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Walden University

College of Psychology and Community Services

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Denise L. Bullock

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Walden University
2025

Abstract

Coping Strategies of African American Cisgender Female Veterans After Experiencing Military Sexual Trauma

by

Denise L. Bullock

M.Ed,. Bowie State University, 2004

BA, University of Alaska, Anchorage, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

Walden University

August 2025

Abstract

The United States Veterans Health Administration (VHA) provides care for female veterans who have experienced military sexual trauma (MST), which is harassment and physical assault that occurs while on active military duty. This generic qualitative study involved understanding coping skills of cisgender African American female veterans who experienced MST and the impact of race on their coping skills. A significant gap exists in literature regarding how African American female veterans have coped with MST. This study involved using the transactional theory of stress and coping, which asserts coping responses reflect an imbalance between demands of a person's environment and what resources are available to respond to those demands. The study included interviews with 15 African American female veterans who met criteria and completed a five-question open-ended questionnaire. Findings suggested coping skills of African American female veterans play an integral role in their ongoing treatment and influence future treatment plans of VHA practitioners as well as those working outside of the VHA. Additionally, study findings can potentially influence policy development for female soldiers facing MST, thereby increasing support for female soldiers during active duty.

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Dedication

This dissertation is lovingly dedicated to the memory of my great aunt, Irene Jackson, who raised me with love and care, and to the memory of my sister, Tyrrell Bullock, whose spirit continues to inspire me. I also wish to express my deepest gratitude to my only brother, Lester Bullock, and my youngest sister, Shelia Bullock-James, for their unwavering support and encouragement throughout this journey.

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Table of Contents

Chapter 1: Introduction to Study 1

Background 1

Problem Statement 2

Purpose of the Study 3

Research Question 3

Theoretical Foundation 4

Nature of the Study 4

Definitions 5

Assumptions 6

Scope and Delimitations 7

Limitations 7

Significance 7

Summary 8

Chapter 2: Literature Review 10

Literature Search Strategy 11

Theoretical Foundation 11

Historical Overview of MST 12

MST and Victimization 14

Sexual Harassment and Sexual Assault Reporting 17

Sexual Harassment and Sexual Assault Prevention 19

Mental Health Effects of Female Veterans after MST 21

Coping Strategies of Female Veterans 23
VHA Care for Female Veterans 25
Summary 29
Chapter 3: Research Method 31
Research Design and Rationale 31
Research Question 31
Role of the Researcher 32
Methodology 33
Participant Selection Logic 33
Instrumentation 33
Procedures for Recruitment, Participation, and Data Collection 34
Recruitment 34
Participation 34
Data Collection 35
Data Analysis Plan 35
Issues of Trustworthiness 35
Credibility 36
Transferability 36
Dependability 36
Confirmability 37
Ethical Procedures 37
Summary 38

Chapter 4: Results 39
Setting 39
Demographics 39
Data Collection 40
Recruitment 40
Protection of Participant Data 40
Conduction of Interview 40
Data Analysis 41
Coding Strategy 41
Coding Process 41
Codes 42
Categories 41
Themes 42
Evidence of Trustworthiness 43
Credibility 43
Transferability 44
Dependability 44
Confirmability 44
Results 45
Summary 48
Chapter 5: Discussion, Conclusions, and Recommendations 49
Interpretation of the Findings 49

Theme 1: Self-Stigma 49
Theme 2: Counseling 50
Theme 3: Family and Friends 51
Theoretical Implications 52
Limitations of the Study 52
Recommendations 53
Implications 54
Conclusion 57
References 58
Appendix A: Recruitment Email 77
Appendix B: Prescreening Questions 80
Appendix C: Guiding Interview Questions 81
Appendix D: Recruitment Flyer 82

List of Tables

Table 1. Self-Stigma……46

Table 2. Counseling ……46

Table 3. Family Friends ……..47

Chapter 1: Introduction to Study

According to Drake and Burgess-Mundwiller (2019), military sexual trauma (MST) is psychological trauma that can only be defined by a mental health provider of the U.S. military or Veterans Health Administration (VHA). The Department of Defense (DOD, 2017) stated there was a 10% increase in MST among service members. Of 5,277 reported cases, 4,193 were women, or an increase of 13% (Ferdinando, 2018, p. 1-2). African American cisgender female servicewomen veterans who have served on active duty to fight and defend the United States experience MST, although cases are underreported.

MST literature includes empirical data on sexual harassment, sexual assault, healthcare for MST survivors, and services they require. This research includes information regarding human service practitioners (HSPs) who offer services for MST survivors. Veterans service organizations (VSOs) are needed by professional human service workers (PHSWs) to help combat MST survivor challenges. Specifically, this study includes coping strategies of African American female veterans who experienced MST.

Background

Female veterans have associated chronic pain diagnoses, symptoms of depression, posttraumatic stress disorder (PTSD), eating disorders, and alcohol and drug use disorders due to MST (Blais et al., 2017; Calhoun et al., 2018; Cichowski et al., 2017; Goldberg et al., 2019). Additionally, regardless of the type of MST incident (i.e., harassment or assault), women have significantly higher rates of victimization than men

(Wilson, 2018). Within the VHA, there is a specific emphasis among healthcare providers on creating care systems for MST survivors, including initiatives for treatment programs, veteran outreach, and ongoing assessment and evaluation (Foynes et al., 2018). MST survivors desire nonspecific support, improved continuity of care, and the ability to choose from a variety of treatment options (Monteith et al., 2020). Active-duty females do not disclose MST they experience with soldiers in their units. Additionally, active-duty females and female veterans whose fellow unit members were assaulted and reported higher self-stigma were less likely to disclose their MST during screening (Andersen et al., 2019). Consequently, there is a need for interventions to reduce nondisclosure (Blais et al., 2018).

Problem Statement

In 2018, 8.7% of women and 1.0% of men reported sexual assault while deployed (Office of People Analytics, 2020). Male dominance in the military and a culture of inappropriate sexual behavior and aggression directly correlates with prevalence of MST (Office of People Analytics, 2020). Women who have suffered MST frequently exhibit PTSD, depression, social phobias, alcohol and substance abuse, suicidal ideology, and self-harm. Women also suffer from depression, sleep challenges, and physical health problems (U. S. Department of Veterans Affairs, 2020).

Although researchers have investigated MST, literature largely excludes African American participants, and rates of self-reporting among African Americans are lower than their Caucasian peers (Galovski et al., 2023; Grau et al., 2024; Reinhardt et al., 2024; Shapiro et al., 2023). During VHA screenings for MST, however, there is a

disproportionate number of African American female veterans at increased risk for MST as compared to Caucasian female veterans (Hargrave et al., 2023; Sexton et al., 2024). Historically, screenings have failed to lead to available resources for African American female veterans (Hargrave et al., 2023). According to Sexton et al. (2024), gender minorities do not frequently seek treatment for MST. Moreover, when reporting to the VHA, African American female veterans who experienced MST also have faced barriers involving racism and internalized heterosexism (Ceroni et al., 2023).

My study involved considering African American female veterans who developed coping strategies post-MST. This generic qualitative study includes critical insights for understanding coping strategies they used after experiencing sexual harassment and sexual assault while on active duty.

Purpose of the Study

The purpose of this qualitative study is to explore coping approaches of adult cisgender African American female veteran service members who have experienced MST. In addition, I address different coping options of female veterans who have experienced MST and their assessments of how the VHA can address mental and physical health disparities. It builds on previous studies that identify sex and race as necessary areas of exploration.

Research Question

What are coping approaches of adult cisgender African American female veterans who have encountered MST?

Theoretical Foundation

Lazarus and Folkes' transactional theory of stress and coping grounded this study. According to Biggs et al. (2017), the transactional theory of stress and coping includes two components: problem-focused coping (PFC) and emotion-focused coping (EFC). PFC manages stressors, and EFC regulates consequences of stressful encounters. Chapter 2 includes a more detailed explanation of PFC and ECF.

According to Lazarus and Folkman (1984), the function of coping helps to manage altering of a phenomenon throughout a stressful event. PFC and EFC determine how a person manages a stressful event. There are sources of stress that cannot be overcome, and effective coping is necessary for people to accept, tolerate, and ignore stressful events (Lazarus & Folkman, 1984). The transactional theory of stress and coping is used for appraising situations and effectively using coping strategies to manage stress (Lazarus & Folkman, 1984).

Nature of the Study

To address the research question in this qualitative study, I used a generic qualitative design. The goal of the study was to use real-world situations to gain a deeper understanding of the phenomenon and examine participants' perceptions. I conducted interviews, and when necessary, prompted participants to elaborate on their experiences.

I used a generic qualitative design to provide a detailed account of full contextual experiences involving coping strategies. Results include information for stakeholders to address military sexual trauma of not only the population under study but all service members.

For my planned research design, I recruited 15 African American cisgender female veterans between 25 and 65 who consented to the study. I developed a questionnaire in order to conduct semi-structured individual interviews. This qualitative research included one-on-one interview questions to gather data. I selected participants from different military branches all over the United States.

Definitions

Active duty: Full-time service in the active military, including reserves on active duty but excluding full-time National Guard (U.S. Department of Veterans Affairs, 2020).

