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Lived Experiences of Rural Female Veterans Seeking Mental Health Counseling

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Walden University
2025

Abstract

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MS, Walden University, 2012

BS, Keuka College, 1985

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Over the past 20 years, the number of female veterans in the United States has doubled. Research has shown a gap in the literature regarding the lived experiences of female veterans seeking mental health care services in rural areas. The purpose of this qualitative phenomenological study was to explore the lived experiences of female veterans seeking mental health services in rural areas. A hermeneutic phenomenological theoretical framework through the lens of health care utilization theory was used to guide the study. Nine women meeting the inclusion criteria of being a veteran, being 18 years or older, having at least 2 years of active duty, residing in the rural United States, and seeking mental health care services participated in semi structured interviews. Giorgi's five step data analysis was used to identify six main themes: (a) finding good gender-specific Veterans Administration (VA) therapies, (b) difficulties finding and scheduling gender-specific VA mental health care, (c) rural locations negatively affecting benefits, (d) difficulty in finding non-VA gender-specific care, (e) finding rural locations good for mental health benefits, and (f) finding good non-VA resources. Findings may encourage positive social change for rural female veterans returning to civilian life through the shared advocacy of military and civilian stakeholders and may inform policy changes for post deployment transitions.

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Dedication

This research is dedicated to "Aunt Anna Tarryk" (posthumously). Aunt Anna was a major influence in my career path, spiritual journey, and this research project. She was a private first class in the 6888th postal Battalion during World War II. Anna Marguerita Tarryk was born in Brooklyn, New York in 1915. She was one of 15 children born to my paternal grandmother, Mary Ann Baranowski, emigrating from Galicia, Austria, and grandfather, Gregorovich Harry Zahrin, emigrating from Kiev, Russia. I see your picture…I wear the watch…Bless you Tizzy!

This research is dedicated to all of the female veterans like Aunt Anna who trusted me to tell their stories for this research project. Thank you to all of the female veterans who served this country before, are serving now, and will serve in the future, for their commitment and bravery.

Acknowledgments

Thank you to Mom, Dad, and faculty of Walden University. I thank Mom and Dad because you made me the strong independent fearless woman I am today. I wish you both lived long enough to see me finish this research project. I thank Walden University for instilling confidence in me to pursue this research, which led to the commitment to complete this important study. I thank Dr. Theodore Remley, Jr., Dr. Katyrzyna Peoples, Dr. Cynthia Briggs, and Dr. Chavez-Stuart for your patience and mentorship. Finally, I thank Walden University's Research & Applications for Social Change Grant Program for their generous financial contribution.

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Chapter 1: Introduction to the Study

According to Maguen et al. (2010), over the past 20 years the number of female veterans in the United States has doubled. This increase in female veterans has been driving new areas of research to address the needs of this growing population with respect to health care and the unique needs of women veterans. Studies have shown that female veterans with chronic illness are more likely to have co-occurring mental health diagnoses (Haskell et al., 2010; Shen et al., 2010). There are several barriers that prevent female veterans from receiving the integrated care they deserve. Haskell et al. (2010) found that women who had experienced trauma also reported higher levels of co-occurring mental and physical illness. According to Sayer et al. (2009), female veterans who have both mental and physical health diagnoses tend to be referred by their primary care physician for mental health care. However, not all primary care physicians may be aware of their patients' need for mental health care due to the focus of physicians on the physical health of their patients (Sayer et al., 2009). If, however, patients are referred to mental health care by their primary care physician, they may not follow through due to the perceived stigma of mental health care (Sayer et al., 2009).

Background

Studies addressing the need for health care services of female veterans in rural areas of the United States have shown that most female veterans needed more local health care options (Aylward et al., 2012, Brooks et al., 2016; Cyr et al., 2019). Those options in order of importance were dental, mental health, family planning, interpersonal violence, mammography, and sleep clinics. Female veterans in rural areas discussed the difficulty

they had with access to mental health care for nonurgent issues when suicidal ideation was not present (Brooks et al., 2016).

Sayer et al. (2009) found that when health care utilization (HCU) factors of *predisposing*, *enabling*, and *need* were identified, veterans felt more supported. As a result, the veterans were successful in seeking and securing care for medical health issues. The lens of HCU theory provided a framework for investigating how female veterans experience the process of determining the possible ways in which they seek mental health counseling.

In this chapter, I provide the background for studying the problem of female veterans in rural areas seeking mental health care. I also explain how this study extended previous research related to locating mental health services in the rural areas in the United States.

Problem Statement

A gap existed in the counseling literature regarding the experiences of female veterans finding mental health care services in rural areas. This problem was current, relevant, and significant to the discipline of counseling because findings may inform counselor educators and supervisors about the lived experiences of female veterans seeking mental health care while living in rural areas of the United States and the challenges they face in the process. Although some research Sayer et al. (2009) suggested factors that influence female veterans and their medical health care seeking behavior, more information was needed to know what factors influence female veterans' mental health care seeking behavior through counseling. For example, mental health stigma may

affect women veterans' decision-making process regarding mental health counseling services (Sayer et al., 2009). Why stigma may affect their decision-making process might suggest external or internal factors addressed by HCU theory.

External factors such as military mindset and cohesion in which the pack or team stays together to solve a problem and in which separation from the pack may go against deeply embedded military training may be relevant. The term "battle mind" reflect the military mindset and the needed resilience on the battlefield; however, this aggressive training may be displaced upon veterans' return after deployment. The family unit at home after deployment may suffer with the continuation of the battle mind mindset. This mindset has the potential of carrying over trained behaviors that demand discipline and cohesion by family members and has the potential of initiation of domestic violence behavior (Savitsky et al., 2009). In this regard the military family and its relationships can be perceived as the same as the civilian familial relationships. The individual influences the family, so the family influences the individual in "feedback loops that are never ending" (Stevens & Smith, 2009, p. 246).

Rural female veterans may have a situational conflict in which they are unwilling and unable to talk about problems from their military family of origin. The sequence of this feedback loop of cohesion proceeds as follows: "(a) ambiguity, (b) structure, (c) increased risk taking, (d) increased cohesion, and (e) increased personal responsibility" (Bednar et al., 1974, p. 34). Military cohesion, like the family of origin cohesion, could work to the disadvantage of female veterans and could result in them not seeking mental health counseling. Cohesion can shape various role expectations of female veterans

(Bednar et al., 1974). Internal factors such as the fear of judgment by friends, family, and military cohort members who may think female veterans are unfit as a parent, spouse, or colleague may bring unwanted attention to themselves and discourage mental health care seeking behavior.

Counselors may benefit from the current study by learning about and understanding the lived experiences of female veterans who are seeking counseling in rural areas. Counselors may benefit from a better understanding that informs their practice regarding what factors affect the mental health seeking behavior of female veterans who live in rural areas. Learning about the experiences of female veterans living in rural areas may reveal new insight regarding how to serve female veterans because there are more returning to civilian life than ever before in U.S. history. This contributes to the need for more counseling services available.

It was unknown what factors in female veterans' lived experiences contribute to whether they seek counseling services. If findings indicate barriers to accessing counseling services, this information could inform counseling practitioners and encourage them to implement policy changes to improve access by reducing barriers. The military mindset of cohesion in which the group of individuals moves as one may suggest that there may be a problem with an individual reflecting poorly back to the group. Although this is beneficial during war, it is not beneficial to the mental health care of the individual. Individuals may be resistant and discouraged from reaching out to seek mental health care because it may be perceived as a betrayal of their military mindset,

which may be likened to a family betrayal. A person does not betray their family and expect to be supported without judgment or exclusion.

The increased number of female veterans returning to civilian life requires more counseling practitioners to be aware of how cohesion may interfere with female veterans not reaching out for mental health care even when referred by medical practitioners. This may also affect the follow-through with treatment plans once female veterans engage with a counseling practitioner. In the current study, I explored the lived experiences of rural female veterans regarding counseling and health care services, and how those experiences affect their mental health counseling seeking behavior.

The literature did not address how stigma might influence rural female veterans' mental health care decisions. Sayer et al. (2009) suggested that veterans tend not to reach out into the community for support regarding health issues, possibly because they may be too proud to ask for assistance, or because there is stigma associated with health care. The awareness that stigma may affect the seeking of mental health care by female veterans may benefit counselors by encouraging them to create more sensitive approaches to treatment planning. Regarding treatment planning for this population, I explored the topics of stigma and military cohesion and how they may impact the female veteran's life after military duty. HCU theory comprises three factors including predisposing, enabling, and need and has been used with applications for mental health care, specifically post-traumatic stress disorder (PTSD; Andersen & Newman, 1973, 2005). Predisposing factors refer to the likelihood of individuals using health care services based on characteristics such as where they live, social class, and their beliefs

about health. Enabling factors refer to resources such as income, insurance, and access to health care. Need factors, including the need for health care services, are based on individuals' perceptions of their perceived symptoms and diagnoses (Sayer et al., 2009).

While addressing the need for health care services of female veterans in rural areas in the United States, Brooks et al. (2016) reported that most female veterans needed more local health care options. Those options in order of importance were dental, mental health, family planning, interpersonal violence, mammography, and sleep clinics. Female veterans in rural areas discussed the difficulty they had with access to mental health care for nonurgent issues when suicidal ideation was not present (Brooks et al., 2016). The findings indicated a gap in the counseling field and the recruitment of future counselors because there was not enough interest in working in a rural environment due to lower potential income compared to metropolitan areas of the country. Due to the lower potential income in rural areas, they attracted new graduates to the counselor field to gain experience but then lost them once they gained that experience and moved to better paying areas of the country. Without the anchor of stability of counseling practitioners in rural areas, the quality of care was found to be less than in nonrural areas.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore and understand the lived experiences of female veterans in rural areas in the Unites States regarding seeking mental health counseling services. Female veterans in rural areas are reluctant to seek mental health services (Bednar et al., 1974) because of stigma, distance and quality of care available. The current study explored ways to address the counseling

needs of the increasing numbers of female veterans returning to civilian life, particularly those in rural areas where health care services are limited. Findings may be used to mitigate the barriers of stigma that exist regarding mental health care in the civilian and military mindset.

Research Question

What are the lived experiences of rural female veterans who seek mental health counseling?

Theoretical Framework

Hermeneutic phenomenological philosophy created by Heidegger was the theoretical foundation through the lens of HCU theory to understand the lived experiences of female veterans pertaining to mental health counseling in the current study. According to Wrathall (2005), hermeneutic phenomenology emerged from Heidegger's philosophy that transcends traditional contemporary philosophical principles, rejecting scientific empiricism including modern technology. This philosophy is a direct reflection of Heidegger's German pseudo-existentialist worldview with the exception that the worldview is based on a shared world (Wrathall, 2005). The German term *Dasein* and its cyclical nature has significance in how Heidegger saw human beings and viewed how they give meaning to their sense of being and at the same time how it relates to them as beings (Wrathall, 2005).

One of the major tenets of Heidegger's philosophy was based on *Dasein* as a way of being in the world, and included the hermeneutic phenomenological approach in which researchers must remain aware that they cannot separate themselves from their

preconceptions when working with participants. Preconceptions change and grow as new information and experiences are introduced. The hermeneutic circle creates this continuity of preconceptions that morph and change. Although there are always preconceptions, people experience a paradigm shift based on the continuous intersection of their unique lives and the changing world around them. This phenomenology requires the researcher to "stick with things that appear in experience and learn to see them in such a way that they show up as they really are" (Wrathall, 2005, p. 125).

Although researchers are required to remain professional and unbiased when collecting and analyzing data, it is not entirely possible. Researchers carry an innate bias with which they insert their worldview when they enter the research arena. This is distinct and separate from any additional theoretical lenses such as HCU theory.

HCU theory comprises three factors: predisposing, enabling, and need. Predisposing factors refer to the likelihood of individuals using health care services based on characteristics such as where they live, social class, and their beliefs about health. Enabling factors refer to resources such as income, insurance, and access to health care. Need factors refer to the need for health care services and are based on an individual's perceptions of their perceived symptoms and diagnosis (Sayer et al., 2009). HCU theory was used as the lens with which I conducted this hermeneutic phenomenological study.

Nature of the Study

The nature of this study was qualitative and the research design I used for data analysis was the hermeneutic phenomenological design through the lens of HCU theory within the Heideggerian framework. HCU theory was created as a hybrid of sorts within

the hermeneutic phenomenological methodology (Wrathall, 2005). This approach informed my collection of data through interviewing female veterans living in rural counties in the United States about their lived experiences.

Definitions

The following terms are defined as they were used in this study:

Dasein: A German term used from Heidegger's hermeneutic phenomenology referring to "being-there" and is part of creating a common understanding of the circumstance (Wrathall, 2005).

Enabling: The subcategories of family and community where family collects information about income, health insurance, and access to care, while community inquiries about region of the country and access to health care facility (Andersen & Newman, 1973, 2005).

Female veteran: Female veterans living in rural areas of the United States who served at least 2 years of active duty. These veterans served active duty in any branch of the United States Armed Forces. These veterans identified as having had mental health challenges and were residing in a rural area in the United States (Health Resources and Services Administration [HRSA], 2021).

HCU theory: A theory comprising predisposing, enabling, and need factors used as societal determinants of medical care utilization in the United States (Andersen & Newman, 1973, 2005).

Hermeneutic circle: The cyclical reflection of the continuity of preconceptions that morph and change that are experienced as a paradigm shift based on the continuous

intersection of lives and the changing world external to individuals. I needed to understand the whole that informs the parts and understand the parts that inform the whole (Wrathall, 2005).

Mental health services: Specialty clinics staffed by mental health professionals such as psychiatrists, psychologists, and counselors with expertise in mental health or substance use disorders. These clinics evaluate and treat patients with mental health conditions or substance use disorders (Savitsky et al., 2009).

Mitsein: A German term used in Heidegger's hermeneutic phenomenology that refers to "being-with" and correlates with Dasein as a naturally coexistent creation of a common understanding of the circumstance (Wrathall, 2005).

Need: Information from individuals' perceptions and reality regarding illness level when seeking mental health care symptoms and diagnoses, while confirming actual symptoms and diagnoses (Andersen & Newman, 1973, 2005).

Predisposing: The application of subcategories including demographic, social structure, and beliefs with demographic information addressing age, sex, and marital status, social structure addressing education, race, occupation and ethnicity, and beliefs addressing attitudes toward health care and illness (Andersen & Newman, 1973, 2005).

Rural: A county in the Unites States that has seven residents per square mile (on average) but not more than 500 residents per square mile (HRSA, 2021; Savitsky et al., 2009).

Thrownness: Heidegger's term for the way that people find themselves "thrown" into or "delivered over to circumstances that are beyond our control" (Wrathall, 2005, p. 43).

Veteran: A person who has served in any branch of the United States Armed Forces and is no longer serving. Military veterans who have served directly in combat or in a war may be further defined as war veterans.

Assumptions

I made the assumption that female veteran participants understood their qualifications necessary to participate in this study. I also assumed that participants were forthcoming regarding their lived experiences during interviews. My personal assumptions from personal experiences were as a female mental health counselor and that the participants may reveal additional topics or issues specific to female veterans that were beyond the scope of this study. In Chapter 3, I describe my bias-prevention measures employed to promote trustworthy research.

Scope and Delimitations

The scope of my study included female veterans living in a rural county in the United States (see HRSA, 2021). Inclusion criteria were that participants needed to be female veterans who were 18 years of age or older. These female veterans must have served at least 2 years of active duty and identified as having had mental health challenges.

Limitations

One limitation of this study was the location of the participants. All participants were required to live within rural counties within the United States. Rural counties within the United States were defined as of residing within a rural county within the Unites States that have between 7 residents per square mile (on average) but not more than 500 residents per square mile (see HRSA, 2021). One other limitation of this study was the race of the participants. All the participants reported as White within their rural counties within the United States.

Significance

This study was significant because it could help counselor educators and supervisors understand the behaviors of rural female veterans who need mental health counseling. This study may encourage social change with rural female veterans seeking mental health services and the factors influencing their decision-making process. When female veterans advocate for mental health counseling for themselves, they are influenced by their communities' awareness.

Self-awareness is encouraged by supporting important roles female veterans perform when returning from active duty. Examples of these roles are spouse, mother, colleague, and adult child. Supporting the return of female veterans in these roles through awareness and advocacy is a responsibility that should be shared by the military and civilian communities as stakeholders. The collaboration of the two communities has the potential to affect social change with respect to policy implementation for healthy postdeployment transitions. Collaboration with mental health care practitioners and other

community stakeholders can benefit this population by implementing institutionalized goals, shared responsibility, accountability for success, and shared rewards (Osher, 2002). The results of the current study may inform counselor educators and supervisors regarding the factors that contribute to or detract from mental health care seeking behaviors among rural female veterans. The results may support the mental health needs of rural female veterans and may promote healthy families and communities. This study highlighted the needs of female veterans in rural areas where hospitals and service centers are not easily accessible.

Summary

In this chapter, I began with a brief background of HCU theory and its use in this study. I followed with the problem statement, purpose of the study, and research question guiding this study. I also provided a description of the theoretical framework and operational definitions to help the reader understand the terms used in the study. I concluded with the significance of the study and a transition to the literature review in Chapter 2.

Chapter 2: Literature Review

I was inspired to conduct this study through my military family members and the problem that health care is not readily available in rural areas. Studies conducted in rural areas presented evidence of the problem (Freedy et al., 2010; Maguen et al., 2010; Mattocks et al., 2010; Sambamoorthi et al., 2010; Shen et al., 2010; Stecker et al., 2007). Research showed that barriers to care with respect to geographic distance from health care services, shortcomings with lack of access to gender-specific counseling and mental health care services, and preexisting conditions such as PTSD and military sexual trauma (MST) may contribute to the lived experiences of female veterans seeking mental health counseling (Freedy et al., 2010; Maguen et al., 2010; Mattocks et al., 2010; Sambamoorthi et al., 2010; Shen et al., 2010; Stecker et al., 2007). The purpose of the current study was to provide insight into the subculture of female veterans in rural areas and to explore their lived experiences related to the perception of mental health counseling. Nastasi et al. (1998) suggested that culture should include references to factors beyond race and ethnicity such as gender, age, regional location, socioeconomic status, sexual orientation, and specific family traditions and values. Rural counties in the United States have unique cultures that affect the mental health counseling seeking behavior of female veterans.

Literature Search Strategy

I began the literature search strategy using the Walden University Library and databases such as Academic Search Complete, EBSCOhost, and PsycINFO. This search strategy included academic journals, peer-reviewed articles, and publications pertinent to

veterans in the United States. The initial keywords I used kept the search broad enough to encompass male and female veterans and topics such as medical care, health care, primary health care, and mental health care. I narrowed the literature search strategy by including keywords such as *barriers to mental health services for female veterans*, *women military*, *women veterans*, and *health care for female veterans and women veterans*. More keywords included *rural mental health care, rural health care, depression, PTSD, MST, health care*, and *counseling*.

Theoretical Foundation: Hermeneutic Phenomenology

I used a hermeneutic phenomenological framework described by Wrathall (2005). The Heideggerian framework, which has its origin in the hermeneutic phenomenological approach, was the theoretical foundation for this study, and was applied through the lens of HCU theory (see Andersen & Newman, 1973, 2005). The primary point of hermeneutic phenomenology is that if people are going to transcend current philosophy in research, they must reject empiricism. Empiricism must be rejected because people's perceptions are always based on a shared worldview (Wrathall, 2005). Heidegger saw human beings both observing and giving meaning to their world through *Dasein. Dasein* is a concept that focuses on preconceptions that exist within all researchers that cannot be separated when working with participants. These preconceptions change and grow through the continuity of the hermeneutic circle as researchers evolve with new information being introduced**.** Phenomenology requires the researcher to remain unbiased and aware of the innate bias of all researchers. I analyzed data from audio and video recordings after interviewing female veterans from rural counties in the United States

about their lived experiences, and I used hermeneutic phenomenological methods and applied the lens of HCU theory.

