaner and more stable unidimensional structure in testing.

Lastly, I used Barriers to VA health care which is a 25-item scale adapted from the Barriers to Help Seeking Scale (BHSS) along with additional items that Ouimette et al. (2011) utilized in a previous study to examine institutional and stigma-related barriers to care. Barriers to VA health care is based on a 4-point Likert scale with 1 = *not at all*, 2 = *slightly*, 3 = *moderately*, and 4 = *very much* (Ouimette et al., 2011). The original version of the BHSS consisted of 54 items based on a Likert-type scale ranging from 0 to 4 (Mansfield et al., 2005). This measurement addressed the following variables: staff skill

and sensitivity (SSS), logistical barriers (LB), not fitting in (NFI), discomfort with help seeking (DHS), and concerns about social consequences (CSC). The BHHS is determined to have good to excellent internal consistency with coefficient alphas ranging from .79 to .93 and an internal consistency coefficient for the entire scale at a .95 (Mansfield et al., 2005).

Demographics

Demographic information and survey questions were specific to ensure participants met requirements for the study. Items such as gender assigned at birth, age, years in service, number of deployments, discharge status, enrollment in the VA, location of deployment, and branch of service was included. There were no questions asking a participant's name or birthdate to help ensure anonymity and confidentiality.

Participant Selection

Participants selected for this study had met two main criteria: identification as a cis-gendered female veteran and having participated in OIF and/or OEF. If a participant did not meet those initial criteria, they were not able to participate in the survey. Age, branch of service, and duty status were not factors in whether a participant met criteria for this study.

Data Analysis Plan

In this study, I assessed the strength of the relationship between independent variables stigma, mental health seeking attitudes, and combat exposure and the dependent variable was barriers to VA care. I utilized multiple linear regression models to examine the relationship between the variables. I utilized the Statistical Package for Social Science

(SPSS, Version 29) software to analyze the data. The participants were provided a QR code and link on the flyer that directed them to where the confidentiality form and demographic page and then the survey. All surveys were kept anonymous, and no information was asked regarding their name or birthdate.

Threats to Validity

A threat to internal validity that I was aware of is the self-report nature of this study. I included validity questions to ensure participants are reading and responding accurately. Although I was able to target female veterans, there was still the chance that the respondents did not answer truthfully regarding their experiences due to feelings of invalidation, disconnectedness, and invisibility when discussing their services (see Shuman et al., 2019). Due to only sampling female veterans of OIF and OEF, I could not fully generalize to other veterans who may not have a deployment history and therefore may have different experiences when seeking to receive mental health services through the VA. Another threat to external validity was volunteer bias. When recruiting participants, I provided an explanation of what my study wanted to address. I needed to be aware of my own personal biases. I am a female veteran of OEF, and I need to be aware of any biases in relationship to my own experiences with the VA. This was conducted through consistent contact with my dissertation committee to ensure that any findings in my data analysis are true and consistent.

RQ and Hypotheses

The following RQ and hypotheses guided this study:

RQ: To what extent does stigma, attitudes, and combat exposure act as barriers for female OIF/OEF veterans seeking mental health help at the VA?

H_0: Stigma, attitudes, and combat exposure are not significant barriers to female OIF/OEF veterans seeking mental health help at the VA.

H_1: Stigma, attitudes, and combat exposure are significant barriers to female OIF/OEF veterans seeking mental health help at the VA.

Ethical Procedures and Considerations

A potential barrier when sampling this population is that I may not have recruited enough female veteran participants, which has been a challenge in previous research. This study may have taken additional time to meet the participants needed of $N = 64$. A second challenge I experienced was not being able to recruit enough female veterans from each branch of military service. Recruiting enough female veteran participants is important due to the findings from Shields et al. (2020) identifying a correlation between a female veteran's branch of service and their mental health. Lastly, another barrier that I faced is ensuring that I provided various contact information for mental health providers in case the questionnaires trigger any trauma symptoms. I provided contact information for the VA, the 988 Suicide and Crisis Lifeline, Military One Source, a link to Tricare providers list in Psychology Today and of course 911, if the veteran is experiencing life-threatening thoughts and needed to receive immediate emergency assistance.

Summary

The purpose of this quantitative study was to examine the differences in the perceived barriers to mental health care within the VA within the female veteran

population. This study utilized multiple regression models for statistical analyses to assess any relationship between the chosen variables. I discussed the research design and reasoning as to why each instrumentation was chosen as well as the concerns with validity and ethical procedures.

Chapter 4: Results

Introduction

The purpose of this nonexperimental, quantitative survey research study was to investigate the potential barriers to mental health care that female veterans who participated in OIF and OEF experienced. I hypothesized that stigma and attitudes act as barriers to female OIF and OEF veterans' use of VA healthcare, and combat exposure could predict the use of VA mental health services. I used social media sites such as Facebook and Instagram to recruit participants and Walden's veteran group Salute. I asked participants who met the criteria to participate in an online survey through Qualtrics. The survey included (a) informed consent, (b) demographics, (c) the CES, (d) the ISMI-9 scale, (e) the MHSAS, and (f) the subscale Barriers to VA healthcare.

The following RQ guided this study:

RQ: To what extent does stigma, attitudes, and combat exposure act as barriers for female OIF/OEF veterans seeking mental health help at the VA?

H_0: Stigma, attitudes, and combat exposure are not significant barriers to female OIF/OEF veterans seeking mental health help at the VA.

H_1: Stigma, attitudes, and combat exposure are significant barriers to female OIF/OEF veterans seeking mental health help at the VA.

In this chapter, I will discuss the specific process of collecting data, measures taken to conduct statistical analysis, and findings obtained through data analysis.

Data Collection

After receiving approval from the Walden University's Institutional Review Board (IRB), # 08-06-24-0585960, I began data collection which occurred in Fall 2024. Social media platforms including Facebook and Instagram were primary sources of recruitment. Recruitment occurred through (a) site administrators sharing the recruitment flier directly, (b) site administrators approving me to share the recruitment flier, and (c) site administrators who declined to share my recruitment flier. During recruitment, I encountered some challenges, such as participants reaching out regarding their disapproval of being singled out as a female veteran or not agreeing with the terminology of "cis-gendered." I aimed to have 200 participants in this study. This number was initially met, with 271 participants, but after data cleaning ended with 103 completed surveys, which exceeded my *a priori* minimum sample size of 64 participants calculated.

Data Cleaning and Coding

I began my data analysis process by downloading the data from Qualtrics as an SPSS file. I first removed any responses that did not consent to complete the survey. I then cleaned the data where the participant did not identify as a cis-gendered female, serve on active duty in the U.S. Armed Forces, or served in either OIF or OEF, or served in both. I then cleaned the data further by removing all surveys that had missing item responses. After deleting these quality assurance submissions, I had a total of 103 completed surveys. After removing all responses with missing entries, I began coding the ISMI-9, MHSAS, Barriers to VA Healthcare, and the CES. Next, I conducted a data

analysis containing descriptive statistics, a multiple linear regression, and a one-way ANOVA to meet all statistical assumptions.