Cisgender: A person who identifies with their gender as assigned at birth (Verywell Health, 2020).

Department of Defense (DOD): A federal agency that governs national security for all military branches (Merriam-Webster, n.d.).

Department of Veterans Affairs: A federal department that is responsible for programs and policies for over 23 million serving veterans and their families (Merriam-Webster, n.d.).

Military sexual assault: Unwelcomed and nonconsensual sexual contact or activities while on military duty (U.S. Department of Veterans Affairs, 2021).

Military sexual harassment: Unwelcomed sexual comments and/or sexual advances in exchange for favors and positive treatment (U. S. Department of Veterans Affairs, 2021).

Military Sexual Trauma (MST): A common experience reported by women veterans characterized by repeated sexual harassment or sexual assault while in the military (Acierno et al., 2021).

Posttraumatic stress disorder (PTSD): Traumatic exposure during U.S. military service that typically endures for weeks, months, and or years (Blais et al., 2021).

Veterans Health Administration: According to the U.S. Department of Veterans Affairs (2021), "The Veterans Health Administration is America's largest integrated health care system, providing care at 1,293 health care 9711000/facilities, including 171 medical centers and 1,112 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled Veterans each year" ().

Veteran Service Organization (VSO): A partnership program that helps veterans integrate into civilian life while providing housing and/or vocational, legal, and healthcare resources (U.S. Department of Veterans Affairs, 2021).

Assumptions

Several assumptions guided this study. First, I assumed participants answered interview questions honestly and without feeling coerced. Due to inclusion criteria, I also assumed participants had experienced similar phenomena. In addition, I assumed participants were motivated to share their experiences for the greater good of other female veterans. Furthermore, I assumed participants would exhibit emotions. For this reason, I provided resources for the nearest VA hospital or community-based outpatient clinic for female veterans.

Scope and Delimitations

This study focuses involved coping strategies of African American women veterans survivors of MST. The sample was 15 African American women veterans between 18 and 65. The recruitment period lasted 2 months and concluded when 15 African American women veterans agreed to participate. I delimited the study to women who self-identified as cisgender women and African American.

Limitations

My biases represented limitations for this study. I separated my emotions and role as researcher . Also, self-reporting was a challenge for participants. Also, participants who self-reported potentially experienced memory limitations. Finally, geographical differences impacted this study, causing delays in the interview process and cancelations. Results of this study are relevant only to this sample, and future researchers must determine transferability of this research to other settings.

Significance

This study provides a better understanding of mental support that African American female veterans required from the VHA long after their departure from the military. My study involved identifying why African American female veterans underreport military sexual trauma, necessary protocols for prevention of MST among African American female veterans, insights for mental health practitioners at the VHA to develop interventions and strategies for African American female veterans who have experienced MST.

Results have implications for local, regional, and national-level healthcare and transform how women veterans are screened for MST at VHA community and regional hospitals. In-depth interviews involving women's objectification and the degree to which they lost trust in leadership will help redirect negative behaviors in the military and foster positive human interactions. My study involved addressing the prevalence of racism and sexism in MST screenings and encouraging positive relationships between female veterans and clinical practitioners.

The U.S. DOD, VSOs, and National Institute of Mental Health (NIH) will potentially benefit from this study. My study provides tools for the human services profession to improve its evaluation process and address needs of female veterans who experienced MST and build relationships in veteran communities.

Summary

There is a gap in literature regarding how African American female veterans cope with MST. This generic qualitative study involved using the transactional theory of stress and coping, which is coping responses are influenced by demands of a person's environment and their access to available resources to meet those demands. The study includes insights for transforming how women veterans are screened for MST at VHA community and regional hospitals. Qualitative study results will foster conversations about coping strategies for African American female veterans who experienced MST and contribute to positive relationships between female veterans and clinical practitioners. Chapter 1 includes an introduction as well as the problem statement, purpose of the study, theoretical foundation, methodology, and brief outline of the study plan. Chapter 2

includes a historical overview of MST and interventions that are needed in social services for embodied trauma of cisgender African American female veterans.

Chapter 2: Literature Review

African American female veterans who suffered from MST while on active duty experience negative impacts. Veterans who are enrolled in the VA system underreport MST (Wilson, 2018). Sexual assault and harassment are higher among women than men, and women experience increased deployment (Blaisure et al., 2016). In 2018, 8.7% of women and 1.0% of men reported sexual assault while deployed (Office of People Analytics, 2020). Male dominance in the military frequently manifests as inappropriate behavior, including sexual harassment (Office of People Analytics, 2020).

Female service members are a minority, and male service member perpetrators face limited accountability (Office of People Analytics, 2020). Sexual and gender minorities are underrepresented when seeking treatment for MST (Sexton et al., 2024). Women who experience MST often demonstrate PTSD, depression, social phobias, alcohol and substance abuse, suicidal ideology, and self-harm (Sandhu et al., 2023). Women also suffer from physical health problems, including insomnia and other sleep issues (Department of Veterans Affairs, 2020).

The purpose of this qualitative study is to provide a deeper understanding of coping strategies of African American female veterans who have experienced MST. It builds on other studies that emphasize the significance of sex and race in MST research.

Although researchers have investigated coping strategies of African American female veterans, there is very little literature on direct coping behaviors of female veterans. What is known about women's MST experiences is primarily based on reports from the DOD and recent evidence regarding primary care at the VHA. In this chapter, I

highlight the theoretical foundation of the study and investigate and review recent empirical literature that contributes to this social problem.

Literature Search Strategy

I used the following keywords for this study: *female veterans*, *military*, *military sexual trauma*, and *coping strategies*. I consulted the following databases: EBSCOhost, SAGE Journals, Google Scholar, PsycLIT, Military Medicine, and Walden University Library, in addition to DOD research.

Theoretical Foundation

This study's theoretical foundation was Lazarus and Folkes' transactional theory of stress and coping. According to Biggs et al. (2017), there are two components of the theory: PFC, which involves managing stressors, and EFC, which involves regulating consequences of stressful encounters. Biggs et al. (2017) referred to PFC as psychological wellbeing involved in self-care, healthy quality of life, and lower levels of exhaustion. Biggs et al. (2017) stated EFC is ineffective due to adverse outcomes, escape avoidance, anxiety, and high risks of mortality.

In this study, the term cognitive appraisal refers to primary and secondary appraisal; primary appraisal is transactions involving wellbeing, and secondary appraisal is when a specific transaction is stressful and individuals can identify and evaluate coping resources (Biggs et al., 2017). The transactional stress and coping theory also involves perceptions of imbalances between demands of environments and what resources are available to respond to those demands; it is a cognitive and behavioral response that participants attempt to manage externally (Lazarus & Folkman, 1987).

Sousa and Veronese (2021) demonstrated psychosocial consequences of warfare and emotional survival lead to the cyclical nature of stress and coping.

This study's interview questions were grounded in the transactional theory of stress and coping. Questions were formulated involving how participants coped with the aftermath of MST and stressors they experienced after MST. According to Kong and Jolly (2018), ethnic minority employees who experienced secondary appraisal were primarily likely to engage in EFC to try and alleviate negative emotions by withdrawing, which resulted in fear-driven silence. African American female veteran coping choices were driven by PFC or EFC (Kong & Jolly, 2018; Wurtz, 2022). In this study, interview questions were grounded in their appraisal of stressful events and tools to manage and resolve coping actions. Interviews were open-ended and included semi-structured responses from African American female veterans who detailed their coping responses to MST. In my study, interview questions were used for participants to reflect on their emotions and how they coped with MST. Participant responses were coded analytically.

Historical Overview of MST

The health-related quality of life of female veterans who experienced MST is adversely affected emotionally, socially, and cognitively (Tirone et al., 2020). According to Danan (2017), 47% of female veterans seeking healthcare experienced mental health challenges directly related to MST. During the 21st century, U.S. women deployed to Iraq, Afghanistan, and Yemen to serve in combat. During the 2018 fiscal year, 203,580 screened positive for MST; 38% were female, and 3.9% were male veterans (Garneau-Fournier et al., 2020; Lee, 2021; Wilson, 2018). According to Wolf and Mills (2016),

17% of women in the United States will experience MST at some point, and 33% will experience sexual assault. These findings highlight the ongoing psychological toll of MST on women in uniform who were deployed to combat zones, and the statistical data accentuate the scope of the issue.

During FY20, there were 696 substantiated sexual harassment complaints reported by military services. There were 442 formal complaints, 240 informal complaints, and 14 anonymous complaints (U.S. DOD, 2020). In FY20, military services and the National Guard Bureau investigated 984 formal sexual harassment complaints (U.S. DOD, 2020). Seven hundred twenty cases were resolved; 144 remained pending, and 120 unknowns were reported.

Military services reported a significant issue involving sexual assault cases that was identified in FY20. Out of numerous sexual assault reports, 7,816 involved a service member. Five thousand six hundred forty reports were restricted, and 2,176 were not restricted (U.S. DOD, 2020). The numbers presented during FY2020 contribute to empirical evidence that there is widespread sexual harassment and sexual assault within the military, with pending cases suggesting that there is a procedural obstruction that compromises confidence in the reporting system. The numbers reveal a pattern of justice and question the efficacy of the current reporting system. The number of harassment claims and assault reports establishes a scale for leadership to build interventions.