Lens: HCU Theory

HCU theory and its components of predisposing, enabling, and need factors was derived from the work of Andersen and Newman (1973). Predisposing factors refer to the likelihood of individuals using health care services based on characteristics such as where they live, their social class, and their beliefs about health. Enabling factors refer to resources such as income, insurance, and access to health care. Need factors for health care services are based on individuals' perceptions of their perceived symptoms and diagnoses (Sayer et al., 2009).

HCU theory was used as a societal determinant of mental health care utilization among female veterans in the rural counties of the United States. The theory is a societal determinant of medical care utilization in the United States. I used this theory as a lens and applied hermeneutic phenomenological methods.

HCU Theory Overview and Research

Predisposing factors include subcategories of demographic, social structure, and beliefs with demographic addressing information regarding age, sex, and marital status, social structure addressing education, race, occupation and ethnicity, and beliefs addressing attitudes toward health care and illness (Andersen & Newman, 1973, 2005). Enabling includes subcategories of family and community where family information addresses income, health insurance, and access to care while community information addressed region of the country and access to health care facilities (Andersen & Newman,

1973, 2005). Need if the third component of HCU theory used for this study. I gathered information that applied to individuals' perceptions and reality regarding illness level when seeking mental health care. I also gathered information about participants taking into consideration the possibility of disability and symptoms of any diagnoses.

Concepts of the Theory Applied to Female Veterans

I applied a qualitative hermeneutic phenomenological interview approach using the lens of HCU theory within the Heideggerian framework. HCU theory and its concepts were applied in the hermeneutic phenomenological methodology. I used this approach when analyzing the data I gathered through interviewing female veterans from rural counties in the United States about their lived experiences in seeking mental health care.

Health Care for Veterans in the United States

Veterans in the United States have received postwar health care as early as the British colonial settlers were present on the North American continent. Laws began to be created to provide relief for disabled or sick soldiers. The Continental Congress in 1776 provided half pay for life for officers as the inception of pensions. The Revolutionary War saw a pension program for over 70,000 soldiers, sailors, and widows (Burtin, 2020).

During the Civil War (1861–1865), pensions continued to be adopted until 1862 and were expanded to include all former soldiers and their survivors and by 1907 included all Union veterans older than 62 regardless of disability (Burtin, 2020) Pensioners grew to 900,000 by 1910, and for the first time the United Stated formed the Pension Bureau (Burtin, 2020). The Civil War produced around 2.2 million veterans on the Union side, and new kinds of benefits were introduced that included homes to care for

the old and indigent. Despite The War Risk Insurance Act of 1917 encouraging veterans to return to civilian life as quickly as possible and pay all debts that may be owed when discharged, it included $10,000 in affordable life insurance. This was the beginning of limited pensions for disability or death occurring in the line of duty and allowed veterans medical care and rehabilitation services hoping to heal their "impairment and return them to a productive status as wage-earners once and for all" (Burtin, 2020, p. 8).

By 1932 the Veterans Administration (VA) saw more than 43,000 veteran patients in hospitals treated for non-service-connected disabilities, a dramatic increase compared to 1925 when they made up only 14% of 26,000 patients (Burtin, 2020). This increase in benefits was not welcomed by the public, and in 1933 President Roosevelt cut $460 million in veterans' programs for veterans of World War I; however, pensioners repealed that decision and those programs prior to World War II were reinstituted for veterans. The framework of the VA in 1930 set into motion the clearinghouse for the health care for all veterans in the United States: the G.I. Bill. The G.I. Bill of Rights passed by Congress in 1966 fueled political power for all veterans serving after 1955 with educational and vocational training as well as housing assistance and was a powerful political ally. The Vietnam War and exposure to the herbicide Agent Orange and its dioxin contaminant as well as the politically sensitive sentiment did not see its own committee on veterans' affairs in the Senate until 1970.

Independent reports of exposure to chemical warfare, especially after Operation Desert Storm, showed many veterans with debilitating symptoms years later because of chemicals. Troops typically being on the move made it difficult to track health issues

longitudinally, which created a need for a registry. A 1991 law required registries to be created that included the *Millennium Cohort Study* and *Millennium Cohort Family Study* as ways to increase connectedness between military service and health problems (McCauley & Ramos, 2020).

Approximately 1.8 million female U.S. veterans and 200,000 women on active duty helped to create the development of two decades of women's health services and the beginning of the integration of mental health services. Although the VA has begun integrating mental health services with primary care, there has been a continuous push for coordination with U.S. health care systems because more than half of all veterans seek health care services outside of the VA (McCauley & Ramos, 2020). Reports of long waiting times for access to health care services may be one reason for turning to civilian health care services. The Choice Act of 2014 and the VA MISSION Act of 2018 inspired collaboration between the VA and civilian health systems to gather more data on the availability and quality of care for veterans (McCauley & Ramos, 2020). What needs to happen for health care data collection during and after military service is coordination between the U.S. health care system, the Department of Defense, and the VA to evaluate the "physical, mental, and psychosocial drivers of health among service members and veterans" (McCauley & Ramos, 2020, p. 1804).

Mental Health Care Issues of Veterans

Mental health care issues of veterans, both male and female, seem to be related to their perception of mental health care stigma and whether they initially sought primary health care and were also referred to a mental health care provider or were already

receiving mental health care when they sought primary health care. According to Johnson and Possemato (2020), veterans already receiving mental health care were more likely to have a positive perspective of mental health and to have achieved a higher education level, and they were less likely to have served in the Vietnam era. Johnson and Possemato concluded that "patient perceptions of symptoms as a cause for concern and beliefs about mental health treatment are highly related to treatment utilization in veteran and military populations" (p. 18).

Lack of Integration of Primary Health Care and Mental Health Care Services

Research on the lack of integration of primary health care and mental health care services has come under the radar of the VA in recent years. According to Leung et al. (2020), one of the largest studies of over 5 million primary care patients in 396 clinics measured the percentage of veterans who saw a primary health care clinician along with any other specialist such as mental health care providers between May 2017 and July 2020. This study was conducted to revisit whether the VA's Primary Care-Mental Health Integration program expanded access to mental health care for women to the degree it had for men. Overall, when men and women accessed primary care, there was an increase in outpatient service use for male veterans if the clinics also had mental health care integration; however, for female veterans accessing the same services at the same facilities, results showed that there was a reduction of use of almost 75% (Leung et al., 2020). When looking more closely at utilization by male and female veterans, Leung et al. confirmed that men tended to seek care for their unmet needs by accessing mental

health and primary care practitioners while women sought care for their unmet needs by seeking only primary care practitioners.

Despite women veterans reporting twice the rates of mental health symptoms with depression and anxiety as their male counterparts, they continued to access mental health services differently (Leung et al., 2020). There have been additional and related studies by Leung et al. (2019) involving more than 5 million primary care patients in Veterans Health Administration (VHA) clinics from 2013 to 2016. These studies showed the importance of encouraging female veterans to access mental health care services and implementing integrated care. Integrated care, although costly, appears to be a necessary investment in moving toward a multidisciplinary approach within the health care system in supporting female veterans' mental health care utilization (Leung et al., 2019).

Reluctance of Veterans to Seek Mental Health Services

According to Morgan et al. (2000), reluctance of veterans to seek mental health services may be influenced by two factors: (a) beliefs connected to mental health problems and (b) where veterans can access mental health care services. Common mental health problems may include PTSD, depression, and suicidality. However, many veterans feel stigma toward anyone seeking treatment for mental health problems and these disaffects seeking help, which deters help seeking (Morgan et al., 2020).

Despite these attitudes, there are efforts being made with programs such as the Real Warrior Campaign and Buddy-to-Buddy, which include peer educators to reduce help-seeking stigma (Morgan et al., 2020). These programs reach out to veterans and attempt to remove barriers to the access to care as opposed to the veteran hesitating to

visit a physical mental health clinic as a first point of contact. This approach attempts to change how services are delivered. Prior research supported the approach with these programs and found that veterans with a probable diagnosis of PTSD were 50% more likely to use a program if stigma reduction information was provided (Morgan, et al., 2020). This information increased the motivation to utilize the program compared to veterans without PTSD (Morgan, et al., 2020). However, this overall push to establish programs that encourage acceptance of help-seeking norms developed for the military and veterans to foster a new norm within the culture has not been evaluated for effectiveness.

Women Veterans

Women in the Military

The history of women in the U.S. military began with introducing women due to a need for more soldiers during the last two years of World War I. At that time, approximately 33,000 women served in some form of medical and support staff and functioned primarily within the Army (Carr, 2020). The 1948 Women's Armed Services Integration Act was the initiation of congressional approval for women to serve in noncombat positions. Thirty years after the Integration Act's passage, the U.S. military opened the doors for women to pursue leadership positions including officers. Academies afforded women the opportunity to pursue elite military training and leadership positions as officers (Carr, 2020).

Dr. Williamson Murray, a Yale professor and veteran, noted that servicewomen during Operation Iraqi Freedom helped to improve the atmosphere and contributed to

cohesion within their squads (Carr, 2020). Overall, the utilization of voluntary female enrollees during both World Wars was successful and has produced highly qualified recruits since then. However, not all efforts to increase the percentage of female military personnel have been successful, and as a result, some woman recruits have performed poorly, have been the victims of negative stereotyping, and have dropped out (Carr, 2020). This was evidenced in 2003, during a Nasiriyah situation, where an entire unit was killed, wounded, or captured because of basic errors due to low basic training standards (Carr, 2020).

The Nasiriyah situation resulted in a re-focus on basic training suggesting a better understanding of how the female body develops physical strength. Currently the U.S. Army has acknowledged physical differences and developed the Army Physical Fitness Test and a different scoring system for women. For example, as of 2019, the pull-up standards for women became increasingly successful and were seen as helpful (Carr, 2020).

The War in Afghanistan represents the most recent gender shifting climate for women throughout the U.S. military. The creation of Female Engagement Teams to help with counterinsurgency and an attempt to win over the local populations saw women soldiers sent to engage Afghan women (Keohane & Jakes, 2021). American men in this environment were not allowed to talk to Afghan women privately and because a military rule prevented women soldiers from participating in dangerous missions, the U.S. forces came up with this creative solution. It is being seen that women are valued for their differences in war zones where gender difference is beneficial. Congressman Leon

Panetta recommended that if female veterans choose to put their lives on the line, they should now be allowed to serve in combat roles after female engagement teams were proven effective and successful (Keohane & Jakes, 2021).

Although the number of women in the military varies by service, by the 1973 draft women represented approximately 10% of the those enrolled as either enlisted personnel or officers (www.cfr.org). According to Savitsky et al. (2009) the number of women veterans increased from 2003 to 2012 by 80%. As of 2018 this number grew to approximately 16% for enlisted and 20% for officers respectively. As of March 2021, there were a grand total of 234,685 women enlisted in the Army, Navy, Air Force, and Marines (www.cfr.org) with women accounting for about one-fifth of the officers in every military service.

Health Care Needs of Women Veterans

According to Savitsky et al. (2009), more than half of women veterans accessed outpatient health care facilities, whether VHA or non-VA, with approximately 88% visiting a primary care doctor at least once a year. Women veterans seek primary health care in greater numbers than their male counterparts were more likely to use non-VA Medical Care (31% vs. 15%) with some of the difference accounted for by the need for mammograms (Savitsky et al., 2009). Women under 40 years of age rated a higher need of reproductive condition related care with those 40 or older requiring endocrine, metabolic, or nutritional care, and those 60 years or older reporting the need for cardiovascular and musculoskeletal condition care.

In a recent study that addressed the health care needs of female veterans soliciting open-ended responses, it was found that two-thirds (67%) offered praise for the VA, while (26%) reported feeling uncomfortable or harassed (Moreau et al., 2020). Suggestions for change or improvement were directly related to the VA staff (31%), the care setting (18%), additional and clinical services for women specifically (33%), and the awareness of the need for changing the behavior towards women veterans needs as well as equal care to that of their male counterparts (10%; Moreau et al., 2020). The results of this research study were important in assisting health care settings for women veterans to become more inclusive with attention to staff training. The research study results were important for women veterans in an otherwise male-dominated environment with a specific focus on addressing harassment through the system levels.

Prenatal Care

Mattocks et al. (2010) found that women veterans discharged over a 7-year period who were enrolled in Veterans Health Administration care and pregnant were twice as likely to have a diagnosis of depression than those not pregnant prior to discharge. Those pregnant prior to discharge were twice as likely to have diagnoses of PTSD, anxiety, bipolar disorder, and schizophrenia than those not pregnant (Mattocks et al., 2010). According to the authors, the rate of diagnosis of PTSD and bipolar disorder was much higher due to the inability of the VHA to provide routine prenatal care at most locations due to a lack of coordination of primary and mental health care. Cases of diagnosed psychiatric disorders during pregnancy were higher than their civilian counterparts. If there is lack of coordination between primary and mental health care facilities within the

VHA, it may follow that the same lack of coordination of services may be worse for female veterans living in rural populations.

Interestingly pregnant women veterans had twice the rate of multiple mental health diagnoses such as anxiety, depression, and PTSD than did nonpregnant women veterans. Approximately two thirds were diagnosed with PTSD and depression, and more than half were diagnosed with bipolar disorder which was a big difference from only a few percent of women being diagnosed with anxiety disorders prior to pregnancy (Mattocks, 2010).

Mental Health Care Needs of Women Veterans

Across all age ranges the need for mental health care was rated among the top three conditions needing treatment (Savitsky et al., 2009). When women veterans sought outpatient care regarding mental health for substance use disorder, more women than men accessed these services, 14% vs, 8% respectively (Savitsky et al., 2009). Women veterans who accessed mental health care were typically diagnosed with major depressive disorder, depression, PTSD, and anxiety disorders which were represented across all age groups. The mental health and substance use disorder conditions that were more common with women than their male counterparts were eating disorders, dissociative disorders, and acute stress disorders (Savitsky et al., 2009). A correlation was found between women veterans reporting any service-combat disability rating and the likelihood of also having a mental health or substance use disorder condition across all age ranges.

Specific Mental Health Issues of Women Veterans

Women veterans are the fastest growing segment of new health care users in the VA (Hamilton et al., 2020). In gaining a better understanding about this segment of the population, specific mental health issues that women veterans face was one focus of the research by Hamilton et al. (2020). This research required surveying VA primary care and mental health providers. These researchers then interviewed women about experience with treatment needed, care provided, and their perception of evidence-based treatments applied. The results of this research reflected struggles with how to offer services that resembled collaborative care while taking into consideration various factors such as comorbidities, psychosocial stressors, and an approach that fits this segment of the population. Primary care and mental health care providers concluded that gender-specific care for women veterans was the best approach to improving the quality of comprehensiveness of care in the years to come (Hamilton et al., 2020).

Gender-Specific Issues and Treatment of Women Veterans

Analysis by Haskell et al. (2010) of men and women veterans receiving primary healthcare between 2001 and 2006 indicated that symptoms of PTSD and depression were somewhat less for men compared to women. Women experienced MST at a rate of 14% compared to men at 1% (Haskell et al., 2010). Recommendations that were made for gender-specific treatment could benefit females but it is limited in rural areas suggesting a need for mental health care service access in those areas.

A sample of women veterans in a study by Stecker et al. (2007) had a greater rate of diagnosis than their male counterparts (co-occurring with substance use) of major

depression or bipolar disorder strongly associated with lack of outpatient treatment participation. Women veterans were more likely than men to be diagnosed with PTSD, anxiety, and personality disorders (Stecker et al., 2007). Women veterans with substance use disorders were reluctant to seek help alongside men in the same facilities. The authors concluded that women veterans would benefit from separate treatment facilities.

Furthermore Kelly et al. (2008) found that military sexual assault participants rated the quality of VHA services lower than non-military sexual assault participants. Along with this was the belief that VHA care catered more to men, and that this interfered with their use of services while contributing to perceived barriers to care. They reported that they encountered "more problems with accessing women-specific services, problems with VHA doctors/staff, and the ease of using VHA services" (Kelly et al., 2008, p. 744). This may contribute to women veterans living in rural areas with less access to mental health care facilities being less likely to travel greater distances to seek treatment due to the perception of that treatment being male-centric.

Researchers in this project travelled to various medical facility settings and observed if there were barriers to women veterans' access to gender-specific care. The results indicated that barriers included limited trained providers, inefficient referrals, and lack of coordination with providers compounded by various psychosocial factors such as childcare (Marshall et. al., 2020). Administrators within the VA have suggested that they are beginning to make changes that result in gender-specific trained staff and facilities, more frequent and longer sessions for women veterans, updates to security and patient privacy, as well as increasing the choices of providers. While this is a positive change for

women veterans in urban and suburban communities, researchers have yet to reveal the impacts in underserved communities (Marshall et. al., 2020).

PTSD

Male and female patients, according to Freedy et al. (2010), who sought primary care services at one of four VA health centers were evaluated for symptoms of depression, interpersonal violence, PTSD, and physical and sexual violence related to warzone exposure. Women were more likely to experience PTSD associated with sexual victimization than their male counterparts. The results of this research project suggest that female veterans would benefit from mental health care due to higher reports of sexual victimization. VA health centers are typically located in highly populated areas of the country and may not address mental health care access for females in rural areas.

The number and types of traumas as well as social factors combined may contribute to understanding women veterans' higher rates of PTSD compared to the civilian population (Lehavot et al., 2018). Women diagnosed with PTSD tend to experience higher rates of medical and surgical procedures and are at a higher risk for mental health and substance use disorders. Conversely those diagnosed with major depressive disorder might develop PTSD due to trauma in the war arena. This diagnosis of major depressive disorder includes MST with rates increasing proportionately with exposure (Lahavot et al., 2018).

Further study of connections to health care access and utilization may highlight whether care is appropriate and where there may likely be opportunities for intervention or referral that are overlooked (Dorcas et al., 2006). Additionally, Savitsky et al. (2009)

found that traumatic events contributing to the development of PTSD include, “sexual trauma, seeing dead bodies, being injured, killing others, seeing others killed, and having friends killed” which should be additive to enhancing care through questions addressing trauma (p. 333). Military veterans from the Vietnam and the Afghanistan/Iraq wars exhibiting symptom criteria for moderate to severe depression were at risk for hazardous drinking with more than half of female participants experiencing MST with an overwhelming majority meeting the criteria for probable PTSD (Sayer et al., 2009).

Findings confirmed that sociocultural, social networking, and system-level factors play an important role in determining PTSD treatment. Results from this research study suggest that some individuals may be unlikely to seek professional help because of their circumstances of MST or experiences of not perceiving societal validation regarding their trauma (Sayer et al., 2009). Failure to seek professional help was especially true for Vietnam veterans and women with histories of MST. If the stigma of trauma alone can deter access to mental health care for women veterans, geographical distance may only compound this issue ensuring lack of care.

Access to health care service studies of women veterans who experienced MST reported less satisfaction overall with the VHA services and staff and when compared to men who were more likely to screen positive for MST by a ratio of 14 to 1 (Kelly et al., 2008; Liebert et al., 2010). Sensitivity to gender differences to care, especially with female veterans diagnosed with MST should inform health services within the VA system.

Continued research by Stefanovics and Rosenheck (2020) with respect to female veterans showed that gender-based differences in treatment lead to symptom reduction and greater program participation where health care programs had a greater length of stay and, as a result, overall PTSD symptoms were reduced. Scores for the various sub-symptoms of PTSD such as, numbness, arousal, reexperiencing past traumas, and irritability, were also significant (Stefanovics & Rosenheck, 2020).