Demographic Characteristics

There were 103 participants (see Table 1 for demographic details). The average age of participants was $M = 41.88$ and $SD = 7.195$. The youngest respondent was 31, and the oldest respondent was 62. Most of the respondents served in the Army 46.6% ($n = 48$), Air Force 22.3% ($n = 23$), Navy 18.4% ($n = 19$), and lastly, the Marine Corps 12.6% ($n = 13$). There were no participants from the Coast Guard or Space Force. Participants indicated their race as White 49.5% ($n = 51$), White Hispanic/Latino 17.5% ($n = 18$), Black or African American 13.6% ($n = 14$), two or more races 8.7% ($n = 9$), non-White Hispanic/Latino 4.9% ($n = 5$), Asian 2.9% ($n = 3$), other at 1.9% ($n = 2$), and Native Hawaiian or other Pacific Islander 1% ($n = 1$). Regarding how many tours a respondent served, 45.6% indicated one tour, 41.7% indicated two to three tours, 8.7% indicated four to five tours, and 3.9% served six or more tours. Whether a respondent experienced combat while deployed, the differences were separated by a small percentage; 51.5% stated yes and 48.5% indicating no. In this survey, I also asked participants whether they have ever accessed mental health services; 6.8% answered no, 69.9% answered yes within the VA, and 23.3% answered yes but outside of the VA. When asked if the participant has accessed mental health services since joining the armed forces, 11.7% answered no, and 88.3% answered yes.

Table 1

Demographic Data for Categorical Variables

Demographic variable		*n*	Percent
Branch of service	Army	48	46.6%
	Navy	19	18.4%
	Air Force	23	22.3%
	Marine Corp	13	12.6%
Race	Asian	3	2.9%
	Black or African American	14	13.6%
	Native Hawaiian or Other Pacific Islander	1	1.0%
	Non-White Hispanic/Latino	5	4.9%
	White Hispanic/Latino	18	17.5%
	White	51	49.5%
	Two or more races	9	8.7%
	Other	2	1.9%
Region	Northeast	5	4.9%
	Midwest	19	18.4%
	South	49	47.6%
	West	30	29.1%
Number of tours	1	47	45.6%
	2-3	43	41.7%
	4-5	9	8.7%
	6 or more	4	3.9%
Experienced combat	Yes	53	51.5%
	No	50	48.5%
Accessed mental health services	No	7	6.8%

Demographic variable		*n*	Percent
	Yes, within the VA	72	69.9%
	Yes, outside of the VA	24	23.3%
Accessed mental health services since joining the armed forces	No	12	11.7%
	Yes	91	88.3%

Note. $N = 103$.

Results

This quantitative study was conducted to examine differences in the perceived barriers to mental health care within the VA and the female veteran population of OIF and OEF. In this section, I will describe how I conducted the data analysis. All of the data analyzed were cleaned and coded. I performed an analysis to verify that all the assumptions for a multiple linear regression were met.

Statistical Assumptions

Testing of Statistical Assumptions

The RQ for this study was addressed using a parametrical statistical test. Due to that, there was a need to confirm that the data analyzed in this study met the necessary assumptions for parametric tests. The tests of normality and linearity were completed before running the statistical tests. The tests of multicollinearity and independence of observations were assessed alongside the tests as these were embedded in the regression test in SPSS.

Normality

The test of normality was assessed using the Kolmogorov-Smirnov test because the sample size used in this study was greater than 50. The test was not significant (p = .200), thus indicating that this assumption was not violated and therefore the null hypothesis was accepted, and the data were normally distributed (see Mishra et al., 2019). Table 2 shows the tests of normality.

Table 2

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	*df*	Sig.	Statistic	*df*	Sig.
Barriers to VA care	.067	103	.200	.984	103	.253

a. Lilliefors Significance Correction

Linearity

The assumption of linearity was assessed using scatter plots. This assumption was not violated as indicated in the following scatter plots; each for the dependent variable (barriers to VA healthcare) against the three respective independent variables of the study. Figures 1, 2, and 3 show scatter plots of barriers to VA care.