Accountability and oversight draw attention to the data and the flaws in the military leadership. The information provided in FY2020 can determine if the military's system is meeting established goals. The unresolved cases and underreporting justify

systemic changes needed in military leadership. The numbers provided in FY2020 give a foundation for training enhancement to investigate reform and a needed rehaul of the military culture regarding the leadership influence.

The role of gender has not been broached as it relates to the revictimization of MST of female veterans. In defiance of these alarming figures, there is a critical gap in addressing female veterans who are victimized and the long-term health concerns. MST survivors must have access to trauma-sensitive care coordination and strategies for optimum health care and reintegration into civilian life. (Bergman et al., 2019).

MST and Victimization

More recent evidence proposed that Military Sexual Trauma is a significant public issue with outcomes of substance abuse, depression, suicide, PTSD, and eating disorders (Blais et al., 2019; Burgess et al., 2016; Cichowski et al., 2017; Cloitre et al., 2016; Goldberg et al., 2019). According to Tirone et al. (2020), Military Sexual Trauma survivors are at an increased risk of revictimization. The history of high rates of Military Sexual Trauma, as seen by practitioners at Veterans Health Administration (VHA), includes harassment, physical abuse, and sexual assault (Bergman et al., 2019). What is known about Military Sexual Trauma and female veterans is primarily due to the 1992 congressional hearings, where female veterans described the emotional impact of their experiences of sexual harassment and sexual assault on their daily lives (Foynes et al., 2018). One of the most defining moments that brought national attention to Military Sexual Trauma in the military was the issue of sexual harassment and assault that occurred in 1991 during a naval aviator's conference, where female U.S. Navy and

Marine Corps officers were subjected to MST. The incident is known as the "Tail Hook scandal". The incident emphasized the military's resistance to addressing MST and the embedded cultural norms within the hierarchy of military leadership. (Violanti, 1996). Additionally, women who have been victimized experience poorer health and a lower quality of life when compared to women who have not experienced sexual assault or sexual harassment (Monteith et al., 2020: Nichter et al, 2020).

The research not only underlines the significant psychological and physical effects of Military Sexual Trauma but also shows the systemic nature of existing problems across military culture. The continuous outcomes of PTSD and revictimization across numerous studies suggest patterns of universal and entrenched within the military culture. The 1992 historical hearings continue to frame present-day understanding of Military Sexual Trauma, showing that there is a gap in progress and the leadership accountability. These findings unify the consensus for a stronger, trauma-informed foundation for female veterans and the services that the Veterans Health Administration provides.

The most recent evidence (Rosellini et al., 2017) revealed that 5% of active-duty military women were victimized in 12 months. According to Creech and Orchowski (2016), improved access to interventions would effectively provide progressive mental health resources for women while serving in the military. Understanding the impact of sexual harassment and sexual assault on victimization and revictimization will help contribute to the full development of interventions (Bell et al., 2018; Rosellini et al., 2017).

There is an urgency to integrate preventative and responsive mental health strategies directly into the military system. In the face of an increased awareness and the continuous, relentless acts of MST, it is suggested that intervention access is not adequate. There is a requirement for leadership accountability and survivor-centered policy reform. There is a relentless call for evidence-based intervention, which remains under-examined, and a clear and effective way to address the vulnerability of female veterans while serving in the military.

According to the expanding body of literature on MST, the rates of women military personnel and veterans are higher than that of men in the victimization of MST (Bergman et al., 2019; Burgess et al., 2016; Goldberg et al.; Nichter et al., 2020). The Sexual Assault Prevention Office (SAPO) was established for the improvement of reporting MST (Wolf & Mills, 2016). There is still considerable controversy surrounding the underreporting of MST, due to stigmatization and distrust between the veteran, active-duty military soldier, and the provider (Blais et al., 2018; Wolf & Mills, 2016). Gibson et al. (2016) conclude that understanding the effects of age, sexual assault, sexual harassment, and physical victimization of female veterans will help to provide comprehensive health care. The efforts of SAPO focus on improving reporting and underreporting, but there is still a significant barrier that reflects a more profound distrust in the military and leadership. The literature reveals a disparaging tension between policy changes and implementation. Additionally, the gendered nature of MST is commonly high risks and responses. The literature indicates a need for a multidimensional approach to research and treatment.

Sexual Harassment and Sexual Assault Reporting

What we know about MST reporting was predicted the 1990 studies of active-duty soldiers and veterans who received treatment at VA centers (Burgess et al., 2016). Previous work by the DOD Sexual Assault Prevention and Response Office (SAPRO) indicated that 4.3 % of active-duty women experienced military sexual assault (Burgess et al., 2016). The study re-examined the barriers female veterans experience when reporting MST, as well as underreporting among military leadership (Blais et al., 2018; Wolf & Mills., 2016).

The literature advocates that despite policy change, the core issues encompassing MST reporting impediments related to leadership and military culture have remained largely unaddressed. Some similar statistics and challenges imply continuous stagnation in prevention and response to MST. The underreporting fosters a climate of weakness in accountability and reflects personal barriers of fear and shame of the individuals who have experienced MST.

Bell et al. (2018) asserted that social support helps with reporting and the recovery of service members who have experienced MST. Rejection, self-blame, and shame are reporting deterrents (Bell et al., 2018). Based on their analysis (Bell et al., 2018), women do not join the military expecting to experience sexual assault or sexual harassment. The military requires interventions that will foster sensitivity and raise reporting among women who experience sexual assault and sexual harassment (Bell et al., 2018; Bell et al., 2018). Educating service members about confidential reports will provide an effective outcome of service members' reporting (Miller et al., 2018).

Literature highlights the crucial role that emotions and military culture play in reporting MST. The lack of education on the confidentiality of reporting and the fear of retaliation from military leadership contributes to the silence in the military culture. A systemic reform in the military will address the needed psychological and information gaps.

The DOD has implemented new initiatives to reduce sexual assault and sexual harassment and increase reporting (DOD Annual Report, 2020). On February 26, 2021, the DOD established a 90-day Independent Review Commission (IRC) that included sexual assault reporting. The IRC encourages reporting and holding alleged offenders accountable through the CATCH program (DOD Annual Report, 2020). The CATCH program allowed service members to change restrictive reports to unrestricted and match the names of offenders in previous investigations; meanwhile, service members remained anonymous (DOD Sexual Assault, 2021). According to (Wolf et al., 2,016) female veterans who experienced MST before 2001, their coping skills could create options to reform reporting and care of MST.

Although the literature indicates that the recent DOD initiatives reflect steps toward positive programs for the prevention of MST, will it lead to a measurable reduction in MST or the reporting? The CATCH program does not fully resolve the larger issues of trust in leadership. Additionally, the perspectives of the females prior to 2001 highlighted the effectiveness of reform and survivor experience; their insights could help provide a system for survivor-centered veterans and leadership accountability,

Sexual Harassment and Sexual Assault Prevention

The Department of Defense (DOD) has implemented a layered strategy to prevent sexual harassment and sexual assault within all branches of the military with a combination of structural reform and leadership accountability. The leadership deficiencies of targeted interventions and the evaluation of the program outcomes are central to the DoD's prevention framework (DoD Sexual Assault, 2021). This revolving strategy reflects an effort to improve the system. However, the leadership shortcomings are the spearhead of sexual misconduct, overlooking the cultural issues within the military.

The DOD has included digital platforms to disseminate information that is available involving senior commanders to enhance institutional responsiveness to sexual misconduct (DoD Sexual Assault, 2021). Although the efforts improved transparency and service access, reliability has historically been inconsistent across military installations. There have been policy-level changes to include congressional notifications for updates to the military's restricted reporting process with an attempt to address previously neglected populations by developing toolkits for male sexual assault victims (DoD Sexual Assault, 2021). Generally, while DOD's prevention efforts represent progress, the critical gaps remain in addressing the cultural norms of the military that allow sexual harassment and assault to continue.

Although there have been initiatives for sexual harassment and sexual assault, the problems are still entrenched in the military and pose moral and ethical crises and a threat to national security (Gonzalez-Prats, 2017). Immediate and comprehensive action has

become increasingly urgent to address MST (DOD Sexual Assault, 2021). These efforts have helped identify key personnel, resource allocations, and strategic opportunities, and the combined efforts have rebuilt trust in the military justice system (DoD SAPPRO, 2019). The structuring reflects a shift in unveiling the unchecked sexual misconduct that can erode unit cohesion and operational readiness in the military. Although there are signs of improvement with the military institutional responses, scholars are cautioned that gains are fragile and unsustainable without enduring cultural and leadership reforms (Gonzalez-Prats, 2017; Rossellini et al., 2017).

Additionally, leadership reflects the recurring theme in the literature as a barrier and a catalyst for change. Military leaders actively endorse the policy, set the tone, and enforce a zero-tolerance policy for cultural sexual misconduct (Gidcz et al., 2018). Consequently, this involves proactive engagement with subordinates and modeling respectful behavior for accountability to be consistently applied. Scholars emphasize the necessity of a comprehensive, ongoing strategy to assess the effectiveness of the compliance of survivor outcomes, command climate, and organizational trust (Gidycz et al., 2018).