Despite a predominantly male military environment the VHA, PTSD programs for women showed greater improvement than did programs for men with PTSD symptoms. As a result of this research, one major difference between male and female veterans experiencing trauma came to light. The types of traumas that women were exposed to were found to be different than those of their male counterparts (Stefanovics & Rosenheck, 2020) Trauma that women are exposed to more often is sexual in nature. It is thought that trauma that is interpersonally induced leads to more severe symptoms (Stefanovics & Rosenheck, 2020).

Depression

In a study by Maguen et al. (2010), women veterans' mental health diagnoses were extracted from their medical health records diagnosing PTSD, depression, anxiety, alcohol use disorders, substance use disorders and eating disorders. Female veterans who were younger were more likely to be Black and were more likely to have received a depression diagnosis than were their male or White veteran counterparts. Older age was associated with a higher prevalence of PTSD and depression diagnoses among women veterans but not among men (Maguen et al., 2010). Younger, older, and Black women

veterans needing access to non-existent mental health care may reside in many rural communities.

Military Sexual Trauma

Research on reports of MST from women veterans shows they often prefer to seek out medical and mental health care in non-VHA facilities but not solely because of disappointment with prior care at VA facilities (Monteith et al., 2021). The disappointment rating was labeled as institutional betrayal. A relationship between MST and those reporting institutional betrayal had some effect on the willingness of MST survivors overall to lean towards using non-VHA medical care. However, a greater association was made for willingness to use non-VHA mental health care, non-VHA institutions, and their respective providers (Monteith et al., 2021). The conclusion was that VHA and non-VHA institutions and providers should be prepared to care for women veterans experiencing MST and institutional betrayal specifically with trauma-informed methods of treating and facilitating recovery.

Rural Health Care

A rural health care literature review by Cyr et al. (2019) indicated that while much of the population in the U.S. is rural, only 20% of this population works in and resides in rural areas. This leaves the remaining 80% of the population living in urban and suburban areas. Further rural residents' demographics are typically older, more likely to be uninsured, less educated, have increased poverty rates, are less likely to own their own home, and have high rates of smoking and obesity. These rural residents are also experiencing an increase in "child and young adult mortality" (Cyr et al., 2019, p. 2). In

fact, one large study of more than 9,000 rural residents explored the availability of medical services (Cummings et al., 2013). Results of this study indicated that there was a lack of medical services for this rural population by twice as much as urban and suburban areas (Cummings et al., 2013). According to Cusack, et al. (2022) more recent research found a qualitative study with rural providers themselves, when asked to reflect on access to care for Veterans during COVID-19, reported "a lack of access to medical treatment" and a "lack of specialty medical care in rural areas" with some participants traveling "more than an hour to an hour and a half in any direction from their residence to access a VA or non-VA care facility" (p. e6361). A subsequent study post COVID-19 showed that rural participants' accessing health care saw increased challenges due to the lock down related to increased isolation and challenges associated with "access to healthcare, transportation, and food, as well as increased risks for housing instability" (Hamilton, et al., 2020, p. 5).

Rural Mental Health Care

Aylward et al. (2012), in a study of women living in rural communities who had been diagnosed with breast cancer and were exhibiting symptoms of depression, found that a majority (73%) had to drive more than 30 miles for psychotherapy and cancer treatment, while 17% needed to drive more than 100 miles. Their findings confirmed that depressed women living in rural areas are less able to access needed mental health care than women in non-rural areas. Aylward et al. (2012) emphasized that mental health care will not be equitable until there is a system of health care that provides equal access in rural areas.

Women veterans diagnosed with a chronic physical condition were more likely to be diagnosed with depression. Implications were made for the integration of treatment efficacy. This efficacy requires coordination between medical and mental health services which are often limited in rural communities (Sambamoorthi et al., 2010).

Shen et al. (2010) collected data from women veterans and the VHA/Medicare databases that showed that diagnoses of depression were co-morbid with diabetes and hypertension at rates double that of the civilian population. Depression is an important public health concern and could lead to major depression if untreated. Suggestions were made for the integration of care for depression and chronic illnesses. Women veterans residing far away from VHA facilities may not receive the integration and access to mental health care they need which raises the possibility of a potential public health problem. In a landmark study of veterans (Gill, 2009), PTSD was found to double the rate of medical morbidity and increase additional medical risks in PTSD-affected people.

Medical morbidity was measured by their increased access to VHA services on the VHA delivery systems. This population represents women veterans who are less than 35 years of age. This population increased by over 120%, requiring more reproductive services. As of 2012 women veterans between 50 and 55 will demand greater access to geriatric care with those within the next 10 – 20 years reaching the age of 65 or older. When considering factors beyond age, women veterans in the younger age groups are more diverse racially and ethnically than their older cohorts. The increase in diversity in race and ethnicity not only creates a need for gender-specific care but culturally competent care. Regardless of age, 25% of all women veterans living in rural areas find

the challenges of ensuring “high-quality, equitable, gender-specific VHA primary care services. These women veterans reside in areas remote from the main VHA facilities where numerically low numbers of women reside” (Savitsky et al., 2009, p. 7). When exploring disability ratings of women veterans, Savitsky et al. (2009) found that a greater number of women veterans between the ages of 18 and 44 were likely to have a service-connected (SC) disability compared to men.

Rural Health Care of Veterans

According to U.S. census data in 2014, a higher percentage of veterans (24%) live in rural areas. This is in comparison to all urban veterans (19.3%). However, despite a growing need for physicians, the supply in rural areas indicates a shortage. Compared to urban veterans, veterans living in rural areas experience a greater incidence of disease prevalence with lower physical and mental quality-of-life scores (Albanese, Bope, Sanders, & Bowman, 2020). The VHA, hoping to improve the availability of care, has put forward the Veterans Healthcare Benefits Improvement Act of 2016 to encourage more graduate medical positions in rural areas. Despite their efforts, approximately only 6.4% of resident positions were filled in rural areas. Some of this difficulty has been due to the reduction of partnership options, infrastructure funding, and incentives for residents to train in rural and underserved areas.

As of 2018, the need to support rural and underserved areas got the attention of John S. McCain III and notable officials. The VA MISSION Act 11was introduced with the goal of establishing a more efficient community care program for veterans as well as to modernize and realign resources to expand access to community care through the

Veterans Choice Fund. The hope was that physicians who choose to train in rural areas would remain there after training and continue to serve veterans in rural America.

Rural Health Care of Women Veterans

Research with rural Women veterans show worse physical health functioning compared to their urban counter parts (Cordasco, et al., 2016). This study measured health using the Medical Outcomes Study Short-Form (SF-12); access of regular source of care; health care utilization; unmet needs; and barriers to getting needed care. Results indicated that rural women veterans had less non-VA health care visits compared with urban women veterans and accessed health care facilities a little less than urban women veterans. The study demonstrated that affordability, work release time, and transportation were major factors affecting health care decisions (Cordasco, et al., 2016). The study concluded that disparities in health and health care access for rural women veterans continues to drive the force to meet the needs. Meeting the needs of rural women veterans might require creative ways to deliver care models as part of the solution.

Rural Mental Health Care of Women Veterans

Although the overall number of veterans in the U.S. is decreasing, the number of women veterans is significantly increasing (Ingelse & Messecar, 2016). When evaluating the need for women veterans' access to mental health care, several barriers were found. The first barrier was residing in a rural area. Overall veterans living in rural areas have access to fewer mental health services than urban residing veterans, which is of no surprise. However, women veterans in rural areas have less access to mental health care than their male colleagues, and not much is known about the mental health services needs

of women veterans. What is known is that women veterans have unique problems such as PTSD and MST compared to their male colleagues. Research interviews investigating 10 women veterans accessing mental health care in rural communities reported that all had experienced and needed support for problems related to MST, PTSD or combat trauma. These problems were preceded by events that occurred during active duty that included chronic sexual harassment and ridicule, traumatic sexual assaults, and difficult combat experiences (Ingelse & Messecar, 2016).

Women veterans reported that during active duty, efforts to report mistreatment were unsuccessful or punished (Ingelse & Messecar, 2016). These women reported that if not for a supportive peer, they would not have sought help. However, despite seeking care, barriers persisted to include being made to feel that they were not actual combat veterans, being thought of as lazy, being stigmatized for seeking care, and being subjected to a lack of interest from those providing care in hearing their stories (Inglese & Messecar, 2016).

The results of this study demonstrated the need for continued research on accessible and culturally appropriate mental health services for rural women veterans. This may present an opportunity for counselors who work with rural residents that continue to have unmet mental health care needs by changing the way they practice improving access to care, for example. This opportunity could encourage similar studies in other rural locations such as is the focus of this proposed research study. Counselors working in rural locations could benefit with a better understanding of what rural women veterans need regarding accessible mental health care. The understanding and

accommodation of their needs should not occur outside of the intent to minimize stigma when seeking that care. This could facilitate better communication between counselors and community providers being encouraged to initiate conversations about PTSD and MST in the creation of a better support network for female veterans in rural areas.

Summary

In this literature review, I demonstrated the need to know more about what components of HCU theory influences individual female veterans seeking mental health care, especially in rural areas. It was my hope that the results of this proposed study could inform health care providers regarding the population of female veterans and potential determinants of barriers in accessing mental health care.

This literature review demonstrated that HCU theory was a viable vehicle to be used to collect relevant data from female veterans as an individual determinant of seeking mental health care (Andersen & Newman, 1973; Andersen & Newman, 2005). HCU theory was a powerful tool through the lens of this qualitative hermeneutic phenomenological study to fill in the gaps regarding female veterans affected by PTSD, sexual trauma, depression, integration of care, prenatal care, and gender specific care.

Chapter 3: Research Method

The purpose of this qualitative phenomenological study was to explore and understand the lived experiences of female veterans in rural areas seeking mental health counseling services. In this chapter, I present the research method and design, rationale, and my role as the researcher. I discuss the selection of participants, instrumentation, research procedures, data collection process, data analysis process, and justification for the use of hand coding. I also discuss the threats to validity and reliability with an emphasis on ethical practices.

This study was qualitative, and the research design I used for data analysis was the hermeneutic phenomenological approach through the lens of HCU theory within the Heideggerian framework. HCU theory created a hybrid of sorts within the hermeneutic phenomenological methodology. This approach informed my data collection through interviewing female veterans living in a rural county in the United States about their lived experiences related to seeking mental health counseling services (see HRSA, 2021).

Research Design and Rationale

Research Question

What are the lived experiences of rural female veterans in the United States seeking mental health counseling?

Hermeneutic Phenomenological Qualitative Study

The nature of this study was qualitative, and the research design I implemented for data analysis was the hermeneutic phenomenological approach. I used this design with an additional lens of HCU theory within the Heideggerian framework. The use of

HCU theory in this way created a unique hybrid within a hermeneutic phenomenological design. The qualitative approach was suitable for semi structured interviews of participants and recording information regarding their lived experiences. I recorded participants' responses through interviewing female veterans from rural counties in the United States about their lived experiences.

In this qualitative study, I reviewed audio and video recordings of interviews with participants, transcripts of interview responses by participants, and other documents used to solicit information from the participants as approved by the Walden University Institutional Review Board (IRB) 08-19-22-0087578. I used hermeneutic phenomenological methodology rejecting empiricism, while I collected and analyzed data being mindful that my perceptions were always based on a shared worldview. Heidegger, the creator of this methodological approach, saw human beings as observing and giving meaning to their world through *Dasein. Dasein* is a concept that required me to focus on my preconceptions or biases that could not be separated when working with participants. My preconceptions were likely to change and grow as I gathered new data from my participants. As the data were gathered and analyzed from audio and video recordings through interviewing female veterans from rural counties in the United States, I used a hermeneutic phenomenological design and applied the lens of HCU theory.

My role was as an observer, and I recorded participants' responses to the interview questions. I used the components of predisposing, enabling, and need as I moved through the steps of the study. I applied the hermeneutic phenomenology design during the semi structured interviews to stay mindful of my preconceptions and biases. I

transcribed the interview data for each participant, and 14 final meaning units were identified. As I further transcribed and condensed the data, I looked for how the data fit into the components of predisposing, enabling, and need according to HCU theory. As I assigned the data to those components, similar themes emerged. These themes began to form meaning and began to create a more common narrative for the participants. The gathering, assigning, and analyzing continued in the hermeneutic cycle until formation of a unique meaning and saturation was achieved for all participants.

Role of the Researcher

In the role of researcher and observer, I was also a mental health counselor living in rural New Hampshire. Participants were referred to me, and I had no prior relationship with those who participated in this study. I identified and was aware of my biases and was open to hearing what the participants said. I did not allow my biases to interfere with my analysis of the data collected. One way that I maintained awareness of my biases or preconceptions of participants was to stay open to the idea that those preconceptions may change or morph as new information from participants' lived experiences was shared through interview responses. I believed that female veterans were not seeking or receiving adequate mental health services. I believed this to be true based on several studies indicating that there was a need for basic health care services for female veterans in rural areas (Aylward et al., 2012, Brooks et al., 2016; Cyr et al., 2019). Health care resources include mental health services. In addition, female veterans suffer internal and external stigma related to seeking mental health care. External stigma is a result of military cohesion and internal stigma because of the fear of judgment by friends, family,

and military cohorts not wanting to bring unwanted attention to themselves, thereby discouraging mental health care seeking behavior (Bednar et al., 1974; Savitsky et al., 2009).

I conducted and recorded interviews using the Zoom platform. To the extent possible, I used a platform that was Health Insurance Portability and Accountability Act compliant to conduct interviews to ensure that the privacy of the participants was protected. At least eight participants were required for this study. Nine participants were interviewed to achieve saturation (see Patton, 2001). The interviews were guided by open-ended questions as part of the semi structured interview process. This included asking participants to share additional information beyond the questions initially asked. The additional information provided was the result of conversations and observations that led to more richness in data while strengthening the validity and reliability of the study.

Methodology

Participant Selection

Participants were female veterans living in rural counties of the United States. I interviewed nine participants until saturation was achieved, as recommended when using a phenomenological approach (Patton, 2001). Inclusion criteria were that participants were female veterans 18 years and older who served at least 2 years of active duty and had internet access. Nine interviews were conducted and recorded through the Zoom platform. One interview was conducted in person and was recorded with a handheld digital recorder. I asked participants open-ended questions and the interviews were semi structured informed by components of HCU theory. Fieldwork was not used to increase

the validity of this study. This study involved no member checking, and follow-up interviews were not needed to fill in any gaps in data after transcripts were analyzed.

Recruitment Procedures

I recruited participants by posting flyers in public places. I was granted special administrative access to use social media platforms on Facebook where female veterans might visit. I also reached out to several female veteran organizations by email, such as the American Legion. Participants who indicated interest in being interviewed were contacted by a follow-up email and were provided with an informed consent form. I conducted and recorded interviews using the Zoom platform for eight participants, and conducted one in person with a handheld recorder. All participants except for the one who was interviewed in person had internet access. I followed the interview protocol and asked participants open-ended questions informed by the components of HCU theory. Only data collected from interviews were used in this study. No member checking was used, and follow-up interviews were not needed to fill in any gaps in the interviews.

Purposeful sampling was used because I included both purposive and snowball sampling for the participant recruitment. Female veterans were encouraged to share my invitation within their personal network and social media platforms in rural areas of the United States. Purposive sampling was appropriate for this study because it can "identify cases from standardized questionnaires for in-depth follow-up … [and] can only be used where respondents have willingly supplied contact information" (Patton, 2001, p. 238).

The participants were female veterans who lived in rural areas of the United States who had sought mental health services. With these selection criteria, purposive

sampling was necessary. Snowball sampling was used in anticipation of participant referrals providing greater awareness of the study to more female veterans. I invited female veterans to participate in this study with publicly posted flyers and social media flyers (see Appendix A). I recruited participants by posting the flyer in public places and in social media and email where female veterans might see it. The criteria for recruitment were female veterans who served at least 2 years of active duty, identified as having sought mental health care, and resided in a rural area in the United States (see HRSA, 2021).

Once recruits were willing to be interviewed, I contacted them by email and provided my contact information. I sent them an email with the informed consent form to be read and returned by responding via email with "I consent." I scheduled interviews with the volunteer participants. I asked potential interviewees if they had internet access and were familiar with the application Zoom. All interviewees, except for one, were able to access the internet and the Zoom platform. Phone calls were not used. Before moving on to the interview process, I verbally confirmed via internet or in person that participants were veterans over the age of 18 with at least 2 years of active duty and from the rural United States.

Once interviewees were confirmed by internet or in person, any necessary accommodations were made. Interviewees were sent via email or in person the informed consent form that included the terms of confidentiality. Demographic questions were asked by email or in person prior to interviewing participants. After receipt of returned forms from interviewees, interviews were scheduled.

Instrumentation

I used research to create questions for the interview process. I also developed an interview protocol. Participants were asked to complete a demographic questionnaire prior to their interviews (see Appendix C).

Researcher-Developed Instruments

I used two instruments that I developed to collect data from my participants. These instruments were used to collect personal information from participants that was relevant to the research question and the components of HCU theory (see Sayer et al., 2009). After participants agreed to participate and it was verified that they met the inclusion criteria by agreeing to informed consent, I asked them to complete the demographic questionnaire (see Appendix C). During the interviews, I used the semi structured interview protocol (see Appendix D) to guide the interview.

Demographic Questions

At the beginning of each interview, I asked participants to answer several demographic questions that addressed participants' years of service, if they lived in a rural area of the United States, their income, their race and ethnicity, and other items (see Appendix C). Open ended interview questions followed the demographics questions.

Interview Protocol

After an introductory conversation, I began the interviews by stating why the participants were chosen for the study based on their status as a female veteran 18 years and older with at least 2 years of active duty and who were residing in a rural area in the United States. I asked the participants to describe in detail their experiences seeking

mental health counseling in the rural area where they lived. After the first question, and if I had not already discussed these areas, I asked additional questions related to participants' mental health issues, mental health treatments sought, types of services needed, and how status as a military veteran impacted their access to mental health care in a rural area (see Appendix D). Examples of these questions include the following: What were your experiences with seeking treatment for mental health services since leaving military service? Please describe your experience with the type of mental health services you were seeking and needing at this time. Please describe your experience with any health insurance benefits you have used when seeking mental health services.

Data Collection

I conducted all interviews. I interviewed participants either virtually or in person. Interviews were not coercive because participants voluntarily contacted me after receiving or seeing my flyers. The flyers indicated that this study would be done for Walden University, so it was clear that no other agencies were involved.

I asked participants questions and listened carefully to their responses. Although I am not a veteran, I maintained awareness of potential interference because of my innate biases as a woman and experienced counselor. I confirmed and recorded participants' verbal responses while observing physical reactions that added to the richness of my data collection. I reminded interviewees of the informed consent they had provided, that their participation and disclosures were confidential, and that they could refuse to participate at any time during the interview. I reminded participants that interview data gathered for the purpose of the study would be destroyed 5 years after completion of the project. Each

interview lasted 45 to 60 minutes. Member checking was not used, and no follow-up interviews were needed to fill in the gaps of information with interviews. I thanked interviewees for their contribution and time and ended the interviews. I offered a copy of the transcripts to each participant who requested them. No participants requested copies of their transcripts but wanted to have access to the final published research.