Figure 1

Scatter Plot of Barriers to VA Care by Stigma

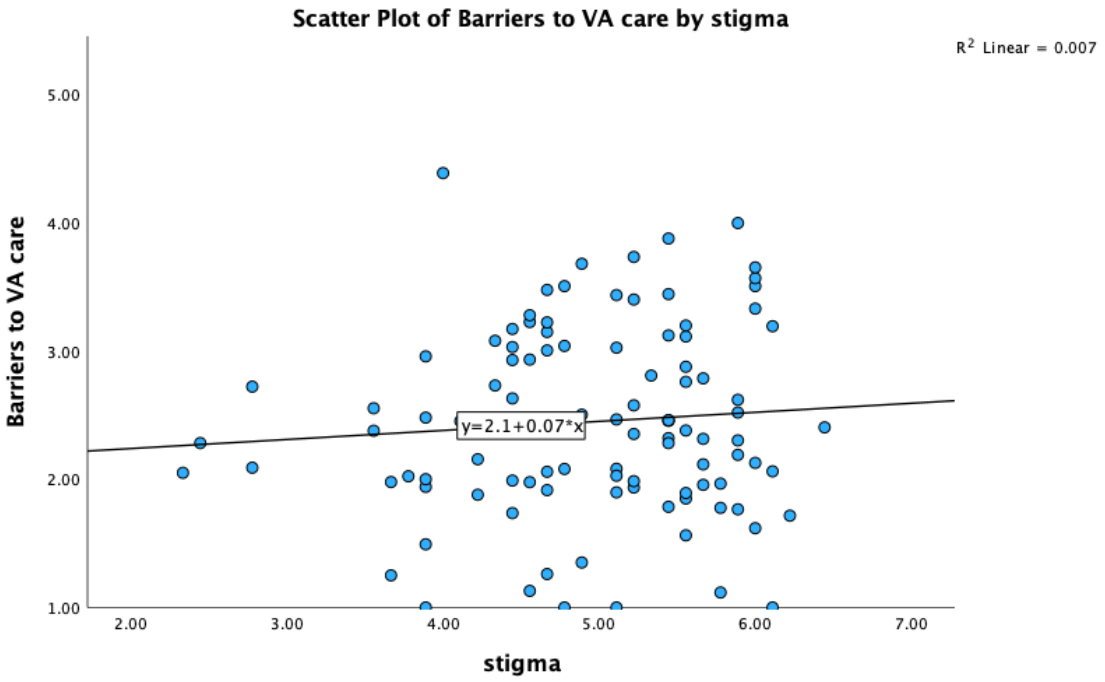


Figure 2

Scatter Plot of Barriers to VA Care by Mental Health Help Seeking Attitudes

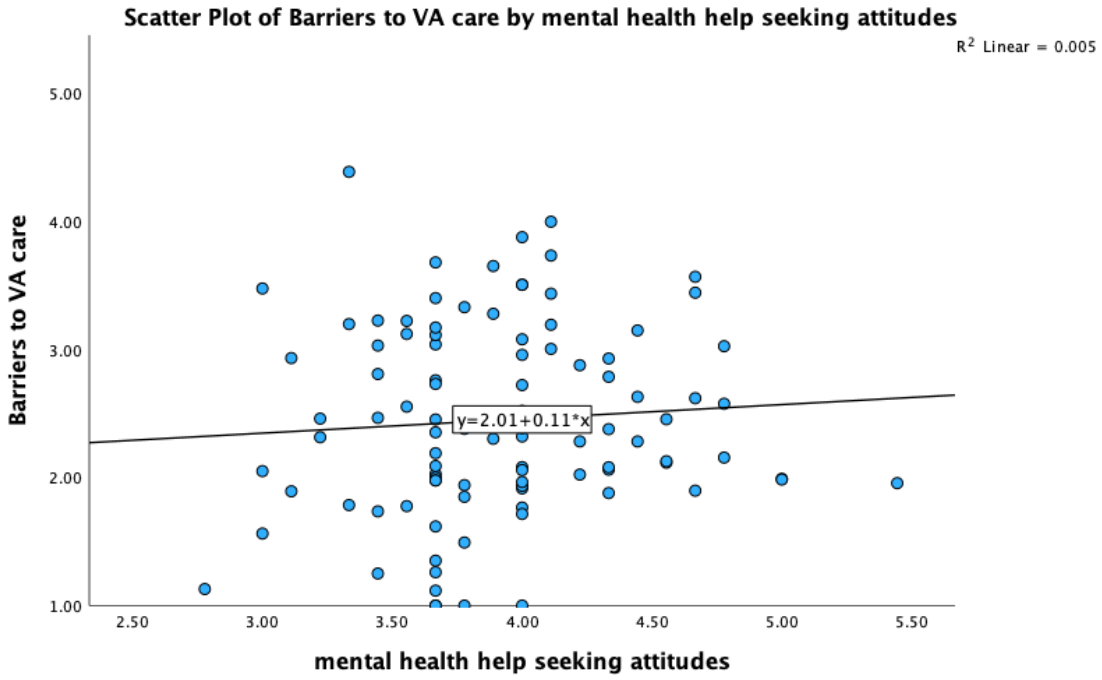
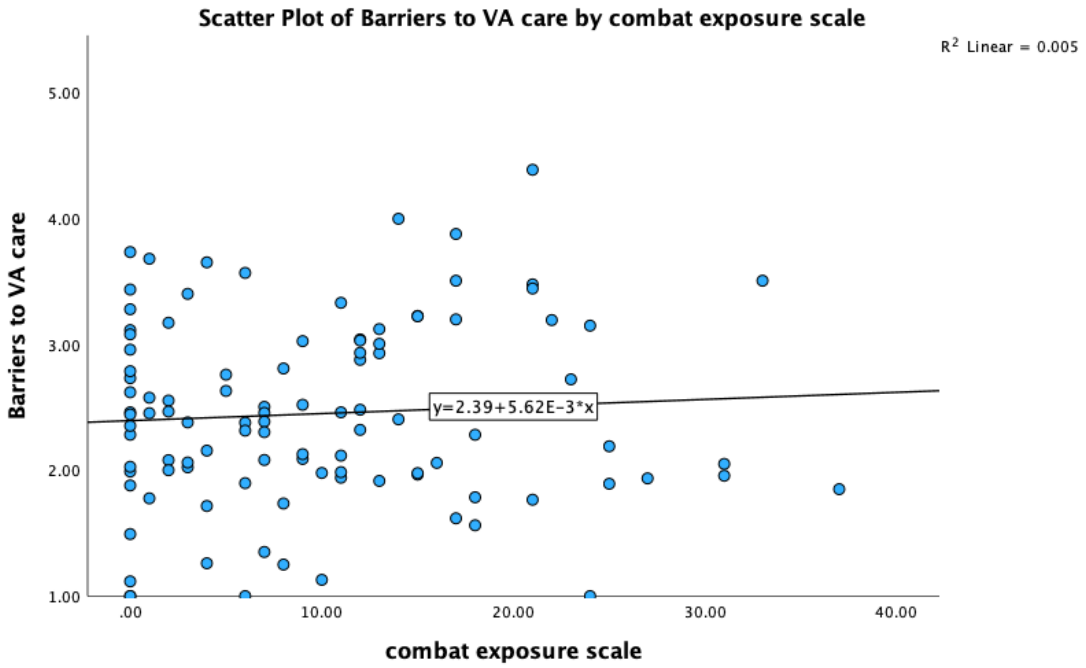


Figure 3

Scatter Plot of Barriers to VA Care by Combat Exposure Scale



Multicollinearity

Multicollinearity was evaluated using the VIF (Variance Inflation Factor) statistic, which was run alongside the linear regression test (see Table 5). All the VIF values for the regression analysis in this study were below five. According to Marcoulides and Raykov (2018), a VIF value of less than 5 is desirable for the assumption of multicollinearity to be met. The assumption of multicollinearity was therefore met in this study and indicates that there is not a significant issue with correlation with my independent variables.

Independence of Observation

The Durbin Watson (DW) test is also embedded within the regression test in SPSS. The DW test value was 1.65, which lies between 1.5 and 2.5. The assumption of independence of observation was met in this study (see Marcoulides & Raykov, 2018).

Sample Size

To fulfill an appropriate sample size, I conducted a G*Power (Version 3.1.9.2) *a priori* analysis for an *F* test for linear multiple regression to calculate the minimum required sample size. I used a 2% margin of error and a 98% confidence level with a large effect size, which resulted in a sample size of $N = 64$. I set the goal to have 200 participants, which I did reach, but once I cleaned the data, I ended with a sample size 103.

Statistical Analysis

Descriptive Statistics

I conducted a multiple linear regression to help answer the RQ for this study. The independent variables were Stigma, Mental health help-seeking attitudes, and combat exposure. The dependent variable was barriers to VA care. The descriptive statistics, shown in Table 3, indicate that overall, this study's respondents experienced fewer barriers to VA care. Whereas the respondents indicated that they had quite a relatively high combat exposure based on the CES, they reported relatively lower levels of stigma and higher attitudes toward seeking mental help.

Table 3

Descriptive Statistics

Variable	Mean	SD	*N*
Barriers to VA care	2.44	.73	103
Stigma	4.96	.85	103
Mental health help seeking attitudes	3.91	.48	103
Combat exposure	9.66	8.78	103

The multiple linear regression was insignificant in predicting whether female OIF/OEF veterans seek mental health help at VAs: F (3, 99) = .498, p = .684 (see Table 4).

Table 4

Model Summary

		Change statistics					Durbin-Watson
Model	R	*R* Square Change	*F* Change	*df*1	*df*2	Sig. *F* Change	
1	.122[a]	.015	.498	3	99	.684	1.652

Examining the independent variables individually, Stigma (ß = .065, p = .523) was not found to significantly predict whether female OIF/OEF veterans seek out mental health help at VAs. Furthermore, neither mental health help seeking attitudes (ß = .070, p

= .492) nor combat exposure (ß = .067, p = .510) was found to have a significant effect on determining whether female OIF/OEF veterans seek out mental health help at VAs. The coefficients table (see Table 5) further details these findings.