Systematic feedback helps to revise the approaches based on empirical evidence and is becoming performative rather than transformative. The literature highlights the need for more profound structural and cultural change through leadership accountability, robust evaluation, and survivor-centered program design. There is a need to foster a long-term cultural shift that effectively prevents MST and restores confidence in the military as a safe and equitable environment for all service members. In addition, future

evaluations should target program implementation on survivor outcomes, long-term systemic change, and accountability of military leadership

Mental Health Effects of Female Veterans after MST

Researchers have associated MST with several underlying disabilities that require treatment (Drake & Burgess-Mundwiller, 2019). We know that post-traumatic stress disorder (PTSD) is prevalent among women veterans who suffer from MST. In a study of women veterans who were examined in VA centers, 32.4% were diagnosed with PTSD (Acierno et al., 2021; Goldberg et al., 2019). PTSD is a predispose psychiatric comorbidity that female veterans experience due to MST (Calhoun et al., 2018; Cichowski et al., 2017).

The literature emphasizes that MST is not a traumatic experience but one that commonly leads to severe mental health conditions, with a highlight on PTSD. There is a widespread diagnosis of PTSD among female veterans at the Veterans Health Administration. The linkage between MST and long-term psychiatric disorders is at 32.4 %. There is a requirement for ongoing intervention for MST survivors.

Several researchers (Calhoun et al., 2018; Banducci et al., 2019) have drawn our attention to women who demonstrate PTSD symptoms related to combat experiences and MST. Women who served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) were exposed to combat-related experiences that led to the symptoms of PTSD and depression (Calhoun et al., 2018; Cichowski et al., 2017). One of the residual symptoms of PTSD is depression (Schnurr & Lunney, 2018).

The literature reveals how combat experiences and MST are combined experiences of multiple forms of trauma that complicate mental health for female veterans. The complexity of diagnosing and providing a service for female veterans is an indication of how trauma triggers symptoms of depression. The importance of acknowledging that female veterans face multiple forms of trauma will provide health practitioners with intervention strategies.

A considerable amount of literature stated that veterans with a history of MST exhibited an increased risk for depression (Blais et al., 2019). In recent years, researchers have demonstrated a increasing interest in the impact of health conditions and the depressive symptoms that female veterans have experienced in sexual harassment and sexual assault (Goldstein et al., 2017; Sairsingh et al., 2018). Goldstein et al., 2017, was among the first to associate the variable of depression with traumatic experiences. Veterans reported MST with more severe symptoms of depression as a result what they regarded as institutional betrayal (Goldstein et al., 2017; Hiraoka et al., 2016).

The military culture has a concept of institutional betrayal where leadership fails to protect or support the victim and enables the trauma to worsen. The neglect of leadership accountability damages the mental health of the female service member. The literature highlights that individuals' treatment is affected and needs a systemic change.

One of the main challenges in expanding our understanding of MST involves clinicians who screen for MST are also encouraged to access MST history for substance-use disorders (SUD), alcohol-use disorder (AUD), and drug-use disorder (DUD) (Goldberg et al., 2019). According to Lee (2021), nurse practitioners have an ethical

obligation to provide culturally sensitive health care for the veteran population, and it seems to be a helpful approach. Also, Lee (2021) recognized that the collaboration between Non-VA and VA nurse practitioners will facilitate a comprehensive mental health program for female veterans who have experienced MST. However, continued outreach, resources, and education initiatives for female veterans are needed to address MST-related mental and physical health problems (Calhoun et al., 2019).

The comprehensive system of care and the essential coordination, outreach, and education are needed tools for interventions and strategies for MST. The need for collaboration between VA and non-VA systems is paramount for the focus of care for MST survivors. The battle for MST survivors also includes substance abuse, which causes perplexity in the recovery treatment.

Coping Strategies of Female Veterans

According to Webermann (et al., 2023), support from other military members, family, and friends is essential for coping with MST. The literature of Galovski et al. (2022), Lee (2021) and Webermann et al. (2023) also disclosed that negative responses to victim-blaming and lack of support are detriments of reporting when not supported by military members and family and friends. Webermann et al. (2023) also stated that only been two studies have highlighted the role of support for military women who have experienced MST. Galovski et al. (2022) stated that 34% of women report MST, and 26% of female minorities are more likely to report MST. According to Galvoski et al. (2022), mind-body interventions and peer support are defined as treatments for veterans experiencing MST.

The support systems for women are vital when dealing with MST. According to the research and the literature, military peers, family, and friends establish a significant ability of the coping strategies of survivors of MST. There is a barrier when the support system responds negatively, which is a significant barrier in reporting MST. It is alarming that Webermann et al. (2023) found only two studies that focus on the support of survivors, drawing attention to the gap in the literature. This is a clear indication of the need for more research for support, or the lack of it affects the recovery and reporting. Galvoski et al. (2022) show a notable portion of minority women that report MST, which has an impact on the importance of culturally competent and trauma-informed support systems.

Lee (2021) asserted that pharmacological management and psychoeducation are practical approaches for veterans coping with MST. Pharmacological management reduces anxiety and depression, and psychoeducation provides veterans with helpful resources that dispel myths about MST (Lee, 2021). According to Katz and Sawyer (2020), managing cognitive and experiential strategies for MST in a group setting supports and targets issues relevant to MST. Positive and emotional experiences help in reducing negative cognition, depression, and anxiety (Katz and Sawyer (2020). Rodriguez et al. (2024) described the coping strategies of female veterans who were seeking emotional support using an adaptive strategy of family and friends.

The combination of medical and psychological treatment is helpful for MST survivors. The literature of both Lee (2021) and Sawyer (2020) advocate for collective spaces for processing trauma. The literature acknowledges that multifaced treatment is

needed for healing emotional, psychological, and social dimensions. The literature of Rodriguez et al. (2024) reinforces that the combination of emotional support from family and friends is aligned with the strategies for coping

The relationship between MST and coping behaviors that are influenced by maladaptive and adaptive is still unclear, according to Rodriguez et al. (2024) and Preston et al. (2023). The literature of Evan et al. (2019) and Krejci et al. (2014), as cited by Braun et al. (2024), specificied that meditation, mindfulness, and yoga are options that ameliorate MST conditions among female veterans. According to the literature, women are at a higher risk of experiencing MST. However, evidence-based psychotherapies based on mind-body interventions and peer support offer strategies for coping (Galvoski et al., 2022).

Acknowledgment of the literature must provide an understanding that therapeutic strategies are emerging and there is an understanding that coping mechanisms are a work in progress for MST survivors. The literature reiterates that women face a higher risk of experiencing MST, and there is an urgency for evidence-based therapies. The encouragement of mind-body practices has alleviated symptoms (Braun et al., 2024).

VHA Care for Female Veterans

Veterans who screen positive for MST are eligible for treatment and care at the Veterans Health Administration (VHA) (Hiraoka et al., 2016). A recent literature review on this topic (Decker et al., 2021) found that nearly 20 million veterans used the VHA, and one in three women reported MST. A growing body of literature has revealed that

the VA requires primary care providers to screen for MST and refer veterans for evidence-based treatment (Acierno et al., 2021).

Although the VA has a directive that primary care providers screen and refer veterans, the literature indicates that the screening process is allocated for services. The question is whether there is adequate follow-up. The effectiveness of the treatment is not just policy driven. The systemic barriers and the treatment quality may compromise the screen policy's initial intent.

Acierno et al., 2021 and Monteith et al., 2020 has drawn our attention to the high dropout rate of women veterans who received evidence-based treatment due to high self-blame and distrust of providers. Tracing the evidence, Monteith et al. (2020) concluded that the VHA has had a positive effect on the recovery of MST, although there remained a lack of compassion among the providers. More recent evidence (Calhoun et al., 2018) revealed that the association between MST and health services among OEF/OIF women is limited. Calhoun et al., 2018 indicated that 48% of women veterans have reported utilizing VA health care. The negative perception of the VHA impacted the distrust of the providers (Monteith et al., 2020).

The literature highlights the positive impact of the VHA's position on the lack of compassion of providers, and it still is a critical gap. Evidenced-based treatment are neglected due to the high drop rate among women veterans who are driven by the distrust of the providers. The failure to address these dynamics is the treatment retention and its efficacy. The clinical interventions are essential, but emotional and psychological safety is first and foremost.

There is still considerable ambiguity in the lack of female-centric care and the sense of belonging in VHA for female veterans. More recent evidence (Haun et al., 2016) proposed that female veterans felt intimidated by male care providers and were discouraged from using services provided by the VHA. Turchik et al. (2024) suggested that psychological avoidance, stigma-related barriers, gender-related barriers, and knowledge barriers are what female veterans face when utilizing the VHA. Turchik et al. (2014) detailed the logistical barriers that involve distance for female veterans to access MST-related care. Cognitive Processing Therapy (CPT) at VHA has been identified as an effective treatment for African American female veterans with MST-related PTSD (Holiday et al., 2017). The VHA has provided optimal treatment to self-identified racial/ethnic minority female veterans with MST-related PTSD (Holiday et al., 2017).