Data Analysis Plan

Hermeneutic phenomenology focuses on the continuously fluid interpretation of context as it is reviewed and revised by the researcher remaining immersed in the evolving process of the hermeneutic circle (Heidegger, 1962). Researchers should, as observers, remain present in the participants' world view of their shared lived experiences when analyzing the phenomenological data. I was informed by Peoples (2020) who recommend Giorgi's (1985) five basic steps for phenomenological data analysis: (a) record verbal data, (b) reading of the data, (c) breaking down the data into some kind of parts, (d) organization and expression of the data from a disciplinary perspective, and (e) synthesis or summary of the data for purposes of communication to the scholarly community. My data analysis steps were as follows:

1. Print and read the entire transcript for each participant and deidentify each participant's transcript while numbering and highlighting preliminary meaning units for each participant on the paper transcript.
2. Organize, condense, renumber and relabel preliminary meaning units' and record that data by participant.

3. Further organize, condense, renumber, relabel, and color-code preliminary meaning units' data across all participants with frequency. Pair the final meaning units alongside the unedited transcript text across all participants.
4. Read and delete irrelevant information from the unedited transcript text to create final meaning units.
5. Create final meaning units (Appendix F).
6. Create preliminary situated narrative and preliminary general narrative of the final meaning units (Appendix F).
7. Apply the lens of HCU theory to final meaning units to create final themes.
8. Create a general narrative for the final themes.
9. Create a general description for the final themes.
10. Create a phenomenological/theoretical summary.

Illustrated Data Analysis Steps

The illustrated steps I took to collect data were as follows: In Step 1 I printed and read the entire transcript for each participant. I then deidentified each participant by number on the transcript. Next, I numbered the preliminary meaning units in order of the transcription data for each participant. Lastly, I highlighted only the numbered data further condensing preliminary meaning units for each participant. A meaning unit is the characteristic of data that emerges and represents a unique idea (Giorgi, 1985). preliminary meaning units for each participant.

Example of Step 1

Preliminary meaning unit: “Hard to Access MH/PCP Vet Benefits for Women Veterans:

P2: “It’s incredibly difficult to find mental health practitioners let alone a mental health practitioner for a veteran and understands the unique experience for women veterans.”

Example of Step 2

Preliminary Initial Meaning Unit: Cohesion neg. affect seeking benefits:

P2: “I was actively a part of conversations where people would be like, you’re going to kill your career.”

Preliminary Initial Meaning Unit: Stopped/started MH due to work scheduling challenges.

P3: “cause the times that I could see with her wasn’t working with my schedule and what she had available was.”

Preliminary Initial Meaning Unit: Waitlisted for tele-health for 2 years without MH care.

P5: “like a couple, maybe 2 summers ago. Now and then I kind of just did nothing in between and then when I went back from my physical, they said that we could do telehealth, and I was like, Oh well, that would have been good to know.”

Example of Step 3

Preliminary final meaning unit condensation: 1 Online MH only due to distance, 2 limited clinicians available online, 3 Prefers online MH during school year for

convenience and no after-hours appointments available, 4 MH experience both online and in person, and 5 Stopped/started MH Due to work scheduling challenges were condensed to: Difficult to Find/Schedule Gender Specific VA MH Care.

Peoples (2020) describes this process consisting of "deleting any information that is irrelevant or unnecessary, like repetitive statements or filler linguistics like "um," "uh," "well," or "you know" (p. 59). This step saved time and effort on parts of the transcripts that were clearly going to be unusable for data analysis yet maintained the integrity of all the details until the final creation of final meaning units.

Examples of Step 4

Original transcription:

P2: "incredibly difficult who find and understands the unique experience and understands the unique experience that is and understands the unique experience that is…. women veterans"…"mental health practitioners" "let alone a mental health practitioner that understands a veteran."

Interviewer: "I see."

Revision:

P2: "[It's] incredibly difficult to find mental health practitioner that understands a veteran's unique experience as a woman."

Examples of Step 5

Final Meaning Unit: Cohesion Affected Service Negatively

P2: "I was actively a part of conversations where people would be like, you're going to kill your career."

P3: “I had almost 22 years in, so I didn’t want to mess up anything with my retirement. Well, I didn’t want [them] to kick me out on PTSD. You know, having any kind of Injuries or anything that they said that I wouldn’t be able to do my job in the guard either.”

Examples of Step 6

Preliminary situated narratives: “Many participants who chose not to use VA facilities found it difficult to access gender specific care that was knowledgeable about the specific needs of the participants’ mental health care vs. female civilians.”

“Most of the participants had military service negatively affected by cohesion.”

“Most participants found that living in a rural location negatively affected access to those benefits due to long waitlists, greater distances to a VA facility, time away from work or family to travel to those facilities, cost of long-distance travel and road conditions due to inclement weather.”

Preliminary general description: “Female veterans desirous of a long-term military career are discouraged and disappointed with the military and chose to leave the service for a variety of reasons.”

“The quality of mental health care providers and services are inconsistent for female veterans whether through the VA or non-VA facilities.”

“Female veterans make greater psychological sacrifices than their male veteran counterparts when enrolling in the military due to the dual nature and cultural expectations of being a parent and/or spouse pre- and post-deployment.”

In step seven I applied two criteria through the lens of Healthcare Utilization Theory (HCU) to the 14 Final Meaning Units. This theory uses the social determinant criteria of “predisposing”, “enabling” and “need” to create the final six themes that emerged. All participants met the criteria of predisposing leaving the criteria of the “enabling” and “need” to use as the lens for 14 Final Meaning Units. The application of the HCU theory lens created a hybrid to the Hermeneutic Theoretical Framework for this qualitative phenomenological study.

Example of Step 7

Theme 5: Finding Rural Locations Good for MH Benefits

P1: “No (enabling) and (need)” [In response to the question]: “Please discuss whether living in a rural area has had any impact on your seeking and receiving mental health services?.”

P7: “So, I needed some support (need), and I asked the VA First, because that’s the easiest thing to do (enabling) and I did have a good telehealth counselor.”

In step 8, I created the situated narrative. The situated narrative according to Peoples (2024) was a “reiteration of each participant’s story where I organized specifics and experiences thematically under the specific interview or survey questions” (p. 60). The meanings of each participant’s experience were highlighted through direct interview quotes.

Examples of Step 8

Theme: Difficulties in Finding and Scheduling Gender-Specific VA Mental Health Care

P3 reported “mental health care from female counselors.”

P5 added that they were “satisfied” [but felt] “like there’s still definitely room to grow” and improve.

Theme: Rural Locations Negatively Affecting Benefits

P3 had to “cancel a time or two because [of] black ice glare ice, squalls” and “the inconvenience of having to leave work to take time off in order to go seek the help [being] much harder.”

P6 “fall into another quasi crisis.”

In step 9, I created a general description from the general narratives solidifying all participant experiences into a general description of all the narratives. According to Peoples (2024) “the goal was to organize the data from the situated narratives while highlighting all of the participants’ meanings of their experiences” (p. 61). Each narrative was organized by the interview or survey questions with “Most” = saturated theme, “Many” = 50% theme and “Some” = theme that was unsaturated but relevant when unity was not established on a certain question (Peoples, 2024).

Examples of Step 9

Q6: “What were your experiences with seeking treatment for mental health services since leaving military service?

Most female veterans report that while seeking access to mental health care with actual symptoms and diagnoses they found good gender-specific therapies. Most female veterans find suitable services but find it difficult to schedule gender-specific VA mental health care services as well as finding mental health practitioners that understand a

female veteran's unique needs. However, most female veterans attribute this to rural locations negatively affecting benefits access to gender-specific VA mental health care services.

Q 10: "Please discuss whether living in a rural area has had an impact on your seeking and receiving mental health services as a veteran? If so, how?

Some female veterans have a good experience with accessing mental health care while living in rural locations finding non-VA and VA resources for mental health benefits.

In step 10 I wrote a theoretical and phenomenological analysis, and the details are included in chapter 4.

Theoretical/Phenomenological Analysis

When using the Hermeneutic Theoretical Framework through the lens of HCU theory I created a hybrid theoretical framework to understand the experiences of female veterans seeking mental health care while living in rural areas. HCU theory has been found to be a societal determinant of whether individuals do or do not access health care. This research specifically focused on the lived experiences of female veterans seeking mental health care and how the components of HCU could explain what was observed.

As I gathered the data and analyzed it from audio and/or video recordings, I remained aware of how understanding the phenomenon and awareness of my *Dasein* "being there" changed when applying the process of the hermeneutic circle while I continued to revisit and put aside any biases. My "fore-sight" and "fore-conceptions" did change and grow regarding the phenomenon of female veterans lived experiences with

seeking mental health care throughout the interviews with rigorous journaling and bracketing.

While reflecting upon the themes that emerged from HCU theory while interviewing female veterans seeking mental health care, I was inspired to explore their unique "storied world" and the concept of Heidegger's "thrownness" or "being-in-the-world" of the military complex and how that informed their lived experiences (Peoples, 2020).

Issues of Trustworthiness

Issues of trustworthiness to establish validity for this research project employed methods including bias disclosure, bracketing, peer review (committee member), participant input, using rich data, and disclosing discrepant information. As a mental health counselor in the role of researcher and observer I had no prior relationship with anyone who participated in this study. I was not known to the participants in any professional role. There was no conflict of interest. By identifying my biases, I was aware of and open to hearing what the participants said and did not allow my biases to interfere with my analysis of the collected data. I had no prior experiences with respect to the phenomenon of female veterans' lived experience or seeking mental health care except for informal conservations.

I minimized the psychological and privacy risks associated with this study by discussing sensitive topics during the interview. I provide participants with information to a local counseling resource if they experienced any psychological distress after the interviews. In this process I remained mindful of personal, preconceived biases, past

philosophical theories, and rigid scientific theories when synthesizing research data. This process was reflected upon by the nature of the hermeneutic cycle where the researcher is required to remain mindful of personal biases while collecting and analyzing data and reinterpreting data to clarify questions and new meaning units.

Female veterans have approached me during informal conversations often expressing that they were generally more comfortable seeking mental health care with a non-governmental counselor like me. Bracketing any biases because of these conversations was not difficult, and I did my best to set aside any preconceived ideas that might remain in my mind and could possibly have influenced how I conducted this study. The individuals who were part of the informal conversations with me were not part of the research participant recruitment for this study. It remains imperative to be vigilant when interviewing research participants because we are never devoid of our own preconceived ideas.

A peer reviewer (committee member) was used for reviewing the data collected and was a resource to discuss ideas and themes as the data collection process developed. I relied upon and welcomed this reviewer as a source to help me maintain integrity with my work. In addition, I consulted with my dissertation committee members as I analyzed the data I collected and developed the themes.

Although gathering data was important, I did offer participants an opportunity to read and provide feedback regarding their summarized interview and the respective developing themes. No participants expressed an interest in their interviews but did

express interest in accessing this research when completed and published. Member checking was not used in this research study.

I analyzed the data collected primarily by hand and an Excel spreadsheet. I synthesized any emerging themes and reintegrated them into the initial understanding of female veterans' lived experiences in relation to seeking mental health counseling. The themes that were developed included direct quotes from several participants to demonstrate their origin. Participants in this study included nine female veterans living in rural counties of the United States. The initial understanding of female veterans' lived experiences of seeking mental health counseling underwent continuous revision until saturation was reached. Any additional conversations, observations, and documentation would add more richness to the data while strengthening both the validity and reliability of the study.

I keep confidential files of my correspondence with participants. I ensured privacy as I conducted interviews while operating from my private office. My private office is soundproof, and I alone work there. There was no one else present and able to overhear the interviews. I confirmed with the interviewees that they themselves were in a private space and if that changed, we could resume the interview at another location when privacy could be assured.

When writing my study report I used pseudonyms for participants that were unidentifiable. I and only one committee member had access to any identifying parts of the data. IRB guidelines suggested following committee members' suggestions and requirements in presenting analyzed data. The IRB suggested that raw data be kept

securely for up to 5 years after the study is completed before being destroyed. I followed both the suggestions of my committee members and the IRB regarding data presentation, analysis, and destruction. All written and recorded data is stored in a double locked filing cabinet where it will be stored for 5 years. All recorded audio data will be stored digitally and erased after 5 years. Video data was destroyed immediately after the interviews were completed. All written data will be shredded after 5 years.

Ethical Procedures

Participants' names and contact information were necessary to schedule interviews. I confirmed that volunteering for this study was to be kept completely confidential and had pseudonyms that would not lead to others learning of the women having participated. I included all perspectives of the research participants even if they were part of a vulnerable population as long as they met the inclusion criteria. They deserved to have their voices heard, unless they did not want to participate, as this was voluntary. While discussing participants' thoughts regarding their perceptions of mental health counseling services, some strong emotions or feelings were triggered by the interview process and participants who appeared to need counseling were encouraged to contact either a counseling agency of their choice by location or other resources such as Northeast Kingdom Counseling (NEK) in Newport, Vermont, the Northeast Kingdom Human Services (NKHS) in Derby, Vermont, or the Veterans Crisis Line at 1-800-273-8255.

Qualitative documented analysis in this study included audio and video recordings of interviews with participants, transcripts of interview responses by participants, and any

other documents used to solicit information from research participants for the interview process and as approved by the Institutional Review Board (IRB). I did not share raw data with anyone other than my peer reviewer if needed (committee member). Participants requested a copy of the completed research project once published. No member checking was used.

I analyzed the various themes that emerged from Heidegger's phenomenology and then created a hybrid theory through the lens of HCU theory. I analyzed the themes and synthesized the themes into *Dasein* for those themes specific to female veterans. The final themes that emerged from the analysis and synthesization were, (a) finding good gender-specific VA therapies, (b) difficulties finding and scheduling gender-specific VA mental health care, (c) rural locations negatively affecting benefits, (d) difficulty in finding non-VA gender-specific care, (e) finding rural locations good for mental health benefits, and (f) finding good non-VA resources.

Summary

In the research method section, I began with an introduction to the research problem and explained why a qualitative hermeneutic phenomenological approach was best for this study. I discussed ethical implications and my role and biases as a researcher. I detailed recruitment procedures, the data collection and analysis process, and the researcher created instruments that included a demographic questionnaire and interview protocol. I clarified the trustworthiness of the research study and discussed the ethical procedures I used to protect research participants. I explored the hermeneutic theoretical framework for both the researcher's and participants' roles through the lens of HCU

theory and concepts of predisposing, enabling and need. In the next chapter I will provide a thorough discussion of the results of this study.

Chapter 4: Results

In Chapter 4, I present the research findings and connect the findings of the study through the lens of Heidegger as the theoretical foundation and then through the lens of HCU theory. I discuss the process of data collection and analysis. I identified 14 final meaning units that were created through hermeneutic theoretical analysis and then narrowed them down to six themes through the lens of HCU (see Appendix F). In this study, I provided a better understanding of the lived experiences of female veterans' pertaining to the components of HCU as societal determinants of the utilization of mental health counseling services.

HCU theory and its main concepts of predisposing, enabling, and need informed interview questions in the semi structured interviews of participants. HCU theory and its components have been found to be a societal determinant of medical care utilization in the United States (Anderson & Newman, 1973, 2005). I applied the theory in a novel way to explore participants' societal determinant of mental health care utilization in the rural United States.

Predisposing

The first component of predisposing reflects the beliefs and attitudes toward health care and illness based on participants' demographics of social structure, including age, sex, marital status, education, race, occupation, and ethnicity (Andersen & Newman, 1973, 2005). I collected demographic data that included, age, sex, marital status, and occupation. All participants in this study reported the same occupation as having served in the military divisions including U.S. Army, U.S. Air Force, Army National Guard, and

U.S. Navy with seven years of active duty on average. All participants were female and White with an average age of 47 years. Five participants reported being married, three reported having been divorced, and one was single. All nine participants lived in rural areas of the United States. Predisposing as the primary lens and foundation of HCU theory for this study included White female veterans, most of whom were married with the average age of 47 years and an average of seven years on active duty.

Enabling

The second component of enabling reflects the concepts of family and community (Andersen & Newman, 1973, 2005). The concept of family includes family income, health insurance and access to care. The concept of community includes the region of the country where one lives and access to health care facilities. The concepts of family and community for the current study were defined as the participants' lived experiences while seeking access to mental health care while living in rural areas of the United States.

Need

The last component of need reflects information gathered from participants' perceptions regarding illness level, symptoms and diagnoses, and confirmed symptoms and diagnoses (Andersen & Newman, 1973, 2005). The concept of need for the current study was defined as the lived experiences of participants seeking mental health care and their actual or perceived symptoms and diagnoses. Peoples (2020) recommended reading through Max van Manen's model of thematizing the lived experiences of participants for identification of themes.

Setting

This qualitative phenomenological study was completed through semi structured interviews. All participants were required to be female veterans at least 18 years of age with at least2 years of active duty and living in the rural United States. The participants were sent consent forms about the purpose of this study, which included further mental health resources, if necessary. Nine interviews were conducted with nine participants. One female veteran reached out to seven other female veterans through snowball sampling, which resulted in eight participants. The ninth participant was referred personally by a current client and was interviewed in person. That interview was recorded via digital handheld recorder and then transcribed. The other eight participants were interviewed via Zoom videoconferencing platform from April 2024 to May 2024.

Interviews were scheduled at the convenience of the participants. Communication with participants was made through my Walden University email address. Through email the participants were sent invitations with a Zoom link where they could choose to use a variety of devices such as desktop, laptop, phone or tablet. All participants were given the option to have video and/or audio recordings according to their comfort level. I set up my laptop in a quiet and confidential space. Whether there was audio and/or video recordings I kept a notebook near me to help with identifying important keywords. All participants could view me on my laptop camera. Participants were able to find a private location for their interviews. A reliable internet connection and minimizing interruptions or background noise helped with completing interviews and collecting rich data. At times questions had to be restated for clarity. The interviews ranged from 45 to 60 minutes with

eight being recorded via Zoom and one being recorded with a digital handheld recorder. All interview recordings were transcribed through Microsoft Word. There was no member checking.

Data Collection

Nine volunteers were invited to participate in interviews. Walden University's IRB gave permission to post requests for participants through the Walden University Research Participant Pool, Facebook, email, and flyers posted on public bulletin boards. One participant was referred via word of mouth, and the remaining eight participants were referred through one female veteran who saw a public flyer posted at her children's daycare.

The semi structured interview protocol was used for all interviewees. I asked the participants to describe their lived experiences as a rural female veteran seeking mental health counseling. Although the interview protocol was the intended plan, there were many opportunities for other questions and topics to arise during the interviews.

I explored the lived experience of nine female veteran participants. The interviews ranged between 45 and 60 minutes and were recorded and transcribed. Eight participants had interviews scheduled via email, and one was in person. All interviewees were informed that interviews would likely not exceed 1 hour. The data were collected using the Zoom platform and a handheld recorder. Both video and audio data were collected via Zoom, and only audio data were recorded with the handheld recorder. There were no variations in data collection from the plan and no unusual circumstances were encountered in data collection. All digital transcripts were saved with passwords on an

external cloud hard drive. All printed transcripts were locked in my office filing cabinet. My office was secured with a lock on the door.

Evidence of Trustworthiness

Strategies of trustworthiness to establish validity for this study included bias disclosure, bracketing, peer review (committee member), participant input, using rich data, and disclosing discrepant information.

Credibility

As a mental health counselor in the role of researcher and observer, I maintained that I had no prior relationship with any of the participants in this study. I maintained that I had no professional role known to these participants. There was no conflict of interest. By identifying any innate biases, I remained aware of not allowing my biases to interfere with my analysis of the collected data. I maintained that I had no prior experience with respect to the phenomenon of female veterans' lived experiences or seeking mental health care except for informal conversations.

Transferability

No member checking was used for this study. What was learned from the lived experiences of these participants may be similar to other populations with the same experiences. The themes and general summary about this phenomenological study offered insights for female veterans seeking mental health care.

Dependability

A detailed explanation of the research process was provided to maintain the dependability of the study. Repeating the steps of this study should produce comparable results. I provided detailed steps in Chapter 3 and followed each step as described.