Table 5

Coefficients

	Unstandardized coefficients		Standardized coefficients	t	Sig.	Collinearity statistics	
Model	*B*	Std. Error	Beta			Tolerance	VIF
(Constant)	1.69	.702		2.41	.018		
Stigma	.056	.087	.065	.64	.523	.966	1.035
Mental health help seeking attitudes	.107	.155	.070	.69	.492	.969	1.032
Combat exposure	.006	.008	.067	.66	.510	.976	1.025

The null hypothesis for the RQ was adopted. The findings of this study were, therefore, as follows:

Stigma does not significantly affect whether a female OIF/OEF veteran seeks out mental health help at the VA.

Attitudes do not significantly affect whether a female OIF/OEF veteran seeks mental health help at the VA.

Combat exposure does not significantly predict the use of VA mental health services for female OIF and Operation Enduring veterans.

Follow-up tests were conducted to understand these findings better and clarify them. I reinspected the descriptive statistics of all the variables (see Table 3) to understand how the nature of the study's respondents may have influenced the study's findings. In particular, the respondents of this study reported relatively low scores regarding barriers they encounter as far as seeking VA care is concerned ($M = 2.44$, $SD = .73$) out of a possible maximum mean of 4.5. Because barriers to VA are the study's dependent variable, the lack of spread of its score values likely influenced the direction of the findings.

Two main components of the barrier to VA healthcare scale are VHA care are perceived as barriers and comparison of VHA care to other facilities. To further clarify the scope of this study's findings, I ran two more linear regression tests with each component separately as a separate dependent variable. None of the independent variables (mental health help seeking attitudes, stigma, and combat exposure) was significant in predicting barriers to VA care in comparisons of VHA care to other facilities, as shown in Table 6.

Table 6

Coefficients[a]

Model	Unstandardized coefficients		Standardized coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	3.150	.863		3.649	<.001
Stigma	-.051	.108	-.049	-.474	.637
Mental health help seeking attitudes	.068	.191	.037	.358	.721
Combat exposure	.000	.011	.002	.020	.984

a. Dependent variable: comparisons of VHA care to other facilities

Using the aspects of VHA care are perceived as barriers variable as the dependent variable, mental health help seeking attitudes and combat exposure were also not found to be significant predictors. Stigma was found to be a significant predictor of barriers to VA care concerning aspects of VHA care perceived as barriers: F (1,101) = 4.46, p = .037, as depicted in Table 7.

Table 7

Model Summary[b]

Model	*R*	*R* Square	Adjusted *R* Square	Std. Error of the Estimate	Change statistics: *R* Square Change	*F* Change	*df*1	*df*2	Sig. *F* Change
1	.206[a]	.042	.033	.66074	.042	4.455	1	101	.037

a. Predictors: (Constant), stigma

b. Dependent variable: aspects of VHA care are perceived as barriers

In an attempt to understand what factors influence female veterans' mental health help seeking attitudes, stigma, and combat exposure, a one-way ANOVA was conducted. The test revealed that there is a significant difference in female veterans' mental health help seeking attitudes (F (3) = 3.55, p = .017) and stigma (F (3) = 3.24, p = .026) based on the number of duty tours they served meaning that more duty tours aligned with higher stigma and higher help seeking attitudes. No significant difference in female veterans' combat exposure could be noted based on the number of duty tours they served: F (3) = 1.78, p = .156). This is indicated in Table 8. Table 9 indicates a general increase in mental health seeking attitudes as the number of tours increase.

Table 8

ANOVA

		Sum of squares	*df*	Mean square	*F*	Sig.
Mental health help seeking attitudes	Between groups	2.268	3	.756	3.545	.017
	Within groups	21.116	99	.213		
	Total	23.384	102			
Stigma	Between groups	6.631	3	2.210	3.235	.026
	Within groups	67.647	99	.683		
	Total	74.277	102			
Combat exposure	Between groups	402.677	3	134.226	1.782	.156
	Within groups	7458.430	99	75.338		
	Total	7861.107	102			

Table 9

Descriptive Statistics (a)

						95% Confidence Interval for Mean	
		N	Mean	*SD*	Std Error	Lower Bound	Upper Bound
Mental health help seeking attitudes	1	47	3.85	.43	.06	3.73	3.98
	2-3	43	3.93	.48	.07	3.78	4.08
	4-5	9	3.79	.56	.19	3.36	4.22
	6 or more	4	4.61	.35	.17	4.06	5.16
	Total	103	3.91	.48	.05	3.82	4.00
Stigma	1	47	4.79	.82	.12	4.55	5.03
	2-3	43	5.13	.80	.12	4.88	5.38
	4-5	9	5.35	.79	.26	4.74	5.95
	6 or more	4	4.14	1.20	.60	2.23	6.05
	Total	103	4.96	.85	.08	4.79	5.12
Combat exposure	1	47	8.30	7.71	1.13	6.03	10.56
	2-3	43	9.91	8.52	1.30	7.29	12.53
	4-5	9	15.56	12.95	4.32	5.60	25.51
	6 or more	4	9.75	10.53	5.27	-7.00	26.51
	Total	103	9.66	8.78	.87	7.94	11.38

Summary

The purpose of this quantitative study was to examine differences in the perceived barriers to mental health care within the VA within the female veteran population. The independent variables measured were stigma, mental health seeking attitudes, and combat exposure. The dependent variable was barriers to VA healthcare. A multiple regression was used to answer my RQ. The multiple regression demonstrated no statistically significant findings between the dependent variable, barriers to VA healthcare, and the independent variables, stigma, attitudes, and combat exposure. Due to these results, I accepted the null hypothesis and rejected the alternative hypothesis.

The significance of these finding will be discussed in Chapter 5. Chapter 5 will highlight the interpretations of the findings and the limitations of the study as well as any recommendations for future research. Lastly, it will describe the potential impact for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative study was to examine differences in the perceived barriers to mental health care within the VA and the female veteran population of OIF and OEF. This study did not find any statistically significant findings between the independent variables of stigma, mental health help-seeking attitudes, and combat exposure and the dependent variable barriers to VA care. In this chapter, I will discuss the interpretation of the findings, study limitations, recommendations, and implications for social change.

Interpretation of Findings

The RQ1, RQ2, and RQ3 results did not show a statistically significant effect; therefore, the null hypothesis was accepted. To understand the data further, I ran a one-way ANOVA and found that there is a significant difference in female veterans' mental health help-seeking attitudes and the number of tours they served. Some of my personal goals for this study were to have participation from each branch of service and an equal number of participants from each region. Having most of the participants reside in the west and south regions could prompt further studies to research participants in the north and east regions to better understand barriers they may experience to VA healthcare. Taking a closer look at the culture of health care-seeking behavior in each region and within different branches could also provide a more in-depth look in how VA services are being utilized. Digging deeper into whether a female veteran resides in a rural versus urban location could also help the VA better plan for the female needs. As Bommersbach et al. (2021) noted, veterans who resided in rural areas had limited access and a lower

quality of life, and although there are 4.4 million veterans who live in rural areas, only 32% of the VA healthcare budget is allocated to rural veteran care (U.S. Department of Veterans Affairs, 2024e).This study might prompt future studies to better understand the attitudes, beliefs, and access to health care services through the VA of female veterans who have served several tours and those who live in rural areas in contrast to access in metropolitan cachement areas.