The literature also states that female veterans feel unsafe in some VHA environments where male providers dominate. A barrier that includes stigma and gender-based biases is very challenging as it pertains to seeking care. A major deterrent is systemic gender insensitivity and intimidation. Although evidence-based interventions are available, female veterans still face a multilayered system of exclusion that prevents access to care.

According to Holiday et al., 2017, when compared to white females, African American females have a higher termination rate from evidence-based treatment, and the literature reveals how racial self-identification affects treatment. Fernando et al. (2024) stated that the racial status and experiences of MST veterans impact their maintenance of

mental health. African American veterans who experienced MST possess only negative beliefs about themselves (Fernando et al., 2024). Of the 139 participants in the study of Fernando et al., 2024, 18.3% were African American female veterans who were seeking treatment for MST. Grau et al., 2022 (cited in Fernando et al., 2024) stated that white veterans benefitted from a more prominent ecological resource than black veterans, but black veterans engaged in spiritual coping.

The focal point of the literature is that African American female veterans terminate at a higher rate, and the negative self-perceptions exceed their white counterparts. Racial disparities limit African American female veterans' access to care. African American female veterans ultimately use alternative coping strategies, for example, spirituality. The underdevelopment of cultural competence reveals a more profound inequity in VHA care.

In the literature of Ceroni et al. (2023), race was a significant factor in increasing the severity of symptoms of African American veterans who suffered from MST. African American veterans had increased symptoms of PTSD, with reduced access to mental and medical health care. A major weakness in the VHA system is its lack of commitment to improving the overall health and quality of life for female veterans.

The literature critiques the insufficient dedication to the VHA improving the quality of life for female veterans. The VHA needs to reform overdue structural inequality in access to care. The disproportionate care for African American female veterans reflects the neglect of the structural racism within the VA system.

The engagement of assessments and individual and group therapy would provide a consistency of optimal health care (Foynes et al., 2018; Monteith et al., 2020). In the literature of Paulson et al., 2024, very little research exists regarding sexual and gender minorities and the identification of determinants of veterans and the treatment of MST, and there is a sizeable percentage sample of non-access to support for sexual and gender minority veterans.

Summary

MST is problematic in the military, and a disproportionate rate of females who have served in the military experience MST (Gibson et al., 2016; Wolf et al., 2016). Exposure to sexual and physical trauma while on active duty leads to harmful mental and physical outcomes (Gibson et al., 2016). Primary care providers at the VHA are developing strategies to address barriers involving insufficient visit time, gender-specific examinations, and trauma-sensitive care (Bergman et al., 2019).

Healthcare services for female veterans suffering from MST are challenging to find (Foynes et al., 2018). Foynes et al. (2018) asserted larger populations addressing issues of female veterans who experienced MST was beneficial for private and community healthcare agencies.

According to Holliday et al. (2017), evidence-based treatment trials focused predominantly on White female veterans. The major theme of this study was coping skills of African American female veterans who experienced MST and ability of the VHA to provide services to this population. This study also extends knowledge of human service practitioners by implementing a range of service models as recommendations for VHA

initiatives. A comprehensive healthcare system that acknowledges diversity of MST survivors is an appropriate way to deliver services (Foynes et al., 2018).

According to Nichter et al. (2022), MST is a public health problem that is recognized by the U.S. Armed Forces. MST is prevalent among female veterans (Brown, 2018; Nichter et al., 2022). Racial and ethnic minorities are also associated with MST (Nichter et al., 2022).

Chapter 3 includes the methodology for this study as well as the research design, rationale, my role as the researcher, population, data collection procedures, data analysis, assumptions and delimitations, and ethical issues.

Chapter 3: Research Method

In this generic qualitative study, I aimed to explore coping approaches of adult cisgender African American female veteran service members who have experienced MST. It builds on other studies which indicate a need to explore cultural markers of sex and race.

In this chapter, I describe the research design and rationale for this study. Also included in this chapter is the phenomenon under study and a discussion of the population and the sample size. Issues related to trustworthiness are also discussed.

Research Design and Rationale

Research Question

The research question for this study is: What are the coping approaches of adult cisgender African American female veterans who have encountered MST? A generic qualitative study was used for flexibility. This provided the opportunity to develop interview questions and collect accurate word data. The generic qualitative design was used for participants to explain their coping mechanisms when dealing with MST.

The rationale for this generic qualitative study is that it may generate and elaborate on new theories that contribute to social practices of coping strategies of African American female veterans who experienced MST. This may provide a better understanding of mental support that African American female veterans need from the VHA for continuum of care after departure from the military.

Role of the Researcher

I was the instrument and gathered data involving individual experiences in addition to remaining unbiased during collection of data. Additionally, I used bracketing in interviews. I employed descriptive bracketing to focus on experiences of the participants and avoid assumptions. I used my self-knowledge, sensitivity, and reflexivity as tools for bracketing during my study. I aimed to be free of assumptions, remain unbiased, not influence interviewees, and exercise reflexivity.

I used reflexive journaling so my thoughts and experiences would not be biased during data collection, analysis, and interpretations. Reflexive journaling was used to avoid personal assumptions. During journaling, I reflected on ethical principles, dilemmas, and decisions that might have impacted data results. When collecting data involving lived experiences, I used open-ended semi-structured interviews with follow up questions. As the researcher, it was my responsibility to ensure participants felt they could be authentic and truthful.

It was imperative that I fully disclose my background regarding the phenomenon. I have 20 years of military active-duty service as an African American female service member. I experienced sexual harassment during this 20-year span in a military culture where women experienced MST more than their male counterparts. Experiencing this phenomenon provided me with the ability to improve my listening skills. My role as the researcher in this phenomenon helped me practice patience and understand the population's vulnerability. My goal was to understand needs of participants so future benefits could be provided.

Methodology

Participant Selection Logic

The study sample consisted of 15 African American female cisgender veterans who were either retired or separated from the military and experienced MST. To meet criteria for involvement in this study, participants were required to identify as African American cisgender female veterans who were 18 or older and experienced MST. Number of participants for this study was derived as a convenience sample from the total number of active-duty military who were sexually assaulted and sexually harassed. Eight thousand eight hundred sixty-six active-duty military members reported being sexually assaulted, and 972 reported sexual harassment (U.S. DOD, 2021). The total number of active-duty military who experienced MST during FY2021 was 9,838.

Data saturation occurs when no further data collection or analysis is needed because no new information is added (Saunders et al., 2017). Saturation is reached once participants say the same claims (Chitac, 2022; Guest et al, 2020). This study achieved saturation after 15 participants.

The total number of active-duty military who experienced MST during F 2021 was 9,838. I used a sample size of 15% of that total, which was 14.757 (rounded to 15). I sought participants who experienced MST and could provide feedback.

Instrumentation

Data for the study were derived from video- and audio-recorded semi-structured interviews with African American cisgender female veterans who experienced MST. I

was the instrument for interviews (see Appendix A). Data collection included five main interview questions aligned with the research question:

What are some coping strategies you would share with other female veterans?

How did your coping strategies helped you?

Tell me who you include in your support network.

Tell me how your support network supported your coping.

What coping strategies did the VHA provide?

Participants were debriefed and provided contact information for the Veterans Crisis Line.

Procedures for Recruitment, Participation, and Data Collection

Recruitment

Participants were recruited from women veterans Facebook groups and social media. I requested permission to conduct research before seeking Institutional Review Board (IRB) approval from Walden University. Once IRB approval was granted to conduct research with human subjects, I began recruiting participants for the study.

Participation

Prospective participants contacted me through their personal email accounts. I provided them with detailed information about informed consent, and I ensured ethical treatment and protection from harm. Furthermore, I informed them about what I expected from them, as well as the purpose and nature of the study. Fifteen women were selected and scheduled for audio-recorded virtual interviews lasting between 30 and 60 minutes

each. I emailed participants informed consent forms which they acknowledged by replying with the words “I consent” in their email responses.

Data Collection

I conducted semi-structured, virtual video- and audio-recorded interviews lasting 30-60 minutes over 11 weeks. I used pseudonyms for each participant and separated their files based on their actual names and the email contacts I assigned to each pseudonym to protect participants' confidentiality. I downloaded the data files was transcripts from Zoom, labeled them independently, transcribed them into written text, and secured them in a locked, password-protected encrypted file.

Data Analysis Plan

The data analysis framework for this study provided further understandings of how to cope with strategies for African American female veterans who have experienced MST (Hargrave et al., 2023). I transformed the audio to close caption transcription. I manually coded the participants terminology in their own words, known as “vivo coding” (Khamung et al., 2022). I grouped the emerging patterns by color coding and clustered them together (Owcarek, 2019). During the manual thematic analysis I used critical words, quotations, coding, and interpretation to begin the coding process (Ozuem et al., 2023).

Issues of Trustworthiness

According to Johnson (2020) and Nassaii (2020), protocols for trustworthiness in qualitative research involves: (a) credibility; (b) transferability; (c) dependability; and (d) confirmability.

Credibility

I ensured the rigor of the interviews to help describe the moments and meanings of the coping experiences of African American female veterans who experienced MST (Deshpande & Sathyanavayano & Rao, 2024). The well-documented interviews and accurate reporting contributed to the study's credibility and the data triangulation of the observation notes during the interview and the interview transcriptions (Thomas et al., 2024).