Confirmability

To protect the research from personal bias, I noted possible areas of bias in Chapter 3 and used journaling and bracketing to make my personal biases explicit and to anticipate any projections. I focused on the lived experiences of the participants throughout the interview process despite occasional distractions and biases. My consistent goal was to replace my conceptions at that time with more suitable ones through the process of review and reflection.

Data Analysis

The steps that were taken to collect data began with reading the entire transcript of each individual interviewee to determine descriptions. Follow-up interviews were not needed to record any missing information from incomplete responses to create a fuller version. Hand coding was used to generate preliminary meaning units. Entire transcripts were printed and reviewed with preliminary meaning units identified with a number for each participant's experience. The numbered preliminary meaning units with their respective transcripts were copied onto an Excel spreadsheet in side-by-side columns and renumbered and labeled to prepare for synthesizing to final meaning units. The final meaning units were color coded into themes for each participant to show frequency and saturation, then recombined with the participants' respective direct quotes to establish the

final synthesized themes. Any gaps, missing information, and incomplete responses were searched for and applied only to relevant data that produced final meaning units and then final themes later on in the data analysis process. No follow-up interviews were warranted, and member checking was not used.

Results

Demographics

Participants were female veterans at least 18 years of age with at least two years of active duty and living in the rural United States. I recruited the participants using the Walden University Participant Pool, using Facebook, and posting public flyers at a local college, various local merchants, high school, and a variety of veteran organizations (e.g., the American Legion and the Elks Club). A mass email to more than 100 personal and professional colleagues was also sent. The sample was 100% female participants who served in the U.S. Army, U.S. Air Force, Army National Guard, and U.S. Navy. The women all identified as White and ranged in age from 26 to 64 years with an average age of 47 years. The participants' average years on active duty were 7.3 years, and post active duty averaged 16.3 years. When participants were asked if they were satisfied with their household income level, two reported "not satisfied" and seven reported "satisfied." Out of nine participants, one reported being single, three reported having been divorced, and five reported being married. All nine participants reported living in rural areas of the United States. Table 1 summarizes the participants' branch of the U.S. Armed Services served, years on active duty, years since active duty, age, race/ethnic background,

satisfaction level with household income, number of household members [they] support, marital status, and whether they live in the rural United States.

Table 1

Participant Demographics

Participant number	Branch of U.S. Armed Services served	Years on active duty	Years since active duty	Age	Race/ethnic background	Satisfaction level with household Income	Number of household members supported	Marital status	Live in rural United States
P1	U.S. Army	3	42	63	White	Not satisfied	2	Married	Yes
P2	U.S. Army	20	4	31	White	Satisfied	6	Married	Yes
P3	U.S. Air Force, Army National Guard	2.5	7	57	White	Satisfied	2	Married	Yes
P4	Army National Guard	1	2	32	White	Not satisfied	1	Single	Yes
P5	U.S. Army	2	2.5	26	White	Satisfied	5	Married	Yes
P6	U.S. Air Force	13	4	45	White	Satisfied	2	Divorced	Yes
P7	U.S. Air Force	10	9	44	White	Satisfied	5	Married	Yes
P8	U.S. Navy	8	38	64	White	Satisfied	1	Divorced	Yes
P9	US Air Force	6	38	63	White	Satisfied	1	Divorced	Yes

Themes

All participants lived experiences in the following themes met the criteria of predisposing through the primary lens of HCU theory. Six participant themes highlighted the components of enabling and need and how they contributed to the societal determinants of mental health utilization for these participants while seeking mental health care. The six themes were (a) finding good gender-specific VA therapies, (b) difficulties in finding and scheduling gender-specific VA mental health care, (c) rural locations negatively affecting benefits, (d) difficulties in finding non-VA gender-specific

care, (e) rural locations good for mental health care, and (f) finding good non-VA resources.

This study created a modified primary lens of HCU theory of participants who identified as white, rural, most married, all female veterans, with the average age of 47 and an average of 7 years of duty and their lived experiences seeking access (enabling) to mental health care with actual symptoms and diagnoses (need). All the following themes discussed have the components of *enabling* and *need* demonstrated from participants direct quotes (see Table 2).

Table 2

Participant Themes

Theme	P1	P2	P3	P4	P5	P6	P7	P8	P9
Found good gender-specific VA therapies		X	X		X		X	X	X
Rural locations negatively affected benefits		X	X	X	X	X		X	
Difficult to find/schedule gender-specific VA MH care		X	X		X	X	X		
Difficult to find non-VA gender-specific care		X						X	X
Rural location good for MH benefits	X						X		
Good non-VA resources	X			X					

Illustrated Themes

Theme 1: Finding Good Gender-Specific VA Therapies

Participants reporting lived experiences seeking access (enabling) to mental health care with actual symptoms and diagnoses (need) reported lived experiences with the theme of finding good gender-specific therapies. A total of six participants interviewed reported that they were able to find good gender specific VA therapies both supporting physical and mental health care (P2, P3, P5, P7, P8, P9).

P2 begins with “I was offered (enabling) the opportunity to go skiing with recreational therapy (need)”, with P3 reporting having access (enabling) to mental health care from female counselors, stating “It is a lot better than it used to be.” P5 added, “I’m satisfied (need). I feel like there’s still definitely room to grow, but I think it’s better (access)..” There weren’t any female counselors (need) for a long time”, access to mental health care through telehealth with P7 sharing, “I had telehealth (enabling) for mental health (need) first, so I got mental health care from home. I am happy with it” and P8 who offered, “At the VA … my mental health care (need) has been great”, and finally with P9 adding “being able to do it by video (enabling) has made a big difference, as well as one participant having encountered no problems with access (enabling) to care.”

Theme 2: Difficulties Finding and Scheduling Gender-Specific VA Mental Health Care

Participants reporting lived experiences seeking access (enabling) to mental health care with actual symptoms and diagnoses (need) reported lived experiences with the theme of difficulties finding and scheduling gender-specific VA mental health care.

Five participants interviewed reported experiencing difficulties finding and/or scheduling gender specific VA mental health care (P2, P3, P5, P6, P7).

P2 begins with, “[It’s] incredibly difficult to find (enabling) mental health practitioner that understands a veteran’s unique experience as a woman (need) and P3 continues, “She had very limited times (enabling) that I could see her (need) and it was difficult for me to get to the appointment, follow by P5 where travel affected access (enabling) and “I would have had to make a point of traveling to a different base”, and (need) I was being treated like other female soldiers were being treated.” P6 followed with, “It just seemed to be hard (enabling) to get an appointment. They don’t seem to really understand what our needs are yet as female veterans (need), and I have PTSD. P7 reported that “I can’t remember all the names for all the different avenues for mental health care (enabling), but I needed help. I had 3 or 4 sessions with this new counselor (need) and all of them were a complete waste of time and completely diminished my confidence in the VA’s hiring practices.”

Theme 3: Rural Locations Negatively Affecting Benefits

Participants reporting lived experiences while seeking access (enabling) to mental health care with actual symptoms and diagnoses (need) also reported those same lived experiences with the theme of rural locations negatively affecting benefits. Six research participants interviewed reported that living in a rural location negatively affected access to health care benefits (P2, P3, P4, P5, P6, P8).

P2 reported, “Rural medicine is its own little niche outnumbered by cows and corn, and not much you can do about it (enabling). I’ve cancelled (need) a time or 2

because [of] black ice, glare ice, squalls (enabling) and P3 continues with, “maybe somebody closer (enabling) would be a lot better and being able to get different types of [care] (need). P4 shared that, “Especially living in the rural areas (enabling) because having to leave work to take time off in order to go seek the help [is] much harder. P5 began with, “It’s hard to get anything that close to where I live (enabling), but I wouldn’t drive if there was a snowstorm or something. There’s no way (enabling), and P6 follows with “The next closest VA to me is an hour and a half one way or an hour and a half or more the other way and it’s not really an option. I’ve just been kind of posting and hoping that I don’t fall into another quasi crisis (need)” and P8 was clear that, “It’s too far. It’s too hard. It takes too long to get there and in receiving the lack of resources. I was trying to get in with anywhere (need). My sense is that it’s different in rural areas (enabling).”

Theme 4: Difficulty in Finding Non-VA Gender-Specific Care

Participants reporting lived experiences seeking access (enabling) to mental health care with actual symptoms and diagnoses (need) also reported those same lived experiences with the theme of difficulty in finding non-VA gender-specific care. A total of three participants interviewed reported experiencing difficulties in finding non-VA gender specific care (P2, P8, P9).

P2 shared, “[It’s]incredibly difficult to find (enabling) who understands the unique experience of women veterans, let alone a mental health practitioner that understands a veteran (need) and P8 follows with, “seeking and receiving the alcohol treatment at a reputable hospital clearly did not specifically get female veterans (need)” and P9 finished with, “I had depression and PTSD (need). I had gone to counseling at a

non-VA facility in New England and it was nice, but it wasn't really mental health services (access)."

Theme 5: Finding Rural Locations Good for MH Benefits

Participants reporting lived experiences seeking access (enabling) to mental health care with actual symptoms and diagnoses (need) also reported those same lived experiences with the theme of finding rural locations that were good for mental health benefits. Two participants interviewed reported having good experiences with accessing mental health care while living in a rural location (P1, P7).

P1 reported simply, "No (enabling) and (need)" [In response to the question: "Please discuss whether living in a rural area has had any impact on your seeking and receiving mental health services?", and P7 stated, "So, I needed some support (need), and I asked the VA First, because that's the easiest thing to do (enabling) and I did have a good telehealth counselor.

Theme 6: Finding Good Non-VA Resources

Participants reporting lived experiences seeking access (enabling) to mental health care with actual symptoms and diagnoses (need) reported lived experiences with the theme of finding good non-VA Resources for mental health benefits. Two participants interviewed reported having positive experiences with non-VA resources (P1, P4).

P1 stated, "I haven't had to [use VA benefits]. I used the regular mental health services. [They] have been good. I didn't have a problem. I had some good counselors,

some excellent counselors' and P4 shared, "It's been positive it's helped me out so much. I like the fact that she is a civilian. For yes, for me. It's positive."

General Narrative

The components of HCU theory created a hybrid of Heidegger's hermeneutic theoretical framework with the components of predisposing, enabling and need. All participants met the criteria of the component of predisposing based upon their common demographics and this component will not be further discussed. This narrative will address the components of enabling and need. Most participants reported that while seeking access (enabling) to mental health care with actual symptoms and diagnoses (need) that while they found good gender-specific therapies as P2 was offered "recreational therapy" and P3 reported having "mental health care from female counselors" and P5 adding that they were "satisfied…but felt "like there's still definitely room to grow" and improve.

Most participants' fore-conceptions of seeking mental health care with actual symptoms and diagnoses, found good gender-specific therapies, but revised their *Dasein* (being there) and their understanding of that care to include recreational therapy. This contributed to their new understanding of *Mitsein* (being with) others for that recreational therapy as well as the need for improvement regarding the quality of female counselors for mental health care.

When participants finally found suitable services for most it was difficult to schedule gender-specific VA mental health care services. Mental health practitioners that understood a "veteran's unique experience as a woman" according to P2 was one issue

and P3 found that practitioners “had very limited time [in addition to being] difficult to get the appointment.” However, most participants attributed this to rural locations negatively affecting benefits access to gender-specific VA mental health care services with P5 having to “make a point of traveling to a different base” further away that were more experienced in treating female veterans.

Most participants’ fore-conceptions of finding suitable gender-specific VA mental health care services with practitioners that understood a participant’s needs without having to travel great distances revised their *Dasein* (being there) because the care they sought was not readily available closer to their residence. This required them to rethink their *Mitsein* (being with) other participants that required having to travel greater distances for that care.

Some participants reported that while seeking access (enabling) to mental health care with actual symptoms and diagnoses (need) that they had trouble finding non-VA gender specific care. P2 found that her search was “difficult with finding a mental health practitioner that understands a veteran” whether male or female and P8 needing alcohol treatment found that an Ivy League hospital “clearly did not get female veterans.”

Some participants’ fore-conceptions of finding non-VA gender specific care with practitioners that understood participants’ unique needs revised their expectations of *Dasein* (being there) with practitioners because they did not understand the participant’s needs. The participants realized that their *Mitsein* (being with) another Ivy League hospital did not guarantee practitioners specific knowledge of how to treat the participants.

Conversely, some participants had good experiences with accessing mental health care while living in rural locations and a positive experience finding good non-VA and VA resources for mental health benefits. P1 shared that I "have never had a problem with non-VA benefits" and when asked whether living in a rural area has had any impact on their seeking and receiving mental health services, they emphatically responded proudly with "NO and P4 added that they had a "positive experience and liked working with a civilian" practitioner. P7 rural area asked the VA first "because that's the easiest thing to do and I did have a good telehealth counselor."

Some participants' fore-conceptions of finding good non-VA and VA resources specifically for mental health care supported their *Dasein* (being there) despite living in a rural area. This reinforced their expectations of *Mitsein* (being with) mental health care facilities and continued experiencing quality mental health care.

Whereas participants like P3 living in a rural area had to "cancel (need) a time or two because [of] black ice glare ice, squalls (enabling)" and "the inconvenience of having to leave work to take time off in order to go seek the help [being] much harder" with distance negatively affecting the urgency should P6 "fall into another quasi crisis (need)."

However, some participants' fore-conceptions of desiring to reside in a rural area and still access quality care revised their *Dasein* (being there) due to the realities of inclement weather, distance and travel conditions making it more difficult. This was imperative, especially if there was an urgent need for care. As a result, the participants needed to revise *Mitsein* (being with) this reality of care when road conditions were a consideration.

General Description

Most female veterans report that while seeking access to mental health care with actual symptoms and diagnoses they found good gender-specific therapies. Most female veterans' fore-conceptions of seeking mental health care with actual symptoms and diagnoses, find good gender-specific therapies and now revise their *Dasein* (being there) and understanding of that care to include recreational therapy. This contributes to their new understanding of *Mitsein* (being with) recreational therapy as well as the need for improvement regarding the quality of female counselors for mental health care.

Most female veterans find suitable services but find it difficult to schedule gender-specific VA mental health care services as well as finding mental health practitioners that understand a female veteran's unique needs. However, most female veterans attribute this to rural locations negatively affecting benefits access to gender-specific VA mental health care services.

Most female veterans fore-conceptions of finding suitable gender-specific VA mental health care services with practitioners that understand a female veteran's needs without having to travel great distances now revise their *Dasein* (being there) and the understanding that the care they seek is not readily available closer to their residence. This requires them to rethink their *Mitsein* (being with) like other female veterans who travel greater distances for that care.

Some female veterans report that while seeking mental health care with actual symptoms and diagnoses they have trouble finding non-VA gender specific care. Some female veterans' fore-conceptions of finding non-VA gender specific care with

practitioners that understand female veteran's unique needs are now revised and match their expectations of *Dasein* (being there) with practitioners that may not understand female veterans' needs. Female veterans now realize that their *Mitsein* (being with) other female veterans at an Ivy League hospital but does not guarantee practitioners have specific knowledge of how to treat female veterans.

Conversely, some female veterans have a good experience with accessing mental health care while living in rural locations finding non-VA and VA resources for mental health benefits. Some female veterans' fore-conceptions of finding good non-VA and VA resources specifically for mental health care supports their *Dasein* (being there) despite living in a rural area. This reinforces their expectations of their *Mitsein* (being with) and continuing to experience quality mental health care.

Whereas female veterans living in a rural area due to a desirable lifestyle choice need to navigate the challenges of weather, distance and adverse road conditions, even with the occasional need for more urgent care. Some female veterans' fore-conceptions of desire to reside in a rural area and still access quality care has now revised their *Dasein* (being there) due to the realities of inclement weather, distance and travel conditions making it more difficult. This is imperative especially if there is an urgent need for care. As a result, female veterans are now better able to adjust their *Mitsein* (being with) with the new reality of seeking care when road conditions and inclement weather are a consideration.

Summary

In this chapter, the theoretical phenomenological analysis of this research was discussed through the lens of HCU theory and its components of predisposing, enabling and need and how they influenced the societal determinants of mental health care utilization. The 14 initial final meaning units were created from female veterans' direct quotes providing insight into the phenomenology. A general narrative and description of 6 illustrated themes were created from the original 14 meaning units (Appendix F).

This hybrid theory and its 6 themes were analyzed and synthesized through the Heideggerian phenomenology with an exploration of various *Dasein* and *Mitsein* for female veterans. The results were presented using themes that reflected the participants' lived experience as female veterans residing in the rural United States and seeking mental health care. Chapter 5 will address recommendations, future implications for social change, and conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to provide insight into the subculture of female veterans in rural areas and to explore their lived experiences related to seeking mental health counseling. Rural counties in the United States have their own unique culture that affects the mental health counseling seeking behavior of individuals. Nastasi et al. (1998) suggested that culture should include references to factors beyond race and ethnicity such as gender, age, regional location, socioeconomic status, sexual orientation, and family traditions and values.

The problem is that health care is not readily available in rural areas (Albanese et al., 2020; Cordasco et al., 2016; Cyr et al., 2019; Freedy et al., 2010; Ingelese & Messecar, 2016; Lehavot et al., 2018; Maguen et al., 2010; Marshall et al., 2020; Mattocks et al., 2010; Sambamoorthi et al., 2010; Shen et al., 2010; Stecker et al., 2007). Research has shown that barriers to care with respect to geographic distance from health care services, shortcomings with lack of access to gender-specific counseling and mental health care services, and preexisting conditions such as PTSD and MST may contribute to the lived experiences of female veterans seeking mental health counseling (Freedy et al., 2010; Maguen et al., 2010; Mattocks et al., 2010; Sambamoorthi et al., 2010; Shen et al., 2010; Stecker et al., 2007).

Findings

In this section, I discuss the literature reviewed in Chapter 2. I reintroduce the topics from Chapter 2 and include them in this section. I created a dialogue between what the literature found, and the new information gathered from the current study.

Dialogue With Literature

Health Care for Veterans in the United States

The Choice Act of 2014 and the VA MISSION Act of 2018 inspired collaboration between the VA and civilian health care systems to gather more data on the availability and quality of care for veterans (McCauley & Ramos, 2020). The U.S. health care systems revealed that more than half of veterans seek health care services outside of the VA (McCauley & Ramos, 2020). These data included approximately 1.8 million female veterans and 200,000 women on active duty. Long wait times for access to health care services for female veterans in the VA health care system are a primary reason for turning to civilian health care services.

The findings in my study revealed that participants did not report the reasons they turned from VA to civilian health care services were related to long wait times. Some participants living in a rural area had already chosen civilian health care services. Some participants had a positive experience with those services and continued to use those services with no problems reported. Some participants who chose non-VA gender-specific care chose that care due to living in a rural area. Participants who reported difficulties in finding practitioners reported that those difficulties were related to the competency of the practitioners. Some practitioners were reported to be incompetent in understanding the unique needs of female veterans regarding substance abuse, depression, and PTSD.

I found that participants who lived in rural areas and needed in-person care faced well-known challenges such as distance, inclement weather, and time to access those

services. Participants who lived in rural geographical areas had an ongoing challenge due to their greater distance from those services. Living in rural geographical areas and distance were barriers and delays to accessing care. In addition to distance, inclement weather due to living in rural parts of New England reduced participants' desire to access care. The combined factors of rural residency, inclement weather, and greater distance increased the likelihood of not accessing care or delaying access to care.

Mental Health Care Issues of Veterans

According to Johnson and Possemato (2020), veterans already receiving mental health care were more likely to have a positive perspective of mental health services. These veterans who were patients perceived that their symptoms influenced their beliefs about mental health care. These veterans were more likely to use that available treatment within the military.