The literature review results in Chapter 2 revealed that there is a need to close the gap on gender-specific barriers to care (Godier-McBard, 2022), and this study contributes to the limited body of research on understanding female veterans and offers a point of comparison for future research. Future research could consist of the need to investigate female veterans who had experienced multiple deployments, exploring the health care-seeking difference in the various regions of the United States, and how the different branches of the military prepared service members on how to utilize VA healthcare. This study was predominantly compromised of Army veterans, and it could be helpful to understand if there was a phenomenological reason to that, such as did the Army provide servicemembers a better understanding of how VA services could be utilized once a veteran was out-processed from active duty. Utilizing a feminist and multicultural theoretical lens will continue to help build the foundation of understanding of the female veterans' needs in a male oriented healthcare system (Godier-McBard et al., 2022). Gaining a better understanding of how these perceived barriers affects and intersects in a female veteran's life can help decrease the gap in any social inequity that is being experienced.

Limitations of the Study

Multiple limitations to this study should be considered, such as using a survey approach, and the platforms utilized to gain participants. Using a survey method was cost-effective and could be disseminated to many people at once. Utilizing an online survey method did not allow me to follow up with participants who dropped out. It would be helpful to understand for future research if it was due the survey questions, the length, or it being targeted at only cis-gendered females. Reaching out on veteran-centered platforms could have pooled participants who already have a high sense of self-efficacy and can voice their needs and wants from a provider. Pooling veterans on veteran-centered platforms may already have insight and opportunity to access resources, which could potentially skew their data towards the positive thus reducing the possibility of significance in this research. Following up on this study with a qualitative method would be beneficial in understanding female veterans' lived experiences and discussing any questions they may have had regarding the survey questions.

I received feedback from participants on various Facebook pages that the term cisgender was either found offensive for not including the transgendered community or that acknowledging the term cisgender conflicted with religious beliefs. An assumption that could be made is that performing an in-person survey could allow me to provide a clearer understanding of what the term cis-gender means or what were their hesitations to completing the survey. Several veterans voiced their opinion on the social media post that their religious beliefs did not accept the term cisgender or that they felt it was unethical to have the term cisgender in this study. It could be beneficial to complete another study that

is open to all who identify as female or those females who have transitioned to gain an understanding of any perceived barriers they may have faced. The final limitation noted could be the length of the survey. When my survey closed, I had 271 participants, but after removing responses that were not completed, I was left with 103 completed surveys. One of the possibilities that this happened could be survey fatigue. In this study, I had a total of 69 questions, not including the demographic. Singh and Sagar (2021) discussed having shorter surveys with few simple questions to decrease survey fatigue or participant disinterest. Participants could have experienced survey fatigue. Survey fatigue could explain why some questions were not fully completed and had to be eliminated from the sample.

Recommendations

Although the results of this study were not statistically significant, this research adds to enhancing the female OIF/OEF veterans' healthcare experience within the VA overall. Continuing to add to the research towards female veterans can help policy makers and mental health care professionals gain a better understanding of this growing population. Future research might focus on sampling participants in more rural areas and attempting to gather an equal number of participants from each branch of service. Only n = 5 (4.9%) of participants who responded to this study resided in the Northeast region, and n = 19 (18.4%) resided in the Midwest region, compared to participants in the Western region n = 30 (29.1%), and the South region, n = 49 (47.6%). Understanding how regional culture and geographic distances to VA health centers could be a barrier to

female OIF and OEF veterans' use of VA healthcare could be beneficial in future research.

Female veterans from the Army had the highest participation rate which could indicate based on the outcomes of the data, perhaps the veterans in this study made use of Army tools. Another possibility for the high participation from female Army OIF/OEF veterans is that according to the VA by 2025 the anticipated number of female veterans for the Army is 916,948 followed by the Air Force at 464,069, Navy at 409,586, and Marines at 124,169 (U.S. Department of Veterans Affairs, 2024f). As mentioned previously, a qualitative study could help with the survey fatigue that may have contributed to the surveys needing to be completed and provide clarity on questions that may have needed to be more specific in context, such as question two on the CES. Some participants questioned whether experiencing a mortar attack on a large forward operating base (FOB) or Bagram Airfield would count even though they did not feel that they were in danger.

Implications

Although this study did not result in any statistically significant main findings, the data do add to the body of research regarding veteran female needs and experiences. As a veteran myself, it is my goal to share this completed study with my care team within the VA as well as a connection I have with a liaison who works within the suicide prevention administration within the VA. This research can continue to help the VA understand female veterans' perceived mental health stigmas and the impact it has on that population.

As the female veteran population continues to grow, so does the health care treatment needs of that population.

As the VA continues to work to meet female veterans' needs, this research could help understand what is working and what is not. My findings showed that stigma is a significant predictor of barriers to VA care, but, overall, the female veterans who participated in this study felt positive regarding the healthcare they were receiving at the VA. Counselors and counselor educators must understand the unique needs of veterans overall. Understanding the needs, specifically, gendered needs, requires continued research on the best ways to advocate and intervene.

Lastly, removing the negative stigma around mental health is a challenging task. However, as each branch of the military continues to adopt the belief and value that mental health treatment can be impactful, it may reduce the feelings of needing to be stoic, invincible, and self-reliant (Roscoe, 2021). This can be done through quarterly trainings, providing service members with access and time off for mental health needs as well as pre- and post-deployment education regarding mental health access and various needs that could arise such as struggles with stigma, MST and PTSD.

Veterans are a unique subset of the population that is constantly growing. To effectively provide proper education to future counselor educators, programs should provide students with an education that helps students apply theoretical knowledge when working with this population. When working in community mental health, it is unknown who will be assigned to a counselor's caseload and developing an understanding of the needs of this population through internships, practicum placements, and class work could

help a veteran feel more at ease and understood in the counseling process. Furthermore, providing professional workshops to various mental health organizations across the nation will help practicing professionals develop or advance their skills for working with veterans and the unique differences and experiences that lies between the female and male population. These workshops could cover topics such as understanding stigmas veteran females face, combat exposure, MST, PTSD, and imposter syndrome that comes from not feeling equal to their male counterparts.

Conclusion

The purpose of this quantitative study was to examine differences in the perceived barriers to mental health care within the U.S. Department of VA within the female veteran population of OIF and OEF. Historically, military culture has been based on male societal influence, which could affect female veterans being underserved. Although this study did not provide statistically significant findings, it does help add to the literature on female veterans. The findings in this study can help medical and mental health providers better understand a female veteran's needs and if any barriers are being experienced. My goal for this study's findings is that it can help identify gaps in research that may impact mental health care within the VA.