Transferability

The thick description was a component of external validity in the study known as transferability (Fusch et al., 2018). Participants answered semi-structured, open-ended questions that required extended responses. The open-ended interview questions were developed to solicit detailed, thick responses. Based on the sampling factors, there was a degree to which other female veterans could apply the study results to their own situations (Goretzko, et al. 2024).

Dependability

Dependability in this study was demonstrated by the researcher journaling after each interview with participants, allowing future researchers to repeat the study based on conclusions grounded in the data (Goretzko, et al., 2021; Lim, 2024). As qualitative research evolved, other researchers examined the accuracy by reviewing the data interpretations for similarities (Lim 2024). Methodological triangulation in this qualitative study originated from multiple sources of semi-structured video and audio interviews and transcripts (Fusch et al., 2018).

Confirmability

Lastly, confirmability was obtained when the researcher's accuracy of the interpretations and conclusions could be confirmed, and the standards of rigor were applied (Thomas et al., 2024; Goretzko, et al., 2021). Bracketing in the study served as a guideline for impartiality. I used journaling and peer audits to ensure my neutrality while investigating the phenomenon. The analytical data was supplemented by reflexive notes obtained during the audit trail (Janis, 2022; Lim 2024).

Ethical Procedures

According to Sanjari (2014), ethical protocols that should be followed in qualitative research included anonymity, confidentiality, and informed consent. Walden University's IRB provided approval before I conducted my research study. Confidentiality and informed consent were electronically acknowledged through email responses by each participant before conducting each individual interview. The participants were informed of (a) an explanation of the study, (b) the study's purpose, (c) information about the researcher, (d) the data collection process, (e) the right to privacy, (f) the publication of the study's results, and (g) the right to withdraw from the research.

The participants were informed of the free Veterans Crisis Line available 24/7 for any adverse effects due to the sensitive nature of the study. They were also informed of their privacy and confidentiality during the interview process. Participants were told that all video and audio would be anonymously coded and that their data would be stored in a locked firebox in my residence. The participants were further informed that all information stored on their computers was password protected. Additionally, after

completing the study, I removed all data from my laptop and stored the data on a thumb drive in a locked firebox.

Summary

The phenomenon of interest in this study was coping strategies of African American cisgender female veterans who have experienced MST. I used a generic qualitative research design to collect and analyze participant data and understand their points of view regarding the phenomenon. I used in-depth interviews to investigate lived experiences and address gaps in literature while using thematic analysis to answer the research question. Chapter 4 includes results of the study with supporting documentation.

Chapter 4: Results

This study involved addressing coping strategies of African American female veterans who experienced MST. Through data analysis, I identified emerging themes that African American female veterans used while coping with MST. Chapter 4 includes information about the research setting, data collection and analysis processes, evidence of trustworthiness, and results. It concludes with a chapter summary.

Setting

The primary setting for each interview was my home office. I recorded and transcribed each interview verbatim from July 5 to September 13, 2024. Each participant selected a specific date and time for their interviews, which were conducted via Zoom in my home office and their chosen individual locations. They received Zoom invites, passwords, and links for their in-depth interviews.

Demographics

There were 15 African American participants throughout the United States who participated in this study. I assigned each participant a different alphabet letter starting with A and ending with O. Participants ranged in age from 55 to 75. Each participant experienced MST during their service and did not reach out for counseling while on active duty but pursued counseling once they departed service. Participants departed the military between 1989 and 2009.

Data Collection

Recruitment

The recruiting process commenced once I obtained Walden's IRB approval. I placed my recruitment flyer on social media sites including Facebook and female veteran organization websites. According to Goodwin et al. (2024), the social media recruitment process reaches underrepresented and underserved populations. This resulted in 15 participants who were interested in this study.

Protection of Participant Data

I provided participants with informed consent forms to review and encouraged them to ask questions before participating. If participants agreed, I asked them to reply with the words "I consent" via email. I provided unique identifiers for participant emails which corresponded to interview in protective folders. All electronic documents were stored on a secure computer that I own. All printed documents were locked, maintained, and destroyed according to Walden University policies. In-depth interviews were scheduled based on availability of participants.

Conduction of Interview

I used in-depth semi-structured interviews for 15 participants who scheduled interviews. These were completed using Zoom and lasted 30 to 45 minutes. At the beginning of interviews, I informed participants they were being recorded, and at the end, I thanked them for participating in the study and serving the United States. I also asked them if they would like to provide any additional thoughts or words regarding this subject matter.

Oral narrative data was transcribed using Zoom's closed captions feature. I validated accuracy of transcriptions by listening to audio and making necessary corrections. Additionally, I conducted 10 to 15-minute follow up interviews with each participant to review transcribed text, ensuring it accurately reflected their insights and not my own.

Data Analysis

Coding Strategy

Data analysis began with closed caption transcriptions. I then organized data. I became familiar with the data. I manually coded participants in their own words using in vivo coding. I had three codes in mind: communication, family, and counseling. During the second cycle of axial coding, I redefined connections and grouped emerging patterns by color coding and clustered them together . This led to the themes self-stigma, counseling, and family and friends.

Coding Process

Via thematic analysis, I used critical words, quotations, coding, and interpretations during the coding process. This started with in vivo coding followed by axial coding, during which I searched for patterns in data regarding codes involving coping strategies and support systems for female veterans. Via selective coding, themes and categories emerged.

Codes

During data analysis, 89 codes resulted involving words and phrases, leading to 13 redefined codes that emerged in this qualitative study. Codes related to African American female veterans' coping strategies when dealing with MST.

Categories

By using 13 descriptive codes, I began to see patterns that I grouped involving five interview questions, resulting in five categories representing participant responses for each question. In terms of communication, Participant E stated, "You should be transparent and talk to someone you trust." Participant L stated, "You should talk to someone you trust." The second category was not blaming oneself. Participant C stated, "It was not my fault," and Participant H stated, "It's not my fault and I did not feel guilty." The third category was family and friends. Participant I stated, "I talked to my sister," while Participant H stated that she talked to other female veterans. The fourth category was VA counseling groups. Participant B and Participant C both mentioned counseling and Participant D and Participant M addressed group counseling. The fifth category was therapy. Participant A stated, "I would share just go to therapy."

Themes

Five categories emerged. There was one research question, and all three themes answered the research question that was derived from interview questions. A theme was self-stigma that was felt among most participants who expressed how their support systems helped their coping strategies. Participant D stated, "My support system kept encouraging me that it was not my fault." Participant H stated, "My support system said

you don’t have to feel guilty. It is not your fault.”. The second theme emerged from participants talking in small group therapy and counseling as it pertained to coping strategies that helped them during their MST. Participant D stated “ being part of a group helps with coping strategies.” Participant H stated 20 years of continuous therapy helped her coping strategies.

Participant M stated that "the Veterans Health Administration provided group counseling, and Participant D stated "that the Veterans Health Administration provided 6–8-week counseling sessions (see Table 3). The third theme that emerged from the participants included in their support network, which consisted of family and friends. Participant K stated, "My family was my strong support system." Participant E stated, "Both my friends and family supported me through some rough times" (See Table 4). The data analyzed showed no significant discrepancies among the participants in how they individually used their coping strategies. Their coping experiences were reflected in their comments during the interview.

Evidence of Trustworthiness

Credibility

To establish the trustworthiness of this study, I emphasized the understanding of the nuances of the human experiences of my participants through in-depth interviews (Subedi, 2023). The member checking was crucial for the information, as the participants provided their own meaning and not the researcher's perceptions. According to Thomas et al. (2024), allowing the participants to give feedback and validation is one of the best practices of member checking. The triangulation process of manual coding, interview

transcripts, and video replay generated the categories and themes from the participant's perceptions and not the biases of the data from the researcher.

Transferability

Transferability in this study was achieved by recruiting African American Army Female veterans as well as all female veterans who used their coping skills to manage how they processed MST. The rich descriptive details of the participants' coping skills were captured during the interviews and provided an understanding of the social phenomena (Subedi, 2023). Utilizing the participants' words and phrases facilitates reading for anyone to hear their voices in this study. The study's descriptive details allows readers to apply the findings in other situations or groups (Lim, 2024).

Dependability

To ensure the dependability of this study, the utilization of a clear and detailed record of the research process that included data collection, analysis, and interpretation was identified as the audit trail (Subedi, 2023). The method used to gather data for the research was consistent across participants to minimize errors and biases. (Lim, 2024). The interview guide was paramount in processing the data's organization to ensure accuracy from the participants. The data collection findings in this study illustrate the study's dependability.

Confirmability

The interview protocol to outline the confirmability of this research study was utilized. Confirmability was used to shape the participant's responses to the data collection and analysis, not the researcher's subjective view (Lim, 2024). This study

achieved confirmability through triangulation, audit trails, and member checking (Subedi, 2023; Lim, 2024). I achieved data triangulation by reviewing the participant's interview responses, and they were aligned and strengthened the results. Reflexive journaling was completed in my audit trails by journaling any biases and my perspective in order to ensure they did not influence the research. I achieved member checking by allowing the participants to review my writings of the data to reflect their experiences.

Results

This study explored the coping approaches of adult cisgender African American Female veterans who have encountered Military Sexual Trauma (MST). During the analysis, I identified frequent words utilized by the study participants that described their feelings, coping mechanisms, and support system.