I did not find that participants had a negative perception regarding mental health care with respect to seeking out that care. In fact, findings showed that any negative perceptions from participants regarding mental health care were related to the quality of the care and competency of practitioners at facilities where practitioners did not understand the unique needs of female veterans. The concern for competency was the main issue shared by participants whether they sought VA mental health care or non-VA mental health care.

Lack of Integration of Primary Health Care and Mental Health Care Services

Despite women veterans reporting twice the rates of mental health symptoms with depression and anxiety as their male counterparts, women veterans continue to access

mental health services differently (Leung et al., 2020). Studies showed the importance of encouraging female veterans to access mental health care services and suggested the implementation of integrated care (Leung et al., 2020). Integrated care, although costly, appears to be a necessity within the health care system in supporting female veterans' mental health care utilization (Leung et al., 2019).

The findings in my study indicated that participants actively chose to seek out mental health care. Their lived experiences did not indicate whether they sought that care as a result of a visit to a primary care physician. However, it remains well documented that female veterans need a different type of support within the health care systems that understands their unique needs (Lehavot et al., 2018; Leung et al., 2020; Moreau et al., 2020; Stefanovics & Rosenheck, 2020.

Reluctance of Veterans to Seek Mental Health Services

According to Morgan et al. (2000), reluctance of veterans to seek mental health services and the reasons why they may go unreported are influenced by beliefs connected to mental health problems and where they can access mental health care services. When veterans seek mental health care services, there is an increase in motivation to use a program if the stigma reduction information is provided (Morgan et al., 2020). This is especially true with veterans seeking mental health care services with PTSD compared to veterans without PTSD (Morgan et al., 2020). However, this push to establish programs that encourage acceptance of help-seeking norms developed for the military and veterans to foster a new norm within the culture has not yet been evaluated for effectiveness.

The findings in the current study did not address access to mental health care services for all veterans but did address access to mental health care by female veterans. This research did not find any reported issues of stigma or beliefs connected to mental health problems that affected access to mental health care services for these participants. Seeking out mental health care services for these participants was the selection criteria and the starting point for all participants in this study.

Some participants, however, had barriers to accessing mental health care services due to their rural locations, inclement weather, distance from facilities, and need to time away from work to travel to those appointments. Some participants had barriers to accessing mental health care services due to the lack of availability of in-person appointments with a practitioner compared to being offered virtual appointments. However, some participants preferred virtual appointments depending on their mental health problems. For example, if a participant needed support for substance abuse issues or PTSD, most would prefer in-person treatment with practitioners. For other participants who were diagnosed with depression or anxiety, virtual appointments were an effective treatment.

Women Veterans

Women in the Military

The Women's Armed Services Integration Act's passage in 1948 opened the doors for women in all branches of the military to pursue leadership positions as officers and elite military training. However, not all efforts to increase the percentage of female military personnel have been successful, and as a result some woman recruits have

performed poorly, have been the victims of negative stereotyping, and have dropped out (Keohane & Jakes, 2021). The U.S. Army finally acknowledged physical differences with female military personnel and developed the Army Physical Fitness Test and a different scoring system for women, opening the doors to enrollment for more diversity.

The War in Afghanistan represented the most recent gender-shifting climate for women throughout the U.S. military. Women were valued for their differences in war zones where gender difference was beneficial. One example was that after female engagement teams were proven effective and successful in war zones (Keohane & Jakes, 2021), female veterans were allowed to serve in combat roles. As of March 2021, there were 234,685 women enlisted in the U.S. Army, Navy, Air Force, and Marines combined. Overall, women account for about one fifth of the officers in every military service (Keohane & Jakes, 2021).

The current study findings were based on the criteria of all participants were female veterans. The themes did not indicate that participants were not valued for their differences or were not allowed to serve in combat roles if it was their choice. However, all participants expressed that they experienced unwanted and unsolicited behavior because of being a female enrolled in the military. All participants experienced and reported MST to varying degrees.

Health Care Needs of Women Veterans

According to Savitsky et al. (2009), more than half of women veterans accessed outpatient health care facilities, whether VHA or non-VA, with approximately 88% visiting a primary care doctor at least once a year. Women veterans seek primary health

care in greater numbers than their male counterparts and are more likely to use non-VA medical care (31% vs. 15%) with some of the difference accounted for by the need for mammograms (Savitsky et al., 2009). Studies addressing the health care needs of female veterans indicated that 67% offered praise for the VA, while (26%) reported feeling uncomfortable or harassed (Moreau et al., 2020). Suggestions for change or improvement to outpatient health care facilities were directly related to the VA staff (31%), the care setting (18%), and additional clinical services for women specifically (33%; Moreau et al., 2020). This led to the awareness of the need for changing the behavior toward women veterans' needs as well as equal care to their male counterparts (10%; Moreau et al., 2020). This important change in health care settings for women veterans became more inclusive with attention to staff training and added focus on addressing harassment throughout the system levels.

In addressing the findings on both topics of change or improvement directly related to the VA staff and clinical services for women, some current study participants reported that they had experienced a lack of female counselors, when requested, at VA facilities to support female veterans. However, some participants reported that that those numbers were increasing with more female counselors in some facilities. Some participants in this study reported that even though they were satisfied with their care by VA staff, there was always room for improvement when caring for female veterans. Room for improvement includes VA staff who are well trained to support the unique needs of female veterans.

Health care facilities were sometimes inaccessible for participants living in rural areas due to distance, inclement weather, and time to travel that took them away from work and resulted in an economic loss. Some participants reported difficulties finding and scheduling availability at those care facilities. Those barriers included the availability of female practitioners at the care settings whether in person or through virtual appointments and the potential of the longevity of care. Some participants reported finding rural care settings, when they were able to travel there, that were a good experience regarding accessing mental health care benefits and continuing to use them.

Prenatal Care

Mattocks et al. (2010) found that women veterans discharged over a 7-year period who were enrolled in VHA care and were pregnant were twice as likely to have a diagnosis of depression than those who were not pregnant prior to discharge. Those pregnant prior to discharge were also twice as likely to have diagnoses of PTSD, anxiety, bipolar disorder, and schizophrenia than those not pregnant (Mattocks et al., 2010). In addition, the findings showed that the rate of diagnosis of PTSD and bipolar disorder was found to be much higher due to the inability of the VHA to provide routine prenatal care due to a lack of coordination of primary and mental health care. Cases of diagnosed psychiatric disorders during pregnancy were higher than their civilian counterparts. If there is a lack of coordination between primary and mental health care facilities in the VHA, it follows that the same lack of coordination of services may be worse for female veterans living in rural populations.

All participants in the current study were required to live in rural locations and did not report pregnancy during deployment. Some participants reported having young children and enrolling in the military. Most participants who enrolled in the military and left young children to serve abroad felt an imposed level of guilt by friends, family members, and their male military counterparts. These female veterans reported a level of guilt that they have carried since their service. Some reported that they missed out on the developing years of their young children. One participant felt inadequate at parenting and how to do her daughter's hair when she returned from active duty. There seems to be a double standard for male veterans enrolling and serving their country who are thought of as heroes, whereas female veterans are stigmatized as neglecting their families. This stigmatization of female veterans suggests that it is important to encourage coordination between primary and mental health care facilities and any connection with mental health diagnoses or issues specific to female veterans.

Mental Health Care Needs of Women Veterans

Women veterans who sought outpatient care regarding mental health for substance use disorder accessed services at the rate of 14% compared to 8% among their male counterparts (Savitsky et al., 2009). Women veterans who accessed mental health care services were typically diagnosed with major depressive disorder, depression, PTSD, and anxiety disorders. These diagnoses were represented across all age groups. Substance use disorder conditions were more common with women than their male counterparts, as were eating disorders, dissociative disorders, and acute stress disorders (Savitsky et al., 2009). A correlation was also found between women veterans reporting any service-

combat disability rating and the likelihood of having a mental health or substance use disorder condition across all age ranges.

In the current study, Participant 6 and Participant 9 reported diagnoses of PTSD, depression, and anxiety. They seemed to find sufficient mental health care treatment to support those diagnoses; however, it was beyond the scope of this study to determine whether female veterans were more likely to be diagnosed with certain disorders depending on their service enrollment status. I did not explore how some of those disorders compared to the diagnoses of their male counterparts. However, previous studies indicated that female veterans who are diagnosed with PTSD, depression, and anxiety tend to reach out for support through primary care practitioners (Morgan et al., 2020).

Specific Mental Health Issues of Women Veterans

Women veterans are the fastest growing segment of new health care users in the VA (Hamilton et al., 2020) with research gaining a better understanding about this population's specific mental health issues. When the research surveyed VA primary care physicians and mental health providers and then interviewed women with treatment needed, care provided, and their perception of evidence-based treatments applied, the results reflected struggles with offering collaborative care. Factors such as comorbidities, psychosocial stressors, and a treatment approach that fits this population are important to study. Primary care and mental health care providers concluded that gender-specific care for women veterans was the best approach to improving the quality of comprehensiveness of care in the years to come (Hamilton et al., 2020).

It was shown that many participants found it important to find gender-specific mental health care whether from VA or non-VA facilities. Gender-specific care for participants often meant that they were more likely to choose a female practitioner at these facilities if they were available. Some participants noticed that there appeared to be more female practitioners than in prior years and that there is room to grow for the quality of that gender-specific care.

One significant issue with participants seeking gender-specific care was that they eventually noticed, especially during the pandemic, the greater availability of virtual appointments. This was desirable by Participant 7 and Participant 9, especially when distance due to living in a rural area due to travel considerations might be a barrier to care. The availability of virtual appointments was a positive experience regarding access to gender-specific mental health care for those and other participants who lived in rural areas that would otherwise have created a barrier to accessing the care needed in prior years.

However, there were Participant 1 and Participant 4 who experienced difficulties with finding qualified and competent non-VA practitioners. This was true whether seeking out virtual or in person treatment. Qualified and competent practitioners that understood the unique experiences of female veterans, especially with substance abuse treatment were few and far between. This was also reported to be true for participants seeking qualified and competent treatment for PTSD, depression and anxiety.

Gender-Specific Issues and Treatment of Women Veterans

An analysis by Haskell et al. (2010) of men and women veterans receiving primary healthcare between 2001 and 2006 indicated that symptoms of PTSD and depression were somewhat less for men compared to women. Women experienced MST at a rate of 14% compared to men at 1% (Haskell et al., 2010). Recommendations that were made for gender-specific treatment could benefit female veterans but it is limited in rural areas suggesting a need for mental health care service access in those areas for that specific trauma.

A study by Stecker et al. (2007) showed a greater rate of diagnosis of female veterans than their male counterparts (co-occurring with substance use) of major depression or bipolar disorder strongly associated with lack of outpatient treatment participation and were more likely than men to be diagnosed with PTSD, anxiety, and personality disorders. Women veterans with substance use disorders were reluctant to seek help alongside men in the same facilities and the authors concluded that women veterans would benefit from separate treatment facilities.

Participant 2, Participant 8 and Participant 9, did prefer separate treatment facilities or at least a separate waiting room at a facility than their male counterparts, if possible. These participants reported always being focused on accessing care at facilities that had skilled practitioners who understood the unique needs of female veterans. These participants reported not returning to facilities where they had to wait with their male counterparts for treatment. They reported that the reason for most participants was

because of their experience with MST. All participants reported experiencing MST of varying degrees during deployment.

Furthermore Kelly et al. (2008) found that military sexual assault participants rated the quality VHA services lower than non-military sexual assault participants. They held the belief that VHA care catered more to men which interfered with their use of services. This contributed to perceived and actual barriers to care for women-specific services. Part of this perception was also due to problems with VHA doctors/staff specifically and the lack of ease of with utilizing those VHA services. These research findings may contribute to women veterans living in rural areas with less access to mental health care facilities being less likely to travel greater distances to seek treatment due to the perception of that treatment being male-centric.

All the participants in this study met the criteria of living in a rural part of the U.S. Most participants experienced the challenges of seeking out mental health care facilities that were at a greater distance. Those participants had to navigate challenges regarding inclement weather, work considerations and time due to travel distance. There was no clear finding that their travel to mental health care facilities was less likely due to their perception of that facility being male-centric.

Researcher participants in this project travelled to various medical facility settings and observed if there were barriers to women veterans' access to gender-specific care (Marshall et. al., 2020). The literature results supported that the issue of barriers included limited trained providers, inefficient referrals, and lack of coordination with providers.

These barriers were also compounded by various psychosocial factors specific to female veterans such as childcare (Marshall et. al., 2020).

Some participants experienced limited trained providers when seeking gender-specific care. Some participants preferred female providers although they were in short supply, however, some older participants noted that there are more female providers than there were in the past. Some participants reported that barriers to care along with, providers with limited training for the unique needs of female veterans, distance, weather, and time away from work was the never-ending issue of childcare. Although some of the participants had supportive family members regarding the need for childcare, they felt that it was their primary responsibility as mothers.

Administrators within the VA have suggested making changes that result in gender-specific trained staff and facilities, more frequent and longer sessions for women veterans, updates to security and patient privacy, as well as increasing the choices of providers (Marshall et. al., 2020). While an increase in the choice of providers is a positive change for women veterans, it is typical of urban and suburban communities. Researchers have yet to reveal the impacts in underserved rural communities (Marshall et. al., 2020).

Some participants found that when seeking gender-specific trained staff at VA facilities there was room for improvement with quality of training and hiring practices with the VA. Some participants found that when seeking gender-specific trained staff at non-VA facilities that they lacked the unique experience and understanding of female veterans' needs. All participants were from underserved rural communities.

PTSD

Male and female patients, according to research, who sought primary care services at one of four VA health centers were evaluated for symptoms of depression, interpersonal violence, PTSD, and physical and sexual violence related to warzone exposure where women were more likely to experience PTSD associated with sexual victimization than their male counterparts (Freedy et al., 2010; Ingelese & Messecar, 2016; Lehavot, et al., 2018; Maguen et al., 2010; Mattocks et al., 2010; Morgan et al., 2020; Sambamoorthi et al., 2010; Shen et al., 2010; Stecker et al., 2007; Stefanovics, et al., 2020). This suggested that female veterans would benefit from mental health care due to higher reports of sexual victimization. However, VA health centers are typically located in highly populated areas of the country and may not address mental health care access for females in rural areas.

All participants in this study met the criteria of living in a rural area in the United States. These participants faced various challenges with access to mental health care facilities because they were further away, and a greater travel distance was required. All the participants reported experiencing some form of MST and were consequently diagnosed with a variety of mental health issues including PTSD, depression, anxiety and substance abuse. Some participants reported that it was challenging to find practitioners and facilities that they felt emotionally safe when seeking out treatment for MST.

The number and types of traumas as well as social factors combined may contribute to understanding women veterans' higher rates of PTSD compared to the civilian population (Lehavot et al., 2018). Military veterans from the Vietnam and the

Afghanistan/Iraq wars exhibiting symptoms from moderate to severe depression were at risk for hazardous drinking. More than half of female participants experiencing MST and an overwhelming majority met the criteria for probable PTSD (Sayer et al., 2009). These veterans failed to seek professional help, and this was especially true for Vietnam veterans. This was true for women with histories of MST with the stigma of trauma alone deterring access to mental health care for women veterans and geographical distance compounding this issue with lack of care.

Women veterans who experienced MST reported less satisfaction overall with VHA services and staff when compared to men and were more likely to screen positive for MST by a ratio of 14 to 1 (Kelly et al., 2008; Liebert et al., 2010). Gender differences to care, especially with female veterans diagnosed with MST should inform health services within the VA system. The types of traumas that women veterans were exposed to were found to be different than those of their male counterparts. Trauma that women veterans were exposed to more often is sexual in nature. It is thought that trauma that is interpersonally induced leads to more severe symptoms (Stefanovics & Rosenheck, 2020).

The findings in this research study did not reveal that the types of traumas women were exposed to was more often sexual in nature than their male counterparts. However, all participants in this research reported that they had experienced some type of MST and that it was a major barrier when seeking competent gender-specific treatment for this without experiencing the stigma of military cohesion. Military cohesion encourages that all enrolled military move together as one force with one goal to accomplish. If a female

veteran is courageous enough to seek treatment for MST and find a caring and competent practitioner, they may still feel hesitant to talk about their trauma because it can go against their military cohesion training. Going against the deeply embedded idea of military cohesion could be experienced as a type of betrayal. Participants in this study often talked about how they have their family at home in the U.S. but that they also have a military family when on active duty. The trust that is required of that military family left some female veterans feeling like they have had to betray their family when outing who the perpetrators where when they were on active duty. All the while it is well documented, researched and known by the military complex that women veterans are more likely by a greater percentage than their male counterparts to experience this type of sexual abuse.

Depression

Female veterans who were younger were more likely to be Black and were more likely to have received a depression diagnosis than were their male or White veteran counterparts (Maguen et al., 2010). Being an older female veteran was associated with a higher prevalence of PTSD and depression diagnoses among women veterans (Maguen et al., 2010). This, however, was not found to be true among men (Maguen et al., 2010).

This research study did not find that its participants were more or less likely to receive a particular diagnosis based upon age or race compared to their male counterparts. All participants in this research were White female veterans and reported seeking out mental health care because of a mental health diagnosis. All the participants in this research study met the criteria for living in rural communities but did not suggest

that mental health care was non-existent. However, it is possible that younger, older, and Black female veterans may reside in rural communities where there is non-existent mental health care and must travel greater distances. All the participants in this study were able to find VA and non-VA facilities for mental health care.

Military Sexual Trauma

Findings conclude that VHA and non-VHA institutions and providers should be prepared to care for women veterans experiencing MST and suggests that providers should be prepared to care for women veterans and the experience of institutional betrayal. Trauma-informed methods of treating MST and institutional betrayal and facilitating for that recovery are paramount for women veterans (Monteith et al., 2021).

The participants in this research study reported accessing care from both VHA and non-VHA providers, but not necessarily only for MST. All participants in this study experienced some form of MST. Some participants had positive experiences with finding providers at both VHA and non-VHA facilities for mental health care but there was always some form of stigma felt regarding military cohesion.

Military cohesion is like a code of honor for all active military to work together as a team where the individual does not matter. Participants reported that when a female veteran contemplates reporting sexual abuse from a military family member that she has developed military cohesion where there are two conflicting thoughts. One thought is whether what they experienced as individual matters and the second thought of whether they hold that military family member accountable by talking about their abusive behavior thus challenging military cohesion.

Some participants chose to delay seeking out mental health care services for MST due to this stigma of military cohesion and would seek out other facilities for treatment if they experienced that stigma from VHA providers. All participants eventually reported abusive behavior from superior officers while on active duty. However, some participants remained hopeful that providers could be better trained and that there was room for improvement at both VHA and non-VHA facilities to meet the unique needs of female veterans specific to MST.

Rural Health Care

A rural health care literature review by Cyr et al. (2019) indicated that while the majority of the population in the U.S. is rural, only 20% of this population actually works in and resides in rural areas leaving the remaining 80% of the population living in urban and suburban areas. Rural residents' demographics are typically older, more likely to be uninsured, less educated, have increased poverty rates, are less likely to own their own home, and have high rates of smoking and obesity.

This research study did not collect data for insurance, education, poverty rates, home ownership, or rate of smoking and obesity. However, one large study of more than 9,000 rural residents explored the availability of medical services indicating that there was a lack of medical services for this rural population by twice as much as urban and suburban areas (Cummings et al., 2013).