References

Acharya, A. S., Prakash, A., Saxena, P., & Nigam, A. (2013). Sampling: Why and how of it. *Indian Journal of Medical Specialities, 4*(2), 330-333. https://doi.org/10.7713/ijms.2013.0032

Amsalem, D., Lopez-Yianilos, A., Lowell, A., Pickover, A. M., Arnon, S., Zhu, X., Suarez-Jimenez, B., Ryba, M., Bergman, M., Such, S., Zalman, H., Sanchez-Lacay, A., Lazarov, A., Markowitz, J. C., & Neria, Y. (2022). Treatment dropout among veterans and their families: Quantitative and qualitative findings. *Psychological Trauma: Theory, Research, Practice, and Policy,.14*(2), 578-586. https://doi.org/10.1037/tra0001109

American Counseling Association. (2023*). A closer look at the mental health provider shortage*. https://www.counseling.org/publications/counseling-today-magazine/article-archive/article/legacy/a-closer-look-at-the-mental-health-provider-shortage

Anand, P., Ben-Shalom, Y., & Schone, E. (2020). Factors associated with the acceptance of new tricare and medicare patients by health care providers. *Medical Care Research & Review, 78*(5), 627–637. https://doi.org/10.1177/1077558720942700

Anderson, C. S. (2008). Afterword: Feminist theory, scholars, and the study of south asian religions. *Journal of Feminist Studies in Religion (Indiana University Press)*, *24*(1), 60–71. https://doi.org/10.2979/FSR.2008.24.1.60

Andrade, C. (2021). The inconvenient truth about convenience and purposive samples. *Indian Journal of Psychological Medicine*, *43*(1), 86–88.

https://doi.org/10.1177/0253717620977000

Bayne, H. B., & Doyle, K. (2019). Licensure portability through an ethical lens: Considering multiple stakeholders. *Journal of Mental Health Counseling*, *41*(2), 97–111. https://doi.org/10.17744/mehc.41.2.01

Biscontini, T. (2023). *First-wave feminism*. Salem Press Encyclopedia.

Bommersbach, T., Stefanovics, E., & Rosenheck, R. (2021). Mental health service utilization in rural areas nationally in the veterans health administration. *Journal of Rural Mental Health*, *45*(3), 229-242. http://dx.doi.org/10.1037/rmh0000182

Boros, P., & Erolin, K. S. (2021). Women veterans after transition to civilian life: An interpretative phenomenological analysis. *Journal of Feminist Family Therapy*, *33*(4), 330–353. https://doi.org/10.1080/08952833.2021.1887639

Buckley, M., & Thompson, R. (2021). Introduction: Special issue on women and operation iraqi freedom. *Journal of Veterans Studies, 7*(2), 1–5. https://doi.org/10.21061/ jvs.v7i2.276

Cahill, H. (2022). Using metaphors to cross the divide between feminist theory and pedagogical design. *Gender & Education*, *34*(1), 49–63. https://doi.org/10.1080/09540253.2020.1723496

Caldwell, H., & Lauderdale, S. A. (2021). Public stigma for men and women veterans with combat-related posttraumatic stress disorder. *Current Psychology, 40*(1), 322-332. https://doi.org/10.1007/s12144-018-9940-5

Chakraborty, A. (2021). Feminism: A critical analysis vis-à-vis the role of men. *Ilkogretim Online*, *20*(1), 1610–1615.

https://doi.org/10.17051/ilkonline.2021.01.170

DataUSA. (2024). *Mental health counselors*. https://datausa.io/profile/soc/mental-health-counselors

Dodds, C. D., & Kiernan, M. D. (2019). Hidden veterans: A review of the literature on women veterans in contemporary society. *Illness, Crisis & Loss, 27*(4), 293–310. https://doi.org/10.1177/ 1054137319834775

Dichiara, A., Brandwein, D., Marks, D. R., Edwards, E., & Geraci, J. C. (2021). Mental health service use amongst veterans in a peer-mentor intervention: An analysis of barriers to treatment. *Military Behavioral Health*, *9*(3), 335–344. https://doi.org/10.1080/21635781.2021.1888827

Finneman, T., & Volz, Y. (2020). Leading the second wave into the third wave: U.S. women journalists and discursive continuity of feminism. *Feminist Media Studies*, *20*(6), 863–878. https://doi.org/10.1080/14680777.2019.1644658

Folbre, N. (2023). Telling fortunes: Feminist theory and the future of political economy. Review of political economy, *35*(1), 129-144. https://doi.org/10.1080/09538259.2023.2146379

Godier-McBard, L. R., Wood, A., Kohomange, M., Cable, G., & Fossey, M. (2022). Barriers and facilitators to mental healthcare for women veterans: A scoping review. *Journal of Mental Health (Abingdon, England)*, *32*(5), 951-961. https://doi.org/10.1080/09638237.2022.2118686

Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologists as social justice agents: Feminist and

multicultural principles in action. *The Counseling Psychologist*, *32*(6), 793-837. https://doi.org/10.1177/0011000004268802

Government Accountability Office. (2022). Veterans health care: Efforts to hire licensed professional mental health counselors and marriage and family therapists. https://www.gao.gov/assets/gao-22-104696.pdf

Grzanka, P. R. (2020). From buzzword to critical psychology: An invitation to take intersectionality seriously. *Women & Therapy, 43*(3-4), 244–261. https://doi.org/10.1080/02703149.2020.1729473

Hammer, J. H., & Toland, M. D. (2017). Internal structure and reliability of the internalized stigma of mental illness scale (ISMI-29) and brief versions (ISMI-10, ISMI-9) among americans with depression. *Stigma and Health*, *2*(3), 159–174. https://doi.org/10.1037/sah0000049

Hammer, J. H., & Parent, M. C., & Spiker, D. A. (2018). Mental help seeking attitudes scale (MHSAS): Development, reliability, validity, and comparison with the ATSSPH-SF and IASMHS-PO. *Journal of Counseling Psychology, 65*, 74-85. https://doi.org/10.1037/cou0000248.

Herring, K. D. (2023). Teaching intersectional rhetorical criticism with second-wave feminist music. *Communication Teacher*, *37*(1), 40–47. https://doi.org/10.1080/17404622.2022.2052917

Hirudayaraj, M., Shields, L., Baker, R., Turner, J. R., Yoon, H. J., & Kwon, K. (2019). Feminist theory: A research agenda for hrd. *Advances in Developing Human Resources*, *21*(3), 319–334. https://doi.org/10.1177/1523422319851286

Iodice, E. (2023). Lessons from History: The remarkable leadership of eleanor roosevelt and why it matters today (Part 2). *Journal of Values Based Leadership*, *16*(2), 257–277. https://doi.org/10.22543/1948-0733.1471

Johnson, T.S., Ganz, A., Berger, S., Ganguly, A., & Koritzky, G. (2018). Service members prefer a psychotherapist who is a veteran. *Frontiers in Psychology*, *9*. 1068. https://doi.org/10.3389/fpsyg.2018.01068

Johnson, E. M., & Possemato, K. (2021). Problem recognition and treatment beliefs relate to mental health utilization among veteran primary care patients. Psychological Services, *18*(1), 11–22. https://doi.org/10.1037/ser0000341

Jones, A. L., Fine, M. J., Stone, R. A., Gao, S., Hausmann, L. R. M., Burkitt, K. H., Taber, P. A., Switzer, G. E., Good, C. B., Vanneman, M. E., & Zickmund, S. L. (2019). Veteran satisfaction with early experiences of health care through the veterans choice program: A concurrent mixed methods study. *Journal of General Internal Medicine*, *34*(9), 1925–1933. https://doi-org.ezp.waldenulibrary.org/10.1007/s11606-019-05116-1