The data analysis resulted in three themes: Self-stigma, counseling, and family and friends. There was one research question, and that was: What are the coping approaches of adult cisgender African American female veterans who have encountered MST? Five in-depth interview questions were used to gather data to answer the research questions. I analyzed data from the five interview questions to reach the three themes. In the theme of family and friends (Table 3), eleven participants stated that family and friends were included in their support network. Participant A, Participant B, Participant C, and Participant E stated, "My support network was family and friends. Participant F stated, "I reached out to other female veterans." In Theme of Self-Stigma (Table 2), there were 12 participants who felt that their support network helped them see that they were not to blame themselves for the incident and that it was not their fault. Participant D

stated, "My support network told me it was not my fault." Participant H stated, "My support network told me to stop feeling guilty, it's not your fault." Participant K and stated her support network stated, "Don't blame yourself."

Table 1

Self-Sigma

Theme: 1	**Interview Questions**	**Participation**	**Total**
Self Sigma	Tell me how your support network helps you in coping	A, D, E, F, G, H, I, J,K,M,N,O	12
	What are some coping strategies you would share with other female veterans	C	1
	Tell me how your coping strategies help you	B,L	2

Table 2

Counseling

Theme: 2	**Interview Questions**	**Participation**	**Total**
Counseling	What coping strategies did the Veterans Health Administration provide	A,B,C,D,E,F,G,H, J,K,M,N,O	13
	What are some coping strategies you would share with other female veterans	I	1

	Tell me how your coping strategies help you	L	1

In the theme of counseling (Table 4), there were 13 participants who felt the Veterans Health Administration provided counseling to help with coping strategies. Participant F stated, "The VA provided small group counseling." Participant D stated, “The VA enrolled me in a 6-8 week small counseling group". Participant H stated, "The VA provided yoga and counseling." Participant O stated, "The VA provided small group counseling.” The study concluded that the participants had a healthy support network in coping with MST and that the Veterans Health Administration had a system to engage the veterans when seeking help.

Table 3

Family and Friends

Theme: 3	**Interview Questions**	**Participation**	**Total**
Family & Friends	Tell me who you included in your support system	A,B,D,E,G,H,I,J,K, M,O	11
	What are some coping strategies you would share with other female veterans	L	1
	Tell me how your coping strategies help you	F	1

Summary

I used data to address coping approaches of adult cisgender African American female veterans who encountered MST. Eleven participants stated their family and friends were part of their coping approaches involving MST. Twelve stated their support network helped them not to blame themselves, and 13 stated the VHA provided counseling and small groups as a coping strategy. Results from analysis of raw data are interpreted and discussed in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative study was to explore coping approaches of adult cisgender African American female veteran service members who experienced MST. I

In Chapter 4, I addressed female veteran support networks and how they helped in terms of developing coping strategies. Participants addressed how communicating with family and friends helped them defend themselves from self-stigma. In Chapter 5, I discuss interpretations of findings as well as themes and correlations of themes with the following research question:

RQ: What are coping approaches of adult cisgender African American female veterans who have encountered MST?

I also discuss limitations of the study, recommendations, implications, and conclusions.

Interpretation of the Findings

Theme 1: Self-Stigma

In this study, 12 participants stated their support networks helped them to not feel guilty, and their MST experiences were not their fault. According to Webermann et al. (2023), veterans who reported MST exhibited overwhelming feeling involving self-blame. All participants stated their support systems told them it was not their fault. Participant L mentioned no judgment, Participant K asserted no blame, and Participant A claimed she did not feel alone. Participants showed an overwhelming sense of relief when stating their support networks acknowledged to them their trauma was not their fault. According to Andresen and Blais (2019), female veterans who experienced MST and exhibit self-stigma are less likely to disclose their feelings during VA

screenings. Participant E stated her support system supported her by insisting her MST experience was not her fault.

Self-stigma has a detrimental impact on survivors of MST (Andresen & Blais, 2019). Participant O stated her support system made her feel it was not her fault. Female veterans who experienced MST demonstrated significant guilt, shame, and mistrust (Lee, 2021; Webermann et al., 2023). Participant O relied on her support system to conclude it was not her fault due to the guilt and shame she endured after her MST experience. Participant N also stated that her support network helped her with no blame. According to Katz and Sawyer (2020), MST survivors want to put experiences behind them due to shame, blame, and embarrassment.

Theme 2: Counseling

Thirteen participants stated the VHA provided counseling as a coping strategy. Participants D, F, and stated small groups provided good coping strategies. Gender-specific comprehensive care for female veterans leads to overall healthy lifestyles (Geber et al., 2014; Kelly et al.,2014; Lehavot et al., 2014; Wagner et al., 2015 as cited in Devine et al., 2020). Participant H stated yoga was a good form of counseling that the VA provided, and Participant B and Participant C stated, counseling was a coping strategy provided by the VA.

Participant D stated was beneficial to be in a 6 to 8-week group setting. According to Braun et al. (2024), an 8-week intervention group is a transdiagnostic approach to addressing histories of MST Braun et al. (2024) reported coping skills involving mindfulness and self-compassion ameliorated issues of concern. Participant M

stated sharing stories in a group setting was a benefit. Katz and Sawyer (2020) stated supportive bonding of female veterans in group settings was a positive enhancement. According to Preston et al. (2023), adaptive coping is a common strategy for female veterans. In this study, Participants E and M mentioned talking as an effective coping strategy. In this study, participants vented as a form of adaptive coping with people they trusted.

Theme 3: Family and Friends

In this study, 11 participants stated they included family and friends in their support networks. Participants A, E, and K mentioned family. Participants B and E mentioned family and friends. Participant G referred to best friends. In this study, support networks of family and friends were what most participants trusted and relied upon. Disclosure to family, friends, and colleagues was an important factor for female veterans to share when coping with MST (Rodriguez et al., 2024; Webermann et al., 2023).

Participant H and Participant both shared their daughters were included in their support networks. Other participants chose to include other female veterans, doctors, and therapists in their support networks. All participants shared they were comfortable with including someone in their support networks. Participants N and O both stated, talking to someone is a prominent strategy they would share with other female veterans. According to Preston et al. (2023), psychological clarity can contribute to traumatic events during the overall recovery process. Participant N stated, “listening and taking advice helped during the process.” Participants I and K both stated talking was a coping strategy that helped them. Rodriguez et al. (2024) stated engaging in adaptive coping behaviors

resulted in positive interventions for female veterans who experienced MST. Participants I and K managed their responsibilities by using social skills and talking to other people.

Theoretical Implications

The theoretical framework for this study was the transactional theory of stress and coping. The appraisal process participants used impacted their coping strategies . Participant coping strategies included family and friend support networks and VHA counseling.

The transactional theory of stress and coping highlighted some of the social relationships the participants formed with individuals when coping with their stress . Their support network helped with their coping strategies supported by their individual social relationships and social environments (McCarthy et al., 2019). According to Lazarus & Folkman, 1984, as cited in McCarthy et al., 2019, coping is managing stressful situations and focusing on problem-solving. The participants in this study used their support network of family, friends, and counseling to debunk self-stigma.

Limitations of the Study

The study will make an impact on the understanding of the coping strategies that African American Female veterans utilize when dealing with MST. A limitation of the study is that all the participants were exclusively African American female army veterans, which restricts the generalizability of the findings of male and female veterans of different racial or ethnic backgrounds. The sample did not reflect a full range of diversity within the population of African American female veterans, including geographic locations, military branches, and socioeconomic that may shape the different

coping mechanisms that are used by the veterans and may change the trajectory of the recovery although not the central focus of the study.

This study relied on self-reported data that was collected through interviews that were susceptible to several types of bias; for example, recall bias affects how the participants recount their past and where their coping mechanisms; social desirability bias may lead participants to frame their responses in a socially acceptable manner in a stigmatized topic such as MST. Additionally, trauma-related memories to qualitative research may limit the depth of specific findings. The study also briefly captured data during the participants' time frame but did not provide insight on how coping mechanisms may change or time in response to their strategies. The study limits the ability to assess coping strategies across different phases of dealing with MST.

These limitations have several implications for the broader field of veteran support services, and the restricted generalizability of the findings shows the importance of avoiding the one-size-fits-all approaches in a Veterans Administration healthcare setting. Also, this study provided a snapshot of the critical gap in the literature concerning culturally specific coping strategies of African American female veterans who are survivors of MST, and addressing the gap in the literature will help the development of effective and equitable unique needs of diverse veteran populations.

Recommendations

There is little to no research on the coping strategies of African American female veterans who have experienced MST. Based on the limitations and the key findings of this study, several recommendations are needed for future research and practice. Future

research should conduct a longitudinal study to track the coping strategies of African American female veterans over time to provide an understanding of why coping mechanisms are needed and how they may evolve over time. A mixed method of quantitative and qualitative will allow a more comprehensive understanding of the different coping strategies. Future studies might involve narrative research for in-depth, detailed analysis of their coping strategies. A future study could evaluate current programs that identify the coping strategies of African American female veterans and explore improvements needed for these programs.