The current study found the average age of participants was 47.2 years old. Two out of nine participants reported being "satisfied" with their level of household income and did not support the literature findings. The participants in this research study all had

access to military insurance although for a variety of reasons as this research study has explored, some would use military insurance benefits, and some would choose to use civilian insurance benefits due to a civilian job or spousal insurance post deployment. Some participants reported that sometimes based upon where they lived in relation to a care facility, what that facility could offer, what insurance they accepted and what the participant needed, would play a big part in choosing where to go for treatment.

Rural Mental Health Care

The literature indicated that women living in rural communities who had been diagnosed with breast cancer had to drive more than 30 miles for cancer treatment (Aylward et al., 2012). These women were also exhibiting symptoms of depression (a majority of 73%) and seeking psychotherapy and needing to travel more than 30 miles (Aylward et al., 2012). However, some women (17%) needed to drive more than 100 miles to access the same treatment for both cancer and depression (Aylward et al., 2012).

More recent research with programs trying to make connections with rural veterans during COVID-19 saw increased challenges due to the lockdown that included isolation, access, transportation, food and housing insecurities (Hamilton, et al., 2020). According to Cusack, et al., (2022) a qualitative study with rural providers themselves, reflected on access to care for veterans during COVID-19 and found the same barriers to care that included lack of access to treatment, quality treatment and distance to access VA or non-VA care. If veterans did travel these distances, they would still have to consider time away from work, inclement weather and/or childcare considerations. This

research study did not collect data for the various diagnoses of female veterans living in rural communities and the measured distance traveled to facilities to access care.

Other literature findings confirmed that depressed women living in rural areas are less able to access needed mental health care than women in non-rural areas according to, Aylward et al., (2012) and this efficacy requires coordination between medical and mental health services often limited in rural communities where untreated depression is an important public health concern (Freedy et al., 2010; Maguen et al., 2010; Mattocks et al., 2010; Sambamoorthi et al., 2010; Shen et al., 2010; Stecker et al., 2007). Women veterans residing far away from VHA facilities may not receive the integration and access to mental health care they need which raises the possibility of a potential public health problem (Aylward et al., 2012). Regardless of age, 25% of all women veterans live in rural areas create the challenges of ensuring high-quality, equitable, gender-specific VHA primary care services.

All the participants in this research study met the criteria of living in a rural area and seeking out mental health care. Most of the participants experienced challenges due to residing far away from VHA facilities. These challenges included, inclement weather, work schedules, transportation, trained staff, availability of female providers, childcare needs, travel time and urgency of needed care. Based upon the participants in this research living in a rural area and access to quality mental health care is a challenge. The average age of the participants in this research study was 47.2 years old. All participants met the criteria of living in a rural area and experienced challenges with finding and scheduling good gender-specific VA and non-VA mental health care facilities.

Rural Health Care of Veterans

According to U.S. census data in 2014, a higher percentage of veterans (24%) live in rural areas compared to all urban veterans (19.3%), however, despite a growing need for physicians, the supply in rural areas indicates a shortage. Urban veterans living in rural areas experience a greater incidence of disease prevalence with lower physical and mental quality-of-life scores (Albanese, Bope, Sanders, & Bowman, 2020). The Veterans Healthcare Benefits Improvement Act of 2016 encouraged more graduate medical positions in rural areas of only 6.4% of resident positions were filled in rural areas attributed to by the reduction of partnership options, infrastructure funding, and incentives for residents to train in rural and underserved areas (Albanese, Bope, Sanders, & Bowman, 2020). In 2018, the VA MISSION Act II was introduced with the goal of establishing a more efficient community care program for veterans as well as to modernize and realign resources to expand access to community care through the Veterans Choice Fund. The hope from this research was that physicians who choose to train in rural areas would remain there after training and continue to serve veterans in rural America.

Some participants in this study found difficulties finding and scheduling gender-specific mental health care services at VA facilities and encountered providers who were not trained to understand the unique needs of female veterans. Participant 2, Participant 3, Participant 5, Participant 6 and Participant 7, in this study, found difficulties finding long-term care with younger staff that left some facilities frequently once trained. Sometimes the staff were limited in number if a female practitioner was preferred. Some participants

found that it was harder to start all over again by telling their story every time their practitioner left and then stopped seeking care.

Rural Health Care of Women Veterans

Rural women veterans show worse physical health functioning compared to their urban counter parts (Cordasco, et al., 2016). The conclusion was that disparities in health and health care access for rural women veterans continues to drive the force to meet their unmet needs (Cordasco, et al., 2016). Meeting the unmet needs of rural women veterans might require creative ways to deliver care models as part of the solution. This phenomenological research study endeavored to understand the lived experiences of rural female veterans seeking mental health counseling which is one component of health care through the lens of HCU theory.

Rural Mental Health Care of Women Veterans

According to Inglese & Messecar (2016) it was found that the overall number of veterans in the U.S. is decreasing. However, the number of women veterans is significantly increasing with respect to mental health care. Although there was a significant increase with the need for mental health care, several barriers were found with the first being residing in a rural area (Inglese & Messecar, 2016).

All research participants in this study resided in a rural area. The results are clear that most participants experienced that finding, scheduling and access to gender-specific mental health care from VA or non-VA facilities posed more barriers while living in a rural area. It was found that female veterans had a variety of challenges even when they did access these facilities due to longer wait times, distance, inclement weather, childcare

considerations, and time away from work. Living in a rural area for these research participants created a unique set of challenges compared to their counterparts living in urban and suburban areas.

Overall, all veterans living in rural areas have access to fewer mental health services than urban residing veterans. Specifically, women veterans in rural areas have less access to mental health care than their male colleagues. Not much is known about the mental health services needs of women veterans (Inglese & Messecar, 2016). What is known from the literature is that women veterans who have unique problems such as PTSD and MST, despite seeking care, encounter barriers persisted to include being made to feel that they were not actual combat veterans, being thought of as lazy, being stigmatized for seeking care, and being subjected to a lack of interest from those providing care in hearing their stories (Inglese & Messecar, 2016).

Many participants in this study found it important when seeking gender-specific mental health services that those services come with the ease of making available appointments. Some participants, due to their own mental health diagnosis, found it frustrating and disappointing to consistently call and leave messages for appointments and then return those calls if care was needed urgently. Some participants, due to their own mental health diagnosis, found the availability of female practitioners, practitioners that were well trained to understand and treat the unique needs of female veterans, and consistency of practitioner appointment whether in-person or virtual, added to their struggles with mental health care.

In this research study it was not found that participants felt that they were thought of as less deserving of care whether they were in actual combat or not. Most participants did not express being thought of as lazy or felt stigmatized for seeking care. However, some participants did report experiencing inconsistent and incompetent care when needed.

Counselors working in rural locations could benefit with a better understanding of what rural women veterans need regarding accessible mental health care. The understanding and accommodation of their needs should not occur outside of the intent to minimize stigma when seeking that care. This could facilitate better communication between counselors and community providers being encouraged to initiate conversations about PTSD and MST in the creation of a better support network for female veterans in rural areas.

Limitations of the Study

One limitation of this study was the location of the participants. All participants were required to live within rural counties within the U.S.. Rural counties within the U.S. were defined as of residing within a rural county within the U.S. that have between 7 residents per square mile (on average) but not more than 500 residents per square mile (see HRSA, 2021). This limitation created from this research was that the data gathered may not speak to the rich experience of all female veterans in all rural areas throughout the entire U.S.. This data did, however, speak to the population of female veterans who resided in rural areas of New England. Any information gathered and analyzed producing data may not be applied nor generalized to the entire population of female veterans living

in any other rural geographic regions whether throughout the entire U.S. nor rural New England.

One other limitation of this study was the race of the participants. All the participants reported as White within their rural counties within the U.S.. This limitation from the research may not speak to the rich experiences of non-White people in all rural areas throughout the U.S.. The information gathered did not include all data being generalized to the population of non-White female veterans in those rural areas in New England. Any information gathered and analyzed producing data may not be applied in part to the populations of non-White female veterans living in any other rural geographic regions and not generalized to the entire population.

Recommendations

Recommendations for future research regarding gender-specific treatment around MST could benefit female veterans in rural areas. MST was not the focus of this study. However, it was the most common theme in the data reported by all research participants prior to the application of the lens of HCU theory. The literature shows that barriers to care with respect to geographic distance and pre-existing conditions such as MST contribute to the female veterans not seeking mental health counseling. Reasons such as the stigma of seeking out mental health care, military cohesion, comorbidities of diagnoses and geographical distance produce a strained relationship to accessing healthcare for rural female veterans. This has been proven to create a relationship between MST and reports of institutional betrayal and a drive for survivors to lean towards using non-VHA medical care.

According to Haskell (2010) female veterans experience MST at a rate of 14 to 1 compared to their male counterparts. Recommendations for sensitivity to gender differences to care, especially with female veterans, should inform health services within the VA system. However, providers are not as prepared to provide gender-specific care trauma informed methods for treating female veterans.

Recommendation for future research with VHA and non-VHA institutions and their female veterans' patients and their lived experience having experienced MST would be important. This would be especially important for those female veterans living in rural areas where it is well documented provide less accessible, quality trauma informed and gender-specific care. What could be learned by focusing future research on rural female veterans lived experiences with seeking mental health care who have experienced MST will be life changing.

One last recommendation for future research would be to use the 14 final meaning units (Appendix F) as their own secondary focus for research. This is because some of the more salient data regarding female veterans' lived experiences seeking mental health care that did not come through the lens of HCU theory. This data might reveal other important experiences that have the power to further research.

Implications for Social Change

This dissertation study has filled in the gaps with the research literature regarding the lived experiences of female veterans seeking mental health care who live in rural parts of the United States. This study demonstrated the need for continued research on quality, accessible, gender-specific, and trauma informed mental health services for

female veterans living in rural areas of the United States. This presents an opportunity for both mental health counselors and medical practitioners to collaborate with rural residents to continue that have unmet mental health care needs by changing the way they practice by improving quality, accessible, gender-specific and trauma informed mental health services for rural female veterans.

Counselors working in rural locations could benefit with a better understanding of what rural women veterans need regarding accessible mental health care. The understanding and accommodation of their needs should not occur outside of the intent to minimize stigma when seeking that care. This could facilitate better communication between counselors and community providers being encouraged to initiate conversations about PTSD and MST in the creation of a better support network for female veterans in rural areas.

Being better trained to support female veterans' mental health care needs sends a supportive message for this large and growing population of the military. This growing population deserves this support and reflects one important aspect of positive social change. This sends the message that female veterans who give their lives to serve their country are worthy of quality gender-specific care whether from VA or non-VA facilities. An important distinction with quality gender-specific care is that female veterans suffer some diagnoses at greater rates than their male counterparts and as such should be treated and cared for specific to their gender and not the same as their male counterparts.

Citizens of the United States who choose to reside in rural areas and enjoy the lifestyle may experience fewer quality services because those areas do not typically

attract quality practitioners. Fewer quality services may be a sacrifice to live in a more enjoyable rural lifestyle. They should not have to sacrifice where they live for less health care services. The social change implications with a call for quality health care to grow in rural areas could inspire populations to move away from the sometimes stressful rural or urban areas. Living in rural areas tends to reflect upon a slower, less stressful quality of life with more affordable homes and less financial stress that may contribute to overall better mental health.

Conclusion

In conclusion, in this chapter I revisited the purpose and problem statement of this research study. I created a dialogue being informed by what the literature found in Chapter 2 and the research study findings. The major sections that were part of the dialogue with the literature included, *Health Care for Veterans in the United States, Reluctance of Veterans to Seek Mental Health Services, Women Veterans and Rural Health Care*.

I discussed the limitations of this study regarding participants' data being from rural areas in New England versus the entire U.S. not speaking to the rich experience of all people in all areas. Another limitation discussed was that the information gathered, and the data produced from an all-White participant population does not speak to the rich experience of people of color across all areas. I make recommendations for future research with data that unexpectedly appeared regarding MST. Finally, I discuss implications regarding the information gathered and the data produced that speak to need

for social change and the improvement upon the quality of care for all female veterans living in the rural U.S..

The population of female veterans who choose to enroll in the military and put their lives on the line to protect their country, and are now post deployment, should be afforded the same accessible and quality care for the same commitment to their country as their male counterparts. This quality of care will require accessibility to that care especially if living in rural areas of the U.S. through practitioner incentives to operate there, care that is specific to the unique needs of female veterans, and a collaboration between and within practitioners in VA and non-VA healthcare facilities to maintain a standard of trauma informed training to better serve this population. This awareness sends a message across the military industrial complex that female veterans' services are respected and has the power to inspire and lead future generations of female veterans pursuing a military career who choose to defend our country.

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Appendix A: Recruitment Flyer

Needed:

Female Veterans over the age of 18 in rural counties of the United States who have left active duty two or more years ago who have sought mental health services in the past.

Purpose:

Research Study Volunteers willing to talk about your experiences for an hour or less.

Please contact **Tina Tarryk** by phone, text, or email at (833) 246-6624 or tina.tarryk@waldenu.edu.

I am conducting this study for my Walden University dissertation.

Thank you.

Appendix B: Consent Form

You are invited to take part in a research study about the experience of female veterans seeking mental health care. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study seeks 8 to 10 female veterans volunteers who are:

- At least 18 years of age.
- Female veterans for at least 2 years since service.
- Reside currently and have sought mental health services in a rural county in the United States.

This study is being conducted by a researcher named Tina M Tarryk who is a PhD, CES (Counselor Educator and Supervisor) student at Walden University.

Study Purpose:

The purpose of this study is to better understand experiences of female veterans who have sought mental health counseling in rural counties in the United States.

Procedures:

This study will involve you completing the following steps:

- Initial Interview of participants will be audio recorded and will be 45 to 60 minutes long
- Follow up interview to fill in any gaps of information will be 30 minutes long
- Sending a transcript to each participant via mail or email to confirm accuracy of the content may require no more than 30 minutes of your time

Here are some sample questions:

- What were your experiences with seeking treatment for mental health services since leaving military service?

- Please describe your experience with the type of mental health services you were seeking and needing at this time?

- Please describe your experience with any health insurance benefits you have used when seeking mental health services?

Voluntary Nature of the Study:

Research should only be done with those who freely volunteer. Everyone involved will respect your decision to join or not. If you decide to join the study now, you can still change your mind later. You may stop at any time. The researcher will follow up with all volunteers to let them know whether or not they were selected for the study.

Risks and Benefits of Being in the Study:

Being in this study could involve some risk of the minor discomforts that can be encountered in daily life such as sharing sensitive information. With the protections in place, this study would pose minimal risk to your wellbeing. Participants may run the risk of psychological distress because of discussing sensitive topics during the interview. I will provide you with contact information for free or very low-cost resources if you experience any psychological distress in the interviews. Examples of resources are Northeast Kingdom Counseling (NEK) in Newport, Vermont, the Northeast Kingdom Human Services (NKHS) in Derby, Vermont, or the Veterans Crisis Line at 1-800-273-8255.

This study offers no direct benefit to individual volunteers. The aim of this study is to benefit society by understanding the lived experiences of female veterans living in rural areas of the United States seeking mental health care. As a result, the potential benefit of participating in this study may come in the form of providing more accessible mental health services. Once the analysis is complete, the researcher will share the overall results by emailing you a summary, emailing you a link to a summary, and/or -inviting you to a virtual presentation.

Payment:

There is no form of compensation for participation in this research study.

Privacy:

The researcher is required to protect your privacy. Your identity will be kept anonymous within the limits of the law. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers so this would not involve another round of obtaining informed consent. Recorded data will be kept secure by being stored in a double locked filing cabinet for 5 years. All recorded data will be stored digitally and erased after 5 years. All written data will be shredded after 5 years. Data will be kept for a period of at least 5 years as required by the university.

Contacts and Questions:

You can ask questions of the researcher by telephone or text at (833) 246-6624 or by email at tina.tarryk@waldenu.edu. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research

Participant Advocate at 612-312-1210. Walden University's approval number for this study is Walden University's approval number for this study is 08-19-22-0087578. It expires on July 18, 2025.

You might wish to retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.

Obtaining Your Consent

If you feel you understand the study and wish to volunteer, please indicate your consent by replying to this e-mail with the words "I consent" or if you received a paper version, please sign below and return in the enclosed envelope.

Printed Name of Participant

_____

Signature Date

_____ _____

Signature of Researcher Date

_____ _____

Appendix C: Demographic Questions

1. Which branch of the US Armed Services did you serve in?
2. How many years were you on active duty?
3. How many years ago did you leave active duty and become a veteran?
4. What is your age?
5. What race or ethnic background do you identify?
6. How would you describe your satisfaction level with your current household income?
7. Please share the number of members in your household including yourself that you are directly responsible for supporting?
8. What is your marital status?
9. Do you currently live in a rural area of the United States?

Appendix D: Interview Protocol

Date: _____

Location: _____

Name of Interviewer: _____

Name of Interviewee: _____

Initial Interview:

After the demographic questionnaire, I will begin the interview with the following statement and questions: “You were chosen for this study because you are a female veteran living in a rural area of the United States. Would you please describe in detail your experiences seeking mental health counseling services while you have been living in a rural area?” I will use prompts and probing questions to encourage participants to provide detailed information about their experiences.

After participants have responded to this first question, if they have not already discussed these areas, I will make these requests or ask them additional questions. I will not make these requests or ask these questions if they have already been discussed by participants.

1. Do you currently live in the rural United States?

2. How long have you lived in this general area?

3. How far away is the closest health care facility for veterans?

4. If you have received mental health services as a veteran, how far did you have to travel to receive those services? Tell me about your experiences.

5. Do you feel that military cohesion ideas have kept you in any way from seeking mental health services? Why or why not?

6. What were your experiences with seeking treatment for mental health services since leaving military service?

7. Please describe your experience with the type of mental health services you were seeking and needing at this time?

8. Please describe your experience with any health insurance benefits you have used when seeking mental health services?

9. Please describe your level of satisfaction with your mental health needs being met or not met by the government services that you have been provided?

10. Please discuss whether living in a rural area has had an impact on your seeking and receiving mental health services as a veteran? If so, how?

11. Do you have anything more to add about your seeking mental health services since you have been a veteran?

Appendix E: Recruitment Email

Dear (Name),

Walden University

The Experiences of Rural Female Veterans Seeking Mental Health Counseling

Volunteers Wanted for A Research Study

You are being invited to participate in a research study that seeks to investigate the lived experiences of rural female veterans seeking mental health counseling. You will be asked to participate in an interview (approximately 60 minutes) and participate in a follow-up interview should clarification or additional information be needed. The interviews will be videotaped and/or audiotaped.

In order to participate you must meet the following criteria:

1) Must be at least 18 years of age.
2) Must identify as a female veteran for at least 2 years since service.
3) Reside currently in a rural county in the United States.

Your Confidentiality

This study is not affiliated with any group, and no one will know you are participating, other than the researcher. Reporting the results will not include any identifiers. All personal identifiers will be removed by the researcher, and all audio and video tapes will be destroyed immediately after the study.

If you are interested in participating in this study or would like more information, please contact:

Tina Tarryk at: 833-246-6624 or tina.tarryk@waldenu.edu.

All communication is confidential.

Appendix F: Results and Data Samples

There were 14 final meaning units that emerged from the participant transcripts as a direct result of the semi-structured interview questions. These meaning units were, (a) cohesion affecting service negatively, (b) finding good gender specific VA therapies, (c) location negatively affecting benefits, (d) difficulty in finding/scheduling gender specific VA mental health care, (e) difficulty finding non-VA gender specific care, (f) good non-VA resources, (g) insurance issues, (h) rural locations, (i) military sexual trauma, (j) preferring virtual mental health care due to privacy, (k) pre-post deployment personal issues, (l) support for continued research on female veterans, (m) the pandemic affecting mental health care, and (n) resources and cohesion affecting service positively.