Keane, T.M., Fairbank, J.A., Caddell, J.M., Zimering, R.T., Taylor, K.L., & Mora, C. (1989). Clinical evaluation of a measure to assess combat exposure. *Psychological Assessment, 1*, 53-55. https://doi.org/10.1037//1040-3590.1.1.53

Kysar-Moon, A., & Mustillo, S. (2019). Race/ethnicity and traumatic brain injury: Are there disparities in positive screenings and diagnoses among service members returning from afghanistan and iraq? Armed Forces & Society, *45*(1), 155–176.

https://doi.org/10.1177/0095327X18761852

Lund, M., Foy, D., Sipprelle, C., & Strachan, A. (1984). The combat exposure scale: A systematic assessment of trauma in the vietnam war. *Journal of Clinical Psychology*, *40*(6), 1323–1328. https://doi.org/10.1002/1097-4679(198411)40:6<1323::AID-JCLP2270400607>3.0.CO;2-I

Maley, A. J., & Hawkins, D. N. (2018). The southern military tradition: Sociodemographic factors, cultural legacy, and u.s. army enlistments. *Armed Forces and Society*, *44*(2), 195-218–218. https://doi.org/10.1177/0095327x17700851

Mansfield, A. K., Addis, M. E., & Courtenay, W. (2005). Measurement of men's help seeking: Development and evaluation of the barriers to help seeking scale. *Psychology of Men & Masculinity*, *6*(2), 95–108. https://doi.org/10.1037/1524-9220.6.2.95

Marcoulides, K.M. and Raykov, T. (2018). Evaluation of variance inflation factors in regression models using latent variable modeling methods. *Educational and Psychological Measurement*, *79*(5), pp. 874–882. https://doi.org/10.1177/0013164418817803

Mcafee, N., & Katie, H. B. (2023). Feminist political philosophy. In *The Stanford Encyclopedia of Philosophy*. Metaphysics Research Lab. https://plato.stanford.edu/archives/win2023/entries/feminism-political

McCaslin, S. E., Becket-Davenport, C., Dinh, J. V., Lasher, B., Kim, M., Choucroun, G., & Herbst, E. (2021). Military acculturation and readjustment to the civilian

context. *Psychological Trauma: Theory, Research, Practice & Policy, 13*(6), 611-620. https://doi.org/10.1037/tra0000999

McGuire, J. T. (2014). Beginning an "extraordinary opportunity": Eleanor roosevelt, molly dewson, and the expansion of women's boundaries in the Democratic Party, 1924-1934. *WOMENS HISTORY REVIEW*, *23*(6), 922–937. https://doi.org/10.1080/09612025.2014.906841

Mental Health Counselor Provider Requirements. (2024). Tricare certified mental health counselor. https://www.tricare-west.com/content/hnfs/home/tw/prov/benefits/benefits_a_to_z/mental_health/mhc_requirements.html

Mercadal, T. (2024). Women in combat. *Salem Press Encyclopedia.*

Mishra, P., Pandey, C., Singh, U., Gupta, A., Sahu, C., Keshri, A. (2019). Descriptive statistics and normality tests for statistical data. *Annals of Cardiac Anaesthesia*, *22*(1), p. 67. https://doi.org/10.4103/aca.aca_157_18

Moorhead, H. J. H., Duncan, K., & Fernandez, M. S. (2023). The critical need for professional advocacy: A call to the counseling profession to value professional counselor identity. Journal of Counselor Leadership & Advocacy, *10*(1), 3–17. https://doi.org/10.1080/2326716X.2023.2178985

Morgan, A. A., Fullen, M. C., & Wiley, J. D. (2022). A case of the tail wagging the dog: The medicare mental health coverage gap and its impact on providers and beneficiaries. *Journal of Mental Health Counseling*, *44*(1), 32–48. https://doi.org/10.17744/mehc.44.1.04

National Board for Certified Counselors. (2024). Veterans Affairs. https://nbcc.org/govtaffairs/veterans

Neilson, E. C., Singh, R. S., Harper, K. L., & Teng, E. J. (2020). Traditional masculinity ideology, posttraumatic stress disorder (ptsd) symptom severity, and treatment in service members and veterans: A systematic review. *Psychology of Men & Masculinities*, *21*(4), 578-592. https://dx.doi.org/10.1037/men0000257

Nelson, S. M., Mach, J. J., Hein, T. C., Abraham, K. M., Jedele, J. M., & Bowersox, N. W. (2022). Access to timely mental health care treatment initiation among veterans health administration patients with and without serious mental illness. *Psychological services*, *19*(3), 488–493. https://doi.org/10.1037/ser0000534

Newins, A. R., Wilson, S. M., Hopkins, T. A., Straits-Troster, K., Kudler, H., & Calhoun, P. S. (2019). Barriers to the use of veterans affairs health care services among female veterans who served in Iraq and Afghanistan. *Psychological Services*, *16*(3), 484–490. https://doi.org/10.1037/ser0000230

Ouimette, P., Vogt, D., Wade, M., Tirone, V., Greenbaum, M. A., Kimerling, R., Laffaye, C., Fitt, J. E., Rosen, C. S. (2011). Perceived barriers to care among veterans health administration patients with posttraumatic stress disorder. *Psychological Services*, *8*(3), 212–223. https://doi.org/10.1037/a0024360

Pham, J. M. (2023). “Force multipliers” and “risk multipliers”: Organizational myth and gender integration of the u.s. combat arms military occupational specialties and

units. *Sociological Quarterly*, *64*(1), 46–66. https://doi.org/10.1080/00380253.2021.1981790

Phillips, L. (2023). A closer look at the mental health provider shortage. *Counseling Today*, *65*(11), 25–39. https://www.counseling.org/publications/counseling-today-magazine/article-archive/article/legacy/a-closer-look-at-the-mental-health-provider-shortage

Portillo, S., Doan, A., & Mog, A. (2022). Maintaining male exclusivity: Porcelain privilege in the military. *Armed Forces & Society (0095327X)*, *48*(3), 571–588. https://doi.org/10.1177/0095327X21992369

Pyne, J. M., Kelly, P. A., Fischer, E. P., Miller, C. J., Wright, P., Zamora, K., Koenig, C. J., Stanley, R., Seal, K., & Fortney, J. C. (2019). Development of a perceived access inventory for community care mental healthcare services for veterans. *Military Medicine*, *184*(7–8), e301–e308. https://doi.org/10.1093/milmed/usy429

Richardson, C. & Waldrop, J. (2003). Veterans: 2000 census 2000 brief. Retrieved from: https://usa.ipums.org/usa/resources/voliii/pubdocs/2000/c2kbr-22.pdf

Richardson LK, Frueh BC, & Acierno R. (2010). Prevalence estimates of combat-related post-traumatic stress disorder: critical review. *Australian & New Zealand Journal of Psychiatry*, *44*(1), 4–19. https://doi.org/10.3109/00048670903393597

Roscoe, R. A. (2021). The battle against mental health stigma: Examining how veterans with ptsd communicatively manage stigma. *Health Communication*, *36*(11), 1378–1387. https://doi.org/10.1080/10410236.2020.1754587