Implications

Implications for VHA Practice

Results from this study have implications for research, practice, and social change. Findings from this study illustrate that when African American female veterans share stories, it reduces stigma, contributes to coping strategies, and encourages more veterans to seek help. Results from this study can contribute to cultural competency in veteran services, providing more culturally responsive practices. A Peer Mentorship program for female veterans can match female veterans with trained peers who understand MST and the barriers of military leadership. Mentorship training includes cultural awareness, sensitivity, military structural norms and polices. Additionally, Community-Based Training in a non-VA setting that provides civilian providers with veteran-led discussions to recognize and build skills in communicating about military-related trauma. Also, the findings in this study can increase awareness and understanding

of the coping strategies that African American female veterans utilize while coping with their experiences of Military Sexual trauma.

Implications for Military Leadership

Additionally, the findings in the study have implications for social and cultural change in the military and the Veterans Health Administration. This study highlighted the coping strategies of the support networks that African American female veterans used for coping strengths and their resilience, and this could be used for empowerment initiatives in the Veterans Health Administration. The VHA could incorporate a Tele-Health Base Coping Skills Group that would ensure privacy for female veterans who avoid in person treatment, Trauma -informed care practices this provides female veterans with more of an independent feeling of respect and control, A dedicated MST provider in Non-Va facilties this will provided female veterans an anchor in a civilian setting and help with the healing journey. Incorporating these initiatives will assist female veterans in building coping skills and access to a personalized approach for their lives and addressing the need for control and safety.

Implications for Future Research and Military Policy

This study also carries important implications for institutional policies and training programs within the VHA and DoD. The coping strategies shared by African American female veterans in the study can contribute to the design of MST prevention and response training during military deployment and military training. The findings support the integration of survivor-informed perspectives in program development in advisor roles and research initiatives to enhance MST-related services by improving

patient and provider relationships. VHA facilities in Maryland must expand culturally congruent care options, such as integrating chaplain services, peer mentorship programs, and African American women-led support groups.

The DoD educational curricula could be enhanced for the cultural competence of mental health providers and commanders throughout all military branches.

The findings from the study VHA and DOD can improve intervention strategies and reduce barriers to mental health access. This study contributes to VHA and DOD rebuilding trust in historically marginalized populations. Both DoD and VHA entities in Maryland should use findings to advocate for expanded funding, policy flexibility, and inclusion of culturally specific metrics in MST program evaluations.

This study could impact policy development for female soldiers who face the challenge of military sexual trauma, leading to the redevelopment of better policies and support for female soldiers while they are on active duty. The study can also impact the improved mental health services that practitioners offer, in the hopes of developing a culturally competent practice for the experiences of African American female veterans. Practitioners could use the data from the study to advocate for same-day mental health screening instead of using separate referrals.

Clinicians and practitioners could proactively support remote care for veterans uncomfortable with personal VA appointments. The data could inform group recruitment strategies for veterans who want to share recovery narratives. The data could inform clinicians and Practitioners to be flexible and respond with empathy.

Conclusion

According to Devine et al. (2020), health care for female veterans is challenging in a system unfamiliar with the population of women, and that system is the Veterans Health Administration. This study of African American female veterans builds on other studies that indicate how the cultural markers of sex and race need to be explored (Brownstone et al., 2018). The data of the study revealed that African American female veterans draws extensively on their familial and friendship network, along with professional counseling to confront and destruct the self-imposed shame connected to MST. The strength of family and friends is the buffer for emotional healing. Sharing stories was very instrumental in reclaiming their personal dignity.

As essential was counseling and group therapy when the dynamics of military leadership was an obstacle that could be shared among other female veterans. The informal support as well as therapeutic engagement helped shift the narrative from self-blame to self-compassion. The collaboration of informal networks and clinical support can model empathy and effectiveness. The VHA could facilitate family inclusive interventions to reinforce trusted relationships.

Promoting culturally informed therapy for African American women would provide clinicians and practitioners with the tools to be Intune with the specific experiences of African American women. The results and interpretations of the findings of the study will potentially assist the Veterans Health Administration with the best

possible coping strategies for African American female veterans who have experienced Military Sexual Trauma.

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Appendix A: Recruitment Email

TO WHOM IT MAY CONCERN:

Request Participation in Research Study

You are invited to participate in a research study about African American female veterans who have experienced sexual harassment or sexual assault while on active duty. This form is part of the "informed consent" process to allow you to understand this study before deciding whether to take part. This study is being conducted by a student researcher named Denise L. Bullock, a Ph.D. Candidate for a Doctor of Philosophy in Human Services at Walden University.
In this study, I seek 15 volunteers who are:

1. Study participants must be 18 years of age or older.

2. Study participants who identify as female African American veterans.

3. Study participants are veterans that have experienced sexual harassment or sexual assault.

Study Purpose:

The purpose of this generic qualitative study is to explore the coping approaches of adult cis-gendered, African American female veterans who have experienced MST.

Procedures:

The study will involve you completing the following steps:

1. Zoom interview for 45 minutes, which will be audio recorded.

2. Interviewee Transcripts Review (10 minutes); to complete this step, I will email you a copy of the transcript from the interview and I will ask you to review it to make sure the transcript accurately reflects our thoughts.

The interview questions are listed below:

1. What are some coping strategies you would share with other female veterans?

2. Tell me how did your coping strategies help you?

3. Tell me who you included in your support network.

4. Tell me how your support network supported your coping.

5. What coping strategies did the Veterans Health Administration provide

Voluntary Nature of the Study:

Participation in this research is voluntary, and you may refuse to participate without prejudice. If you decide to join the study now, you can still change your mind later and discontinue at any time.

Risks and Benefits of Being in the Study:

As a participant in this study, it could involve some risk of emotional discomfort that can be encountered in sharing sensitive information. Each prospective participant will be provided the Veterans Crisis Line 24/7 for confidential counseling in case of emotional difficulty. That number is 988 and then press 1. Participants that have discussed their experience with a qualified professional is a benefit of being in the study.
This study offers no direct benefits to individual volunteers. This study aims to provide additional knowledge to veterans' health care administration that serves female veterans who have experienced military sexual trauma. Once the analysis is complete, the results of this research will be reported as a qualitative summary.

Payment:

There will be no payment for participating in this study.

Privacy:

The researcher is required to protect your privacy. The information provided by participants will be treated confidentially. The researcher will not use your personal data 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. As the interviewee, you can keep a copy of this consent form. The results of this research will be reported as a qualitative summary. The records/raw data will be stored securely in a password-coded file only accessible by the researcher and stored for five years as required by the university.

The researcher is a mandated reporter in Maryland and must disclose any mention of child abuse and neglect to the appropriate authorities.

Contacts and Questions:

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 IRB, will enter the approval number here. It expires on IRB and will enter the expiration date. You may ask the researcher or Walden University for a copy using the contact info above. If you have general questions about the study, contact me at denise.bullock@walden.edu (email) 443-422-6068 (phone).
A personal email must be used to participate in this study. You should retain this consent form for your records. You may ask the researcher or Walden University for a copy using the contact info above.

Obtaining Your Consent

If you understand the study and wish to volunteer, please indicate your consent by replying to this email with " I consent."

Thank you for time and interest in my study.

Denise L. Bullock
denise.bullock@waldenu.edu
443-422-6068

Appendix B: Prescreening Questions

Dr. Antoinette Pigatt – (Chair)

1. What is your current age?
2. What branch of the military did you serve?
3. What is your Gender?
4. What is discharge/retirement date?
5. Have you ever received counseling for Military Sexual Trauma while you were on active-duty?
6. Are you currently receiving counseling/therapy?
7. What is your race?

Appendix C: Guiding Interview Questions

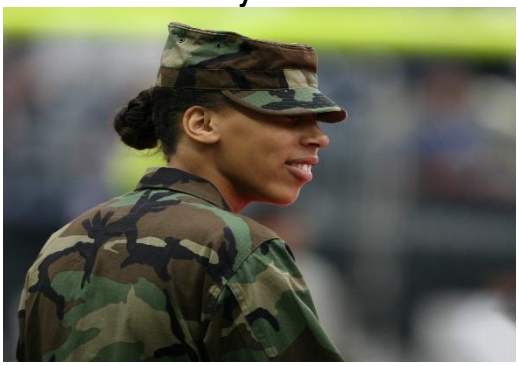
1. What are some coping strategies you would share with other female veterans?
2. Tell me how did your coping strategies help you?
3. Tell me who you included in your support network.
4. Tell me how your support network supported your coping.
5. What coping strategies did the Veterans Health Administration provide

Appendix D: Recruitment Flyer

As an African American Female Veteran did you experience Sexual Harassment or Sexual Assault?

If so, you may qualify to participate in a study on

Exploring the Coping Skills
of African
American Female Veterans who
Have experienced Military Sexual Trauma



You May Qualify to Participate If you are

- At least 18 years old
- Identify as African American Female Veteran
- Experienced Sexual Harassment or Sexual Assault while on active duty
- Study participants that have received follow-up counseling related to the assault or harassment.

Selected Participants will be asked to join a confidential 45 Minute Zoom Interview

This study is being conducted by Denise L. Bullock a doctoral candidate at Walden University. Please email denise.bullock@waldenu.edu if you have any questions and interested in this study.