Final Meaning Units

Final Meaning Unit	P1	P2	P3	P4	P5	P6	P7	P8	P9
Cohesion Affected Service Negatively	X	X	X		X	X	X	X	X
Found Good Gender Specific VA Therapies		X	X		X		X	X	X
Rural Locations Neg. Affect Benefits		X	X	X	X	X		X	
Difficult to Find/Schedule Gender Specific VA MH Care		X	X		X	X	X		
Difficult to Find non-VA Gender Specific Care		X						X	X
Military Sexual Trauma	X			X		X	X		
Prefers Virtual MH Due to Privacy Issues			X		X	X			
Pre-Post Deployment Personal Issues		X				X	X		
Supportive of Research for Female Vets						X	X		X
Insurance Issues					X			X	
Rural Location Good for MH Benefits	X						X		
Good non-VA Resources	X			X					

Final Meaning Unit	P1	P2	P3	P4	P5	P6	P7	P8	P9
Pandemic Affect MH Care		X		X					
Cohesion Affected Service Positively				X					

Below are the 14 illustrated final meaning units of this study supported by participant's responses to each of the final meaning units.

Final Meaning Unit 1: Cohesion Affected Service Negatively

Eight participants interviewed reported that the idea of cohesion had affected their military service negatively (P1, P2, P3, P5, P6, P7, P8, and P9). The experience of the female veterans is described in the following responses beginning with P1 regarding not wanting to report a rape and stated,

"That's not anything you ever wanted to pursue. No, because I don't want to deal with retaliation or going to court and all that [expletive]."

P2 stated, "I was actively a part of conversations where people would be like, you're going to kill your career." P3 stated, "I think I was more worried about it than anybody [who] was going through the disability, the VA disability stuff. But I still didn't let anybody in my unit know what I was doing with that. I wanted to keep everything separate. I had almost 22 years in, so I didn't want to mess up anything with my retirement. Well, I didn't want [them] to kick me out or. PTSD You know, having any kind of Injuries or anything that they said that I wouldn't be able to do my job in the guard either."

P5 stated, "There's definitely an aspect of that. There was a huge investigation among people and our training command. I sat down and told them all the stuff and had

to write statements and everything. Nothing really came of it, anyway. I wanted to make it in my career, and then they said it wouldn't look good if we promoted you right now with all this other stuff happening. I realized that this is just never going to [happen]."

P6 shared, "Military cohesion? Yeah, I would say so. But you know I wasn't willing to go speak as to what was going on, because I didn't want to be taken out of the game. I don't want to be labeled with anything. I just wanted to go home to my family. I was so afraid of being labeled because I was still in the military. I didn't want that to stop me from being able to do what I was supposed to be doing."

P7 reported, "Oh, yes it affected me specifically after I after I got out of service because I did have mental services while I was in which was not supported and dramatically different negative experience."

P8 cautioned, "Yes, I had this idea implanted. Don't ever seek mental health, because it might have this impact on your career. Even after I was not on active duty I was still in the reserves or with my civilian job and I was hesitant to seek care."

P9 added, "You mean from service to now? Definitely. Definitely. I had a top-secret security clearance, and I was openly mocked. The things that aren't said out loud are even more harsh. There's a lack of promotion. I then immediately stopped seeking mental health counseling."

Final Meaning Unit 2: Finding Good Gender Specific VA Therapies

A total of six participants interviewed reported that they were able to find good or helpful gender specific VA therapies both supporting physical and mental health care (P2, P3, P5, P7, P8, P9).

P2 shared, “Recreational therapy, has allowed me to really branch out. I’ve been able to connect with other female vets that have had similar experiences. I got a Qigong and a Yoga instructor. I was offered the opportunity to go skiing with rec therapy, and then I was offered a lot of different little facets. But yeah, I would say, I’m satisfied.”

P3 offered, “The counselors I’ve worked with have been good. Since like, 2010. I’ve never [had someone] that I didn’t like. It is a lot better than it used to be. There weren’t any female counselors for a long time. Sometimes I don’t want to talk to a male. I want to talk to a female.”

P5 asserted, “I would say. I’m satisfied. I feel like there’s still definitely room to grow, but I think it’s better.”

P7 shared, “I had telehealth for mental health first, so I got mental health care from home. Then I also went into that same facility to get care in person. I’m pursuing mental health care through the VA for the rest of my life because I am happy with it.”

P8 offered, “At the VA I never had any problems either with accessing my care. My mental health care has been great.”

P9 finally shared, “Right now, I do it over, video, or I travel an hour. I can use these apps to help [with] meditation. I wish that I could state it more emphatically to say how blessed I’ve been. The people are exceptional, the support staff, they’re all exceptional… everyone. Being able to do it by video has made a big difference.”

Final Meaning Unit 3: Rural Location Negatively Affect Benefits

Six research participants interviewed reported that living in a rural location negatively affected access to health care benefits (P2, P3, P4, P5, P6, P8).

P2 reported, “I know a lot of a lot of people struggle to get on the wait list. I would say that rural medicine is its own little niche outnumbered by cows and corn, and really not much you can do about it. Sometimes there’s moose, sometimes there’s not, but the wait lists are extraordinarily long. I’ve cancelled a time or 2 because [of] black ice glare ice, squalls. There’s been times where inclement weather has played a part.”

P3 followed up with, “Right now, I only have health insurance through my work. I’ve only used VA once. Maybe somebody closer would be a lot better and being able to get different types of [care].”

P4 reported, “Especially living in the rural areas because having to leave work to take time off to go seek the help [is] much harder to do. [For example], taking 3 hours off my workday, [when] I can only take one.”

P5 shared, “It’s hard to get anything that close to where I live. It’s about 40 minutes or so. I work as a nurse, so most of the time I can’t call out either way. So, most of the time I just must brave it one way or another. But I wouldn’t drive if there was a snowstorm or something. There’s no way.”

P6 stated, “The next closest VA to me is an hour and a half one way or an hour and a half or more the other way. It’s not really an option. They don’t have any availability. So, I’ve just been kind of posting and hoping that I don’t fall into another quasi crisis.”

Finally, P8 reported, “It’s too far. It’s too hard. It takes too long to get there and in receiving the lack of resources. The [local hospital] is like not taking new patients. So then, what do you do? I was trying to get in with anywhere. My sense is that it’s different in rural areas”.

Final Meaning Unit 4: Difficulty in Finding/Scheduling Gender Specific VA MH Care

Five participants interviewed reported experiencing difficulties in finding and/or schedule gender specific VA mental health care (P2, P3, P5, P6, P7).

P2 reported, “[It’s] incredibly difficult to find a mental health practitioner that understands a veteran’s unique experience as a woman.”

P3 continued “Who I was seeing this time was virtual. She had very limited times that I could see her and it was difficult for me to get to the appointment. It was difficult [for] me to set appointments that were working.”

P5 stated, “When I was overseas and having basically a horrible year. I would have had to make a point of traveling to a different base, which was like a big deal because you had to submit all these documents and everything. They knew that I wasn’t happy with the way that things were going and the way that I was being treated, like other female soldiers were being treated. I didn’t go because they thought that I was saying something bad about them and didn’t want me to say so. I didn’t go”

P6 had a lot to share, “It just seemed to be hard to get an appointment. So, it was kind of a wait to get in to be seen and I was offered the Vet Center, but the Vet Center is even harder to get into, and I found that to be repeatedly true. I finally got in there and

there was no rapport, and again it just didn't seem like I wasn't getting a whole lot from that. I was disengaged from mental health services at that point. They don't seem to really understand what our needs are yet as female veterans. I don't think they really seem to understand. I have PTSD but I'm being told I'm anxious and depressed.

P7 gave rich data to support this theme and stated, "I was talking to other people, and I was getting the runaround. I'm not sure that the VA is ever able to provide quality, mental health care. Just because of funding and the scope of the patients. I think they're trying. They're trying to do something that they're just not funded for, and they don't understand, and it's a disaster most of the time. It really is more quality of care that concerns me. I can't remember all the names for all the different avenues for mental health care, but I needed help. I couldn't get anyone to call back. There were 2 counselors that I talked with that day, and both of them were shockingly horrible. They were both using swear words when they talked to me, and again they kind of gave me the runaround. I did get in person meeting with this new counselor, and it was a miserable time. She spent a lot of time asking me what kind of therapy I wanted. I had 3 or 4 sessions with this this new counselor and all of them were a complete waste of time and completely diminished my confidence in the VA's hiring practices."

Final Meaning Unit 5: Difficulty in Finding non-VA Gender Specific Care

A total of three participants interviewed reported experiencing difficulties in finding non-VA gender specific care (P2, P8, P9).

P2 shared, “[It’s]incredibly difficult to find who understands the unique experience of women veterans, let alone a mental health practitioner that understands a veteran.”

P8 followed with, “I do think that the non-VA population as a whole, even when I was seeking and receiving the alcohol treatment at a very reputable hospital really clearly don’t get veterans, and they really clearly did not specifically get female veterans.”

P9 stated, “I had depression and PTSD. I had gone to counseling at a non-VA facility in New England when I was living there. It was a perfectly nice person, perfectly nice clinic, perfectly adequate there. It was a nice visit, but it wasn’t really mental health services.”

Final Meaning Unit 6: Military Sexual Trauma

Four participants interviewed reported being affected by MST while serving on active duty (P1, P4, P6, P7).

P1 shared, “I never dealt with it. It was rape. I don’t even want to think about it now. I tried to deal with it and go into counseling, but I had only one session and somehow my records came up missing. The perpetrator basically got away with it. He was in the same unit and in an authoritative position. It was all against me and basically made it look like it was my fault. The situation was not my fault. They didn’t want to take his stripes away. He was like an E 6 or E 7. I didn’t want to deal with the retaliation or going to court. I go about life now and realize that’s why I have screwed up relationships.”

P4 stated, “I’m still working on a lot of my problems. I didn’t feel like I could open up completely and felt more closed off with them [military]. I haven’t told everybody. Not everybody needs to know and not everybody knows the situation which I handled which was [abusive]. Since I deployed my support system, I decided to make a law based on what I went through [while on active duty] to create a civilian protective order for abuse be put into place automatically and now [active-duty military] don’t have to fight for it the way I did when I got out [deployed]. We are now trying to change that law in the State of Vermont.”

P6 continued, “There was a military officer over where I was deployed that was very inappropriate, so there was some of that I was dealing with. I always wondered if I had confronted that…would that have made me unable to deal with what I had to deal with working. It was like a protective mechanism, I would imagine. Added to the fact that I work at that VA and the lack of availability of providers at the Vet center and a wait list for the providers at VA. I was kind of gathering my thoughts. I’ve kind learned to just never want to talk about it ever but that that wasn’t helpful.”

P7 ended with, “I never got deployed. I was the music librarian for the Air Force Band. I never saw anybody. Everyone else was always out doing things and never traveled. I sat in the same chair alone for 10 years in a room with no window and an abusive supervisor who almost never showed up. I had a very different military experience then.”

Final Meaning Unit 7: Prefers Virtual MH Due to Privacy Issues

Three participants interviewed reported preferring virtual mental health care due to privacy issues (P3, P5, P6).

P3 stated, “I also wasn’t working down there [like I am here], so that made it a little easier [to access services], but still you had a lot more privacy. There’s a caution of privacy if you’re accessing services [where I work now] and then and there’s the type of services or the availability of services.”

P5 reported, “I have 2 jobs and kids and everything. I work quite a bit, so it makes it easy to make time for [virtual sessions], whereas if I had to drop everything to go, do it, I think I wouldn’t have been as likely to stick with it. I like being at home and not worrying about anything else. A couple of times I went there [in person counseling] and I saw some people I knew and some people that I don’t particularly like. I was very overwhelmed to be sitting in the little room with a group of people staring at me.”

And P6, shared, “There are things that go through my brain, things that are very private, and I don’t want to walk past somebody in the hallway [where I work] and wonder if in the back of my brain they thinking about what they [counselors] told them? And confidence like, you know? You wouldn’t want to work with your OBGYN.”

Final Meaning Unit 8: Pre-post Deployment Personal Issues

Three participants interviewed reported having pre and/or post -deployment personal issues that affected them (P2, P6, P7).

P2 shared, “After getting out of the uniform you feel like you’ve lost a huge part of yourself. I have boots that are older than my children, and I can’t get rid of them yet even though it’s been years. I have 2 kids that remember seeing me in uniform and not

being around as much. I didn't know how to do my daughter's hair because I was never there when her hair needed to be done. I wasn't sure how to be a mom when I first got out."

P6 reported, "When you get home, you must do like a post deployment questionnaire, and they ask you a bunch of stuff, but you are just so desperate to just be released and go back to your family. It wasn't like a big deal but when I was scared. I went to Iraq twice and it's a pretty big deal in my life. My family will be the first one to tell you like I am not the person I was when I left. I had 3 children at home. My youngest was not quite about a year old and I missed her third birthday because I was deployed again. Then people would always ask me that like, how can you leave your babies? Men leave their babies all the time I was in the military long before I was a mom. I had to beg my mom to not let my son see the news. He knows where I'm at. Constantly would talk to me and say "mommy, you're not going to die, are you?"

P7 stated, "I enlisted in 2006 and went to basic training. They didn't even have female uniforms for their bodies, the camouflage things that you wear every day.
I think it was in 2009. They got the updated camouflage for the Air Force, and it was only then when those everyday uniforms that we all wear came in female sizes. I think that speaks to the overall culture of the military toward females and all the nuances that come with being a female veteran in 2024. They're so behind. For lots of reasons. They didn't understand what it what it meant to be a female airman."

Final Meaning Unit 9: Supportive of Research for Female Vets

Three participants interviewed reported being supportive of continued research for Female Vets (P6, P7, P9).

P6 noted, “I really commend the research that you’re doing. You know, not just the aspect of rural, but the fact that you’re asking women veterans what women veterans need because like I told you that there just seems to be a disconnect. I found that to be true in Wichita. I lived in Arizona for a while, too. I never tried to go to the VA there for mental health, because it’s just really hard to get any kind of appointment.”

P7 shared, “I think it’s important to share what I have been through to help make a positive change. I don’t know how far of a reach you have”.

P9 stated, “I think doctors nurse practitioners need to be educated [through research] about their prejudices around treating people who have mental health issues that are limiting their understanding of people’s physical issues. It makes me feel more supportive seeing the trans women being supported recently. That whole concept of uplifting each other is contagious.”

Final Meaning Unit 10: Insurance Challenges

Two participants interviewed reported having experienced issues with general insurance coverage (P5, P8).

P5 stated, “There are so many people that didn’t take Tricare (military insurance). I couldn’t find anyone to take my insurance. Our pharmacy stopped accepting it. The other day we went to go pick up our like medications, and we’ve been using the same pharmacy forever. And they don’t take Tricare anymore.”

P8 reported, “I have Tricare and Blue Cross Blue Shield, and for some reason the VA doesn’t bill Tricare although I’m service connected. There’s something about government agencies. One can’t bill the other. They don’t bill Medicare. The VA doesn’t bill Medicare, either.”

Final Meaning Unit 11: Finding Rural Locations Good for MH Benefits

Two participants interviewed reported having good experience with accessing mental health care while living in a rural location (P1, P7).

P1 reported, “No [In response to the question: “Please discuss whether living in a rural area has had any impact on your seeking and receiving mental health services?”

P7 stated, “So, I needed some support, and I asked the VA first, because that’s the easiest thing to do and I did have a good telehealth counselor, and she was able to identify what to work on and found a great therapy option for me and [I] made a lot of improvement [and] growth over that time. The distance from the facility doesn’t really matter. I’m willing to take the drive because I embrace the lifestyle. I love to listen to podcasts in the car because I’m home with kids all day. Driving is actually a good thing for me. I would like more care and support for mental health no matter the cost.”

Final Meaning Unit 12: Finding Good non-VA Resources

Two participants interviewed reported having positive experiences with non-VA resources (P1, P4).

P1 stated, “I haven’t had to [use VA benefits]. I used the regular mental health services. [They] have been good. I didn’t have a problem. I had some good counselors, some excellent counselors.”

P4 shared, “It’s been positive it’s helped me out so much. I like the fact that she is a civilian. For yes, for me. It’s positive.”

Final Meaning Unit 13: Pandemic Affect MH Care

Two participants interviewed reported that the pandemic affected their access to mental health care (P2, P4).

P2 shared, “Who would have thought a pandemic would have gotten me to break? The pandemic hitting, and then not really being able to acclimate to civilian life. I really struggled.”

P4 offered, “I think, with having the option of doing Zoom meetings more so since Covid. It’s been a lot easier.”

Final Meaning Unit 14: Cohesion Positively Affecting Service

There was one participant that reported that cohesion has a positive effect on their military service (P4).

P4 stated,

If any lower enlisted saw him [the senior officer] going, they [other enlisted] would be more apt to go themselves if they needed the help. During my situation [there] was cause for me to seek these services. They really pushed me to seek help and wanted to help me within this situation.”

General Narrative

Most of the participants had military service negatively affected by cohesion. They were directly or indirectly discouraged from reporting any mental health issues while enrolled in active duty. Most of the participants found good gender specific VA

therapies to support them. However, most participants found that living in a rural location negatively affected access to those benefits due to long waitlists, greater distances to a VA facility, time away from work or family to travel to those facilities, cost of long-distance travel and road conditions due to inclement weather. Most participants, if they found gender specific VA mental health care, found it difficult to be scheduled for sessions for immediate care or found challenges with finding consistent care providers without continuous staff changeover, however two participants did say this was not an issue for them personally.

Many participants who chose not to use VA facilities found it difficult to access gender specific care that was knowledgeable about the specific needs of the participants' mental health care vs. female civilians.

Some participants did find non-VA resources that supported their mental health care. Some participants had the challenge of insurance issues where military insurance was dropped suddenly or there were billing conflicts between insurance providers. Some participants found that their experience of MST was often not shared due to being negatively affected by military cohesion. Some participants preferred virtual mental health care due to issues of privacy and easier accessibility without the challenges of the length and cost of travel to VA facilities while living in a rural area. Some participants shared pre and post deployment issues with their families. Whereas some participants needed to plan care for their family members prior to deployment, especially if they had young children, were divorced or single parents.

Post deployment issues ranged from challenges with resuming the role of mother or spouse. Some children had difficulty reconnecting with their mothers having lived the formative years without them. Some parents who did not have the skills in raising children pre-deployment had to learn how to be a parent post-deployment. Some participants returning home from post-deployment found that their personalities had changed, as evidenced by family and friends, due to their active duty. Some participants are supportive of this research study and remained hopeful of results that might inspire a better understanding of participants' needs being different than their male counterparts.

Lastly, some participants report that the global pandemic affected their mental health care in unexpected negative and positive ways with access to virtual care coming to fruition. Finally, one participant reported experiencing military cohesion having a positive effect on their service due to the example set by a senior official who themselves sought mental health care when needed.

General Description

Female veterans in this study enrolled in military duty expect to remain there as part of a long-term career choice. They find themselves discouraged from seeking out mental health care without personal or professional risk to their careers. Female veterans desirous of a long-term military career are discouraged and disappointed with the military and chose to leave the service for a variety of reasons. Female veterans are experiencing a variety of traumas as do their male counterparts during active duty; however, the quality of care that speaks directly to female veterans specifically is lacking. The quality of mental health care providers and services are inconsistent for female veterans whether

through the VA or non-VA facilities. Living in a rural area presents its own unique share of obstacles for female veterans going without mental health care altogether. Female veterans make greater psychological sacrifices than their male veteran counterparts when enrolling in the military due to the dual nature and cultural expectations of being a parent and/or spouse pre- and post-deployment. Female veterans in this study, although dedicated and patriotic to their country, would likely not choose to return to military duty after their lived experiences.