Roosevelt III, K., & Tootell, A. (2021). Mirror, mirror on the wall: Disney princesses' reflections of equal protection. *Wake Forest Law Review*, *56*(2), 261–319. https://doi.org/10.1037/e558492014-001

Salvy, S.-J., Carandang, K., Vigen, C. L., Concha-Chavez, A., Sequeira, P. A., Blanchard, J., Diaz, J., Raymond, J., & Pyatak, E. A. (2020). Effectiveness of social media (facebook), targeted mailing, and in-person solicitation for the recruitment of young adult in a diabetes self-management clinical trial. Clinical Trials (London, England), *17*(6), 664–674. https://doi.org/10.1177/1740774520933362

Schuman, D. L., Cerel, J., & Praetorius, R. T. (2019). Suicide in u.s. women veterans: An interpersonal theory perspective on suicide prevention policies. *Social Work in Public Health*, *34*(5), 418–429. https://doi.org/10.1080/19371918.2019.1616028

Schwarzbaum, S.E. & Thomas, A.J. (2008). *Dimensions of multicultural counseling: A life story approach*. SAGE Publications, Inc. https://doi.org/10.4135/9781483329741

Secdef Opens All Military Occupations to Women. (2015). *States news service*. https://link.gale.com/apps/doc/A436600241/EAIM?u=minn4020&sid=ebsco&xid=965c7d35

Shields, M., Thomas, K. H., Bernard, C., & Lumsden, D. (2020). The correlation between female veteran's mental health and branch of military service. *Journal of Health Education Teaching*, *11*(1), 14-23. https://www.jhetonline.com

Silvestrini, M., & Chen, J. A. (2023). "It's a sign of weakness": Masculinity and help-

seeking behaviors among male veterans accessing posttraumatic stress disorder care. *Psychological Trauma: Theory, Research, Practice & Policy*, *15*(4), 665–671. https://doi.org/10.1037/tra0001382

Singh, A. A., Appling, B., & Trepal, H. (2020). Using the multicultural and social justice counseling competencies to decolonize counseling practice: The important roles of theory, power, and action. Journal of Counseling & Development, *98*(3), 261–271. https://doi.org/10.1002/jcad.12321

Singh, S., & Sagar, R. (2021). A critical look at online survey or questionnaire-based research studies during COVID-19. *Asian Journal of Psychiatry*, *65*, 102850. https://doi.org/10.1016/j.ajp.2021.102850

Smith, C. A., Boden, M. T., & Trafton, J. A. (2021). Outpatient provider staffing ratios: Binary recursive models associated with quality, access, and satisfaction. *Psychological Services, 20*(1), 137-141. http://dx.doi.org/10.1037/ser0000449

Strong, J. D., Crowe, B. M., & Lawson, S. (2018). Female veterans: Navigating two identities. *Clinical Social Work Journal*, *46*(2), 92–99. https://doi.org/10.1007/s10615-017-0636-3

Sudom, K. A., Nesdole, R., & Zamorski, M. A. (2019). Validation of a brief measure of combat exposure among canadian armed forces personnel. *Health Reports*, *30*(11), 11. https://doi.org/10.25318/82-003-x201901100002-eng

Tkachuck, M. A., Pavlacic, J. M., Raley, M. J., McCaslin, S. E., & Schulenberg, S. E. (2022). Validating military culture: The factor analysis of a military-related

adaptation of acculturation in veterans. *Psychological Services*, *19*(3), 585–596. https://doi.org/10.1037/ser0000558

Todd, G., Fullen, M.C., Nolan, M., & Blackwood, K. (2023). Becoming a medicare provider. https://www.counseling.org/docs/default-source/government-affairs/how-to-navigate-medicare-reimbursement-for-practitioners-webinar-slides.pdf?sfvrsn=bdd5352c_2

Tricare 101. (2024). What is tricare. https://www.tricare.mil/Plans/New

United States Department of Veterans Affairs. (2024a). Ptsd: National center for ptsd. https://www.ptsd.va.gov/understand/what/index.asp

United States Department of Veterans Affairs. (2024b). National center for veterans analysis and statistics. https://www.va.gov/vetdata/glossary.asp

United States Department of Veterans Affairs. (2024c). Wars & operations. https://publichealth.va.gov/exposures/index.asp

United States Department of Veterans Affairs. (2024d). Determining veteran status. https://www.va.gov/OSDBU/docs/Determining-Veteran-Status.pdf

United States Department of Veterans Affairs. (2024e). Office of rural health. https://www.ruralhealth.va.gov/rural-definition.asp

United States Department of Veterans Affairs. (2024f). Women veterans health care. https://www.womenshealth.va.gov/materials-and-resources/facts-and-statistics.asp

United States Department of Veterans Affairs. (2024g). Education and training. https://benefits.va.gov/gibill/isaksonroe.asp

United States Department of Veterans Affairs. (2024h). Women veterans bravely served during the vietnam war. Vhttps://news.va.gov/86001/women-veterans-bravely-served-vietnam-war/

U.S. Department of Defense. (2022). Department of defense releases annual demographics report- upward trend in the number of women serving continues. https://www.defense.gov/News/Releases/Release/article/3246268/department-of-defense-releases-annual-demographics-report-upward-trend-in-numbe/

Vance, N. (2021). Society and multiculturalism. *Salem Press Encyclopedia*.

Vespa, J. E. (2020). Those who served: America's veterans from world war II to the war on terror. American Community Survey Reports, 43.U.S. Census Bureau, Washington, DC. https://www.census.gov/content/dam/Census/library/publications/2020/demo/acs-43.pdf

Washington, D. L., Kleimann, S., Michelini, A. N., Kleimann, K. M., & Canning, M. (2007). Women veterans' perceptions and decision-making about veterans affairs health care. *Military Medicine, 172,* 812–817. https://doi.org/10.7205/milmed.172.8.812

Wiley, J. D., Fullen, M. C., & Morgan, A. A. (2019). "Bearing the burden": Rural implications of licensed professionals' exclusion from medicare. *Journal of Rural Mental Health*, *43*(4), 118–129. https://doi.org/10.1037/rmh0000119

Williston, S. K., & Vogt, D. S. (2021). Mental health literacy in veterans: What do u.s. military veterans know about ptsd and its treatment? *Psychological Services, 19*(2), 327-224. https://doi.org/10.1037/ser0000501

Wilson, S. R., Hintz, E. A., MacDermid Wadsworth, S. M., Topp, D. B., Southwell, K. H., & Spoont, M. (2021). Female u.s. military veterans' (non)disclosure of mental health issues with family and friends: Privacy rules and boundary management. *Health Communication*, *36*(4), 412–423. https://doi.org/10.1080/10410236.2019.1693128

Zwiebach, L., Lannert, B. K., Sherrill, A. M., McSweeney, L. B., Sprang, K., Goodnight, J. R. M., Lewis, S. C., & Rauch, S. A. M. (2019). Military cultural competence in the context of cognitive behavioural therapy. *Cognitive Behaviour Therapist*, *12*, 1–13. https://doi.org/10.1017/s1754470x18000132