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Women Veterans' Experiences Applying for Veterans Affairs Compensation for Military Sexual Trauma-Related PTSD

Bridget Strong
Walden University

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Walden University

College of Psychology and Community Services

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Bridget D. Strong

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Walden University
2026

Abstract

Women Veterans' Experiences Applying for Veterans Affairs Compensation for Military

Sexual Trauma-Related PTSD

by

Bridget D. Strong

MBA, Florida Metropolitan University, 2006

BA, University of South Alabama, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

Walden University

May 2026

Abstract

Military sexual trauma (MST)—sexual harassment or assault during military service—is more common among women and is a leading cause of posttraumatic stress disorder (PTSD). Veterans Affairs (VA) disability for MST-related PTSD offers financial support, free healthcare, and validation, but women face barriers and uneven access to supports (veteran service organizations, trained advocates, trauma-informed clinicians), reducing their chances of favorable decisions. In this generic qualitative study, semi-structured interviews were conducted with 11 purposively sampled women veterans representing diverse service eras, branches, and adjudication outcomes. Analysis was guided by feminist theory to shift focus from individual blame to structural factors, including how institutional practices, gendered norms, and power dynamics influence who is believed and how claims are adjudicated. Six themes emerged: military challenges, coping mechanisms, MST treatment, gender differences in treatment, the VA benefits process, and opportunities to improve application processes revealed that substantial procedural and interpersonal barriers can retraumatize claimants. Recommended reforms include trauma-informed training for VA staff and clinicians, standardized alternative evidentiary pathways when records are lacking, expanded claimant assistance and targeted outreach for marginalized veterans, clearer communication and faster processing, and stronger accountability within military and VA systems. Future research should assess interventions that streamline claims, promote equity and healing, minimize retraumatization, and measure long-term health and well-being outcomes for MST survivors.

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Dedication

This dissertation is dedicated to all veterans who have endured disabilities as a result of their military service. As a child, sister, and wife of a Navy servicemember, I know how real these challenges are. I recognize the daily struggles you face—both now and for the sacrifices you made to protect us. I stand with you in your pursuit of justice, funding, and the benefits you need to live a productive life. You are not alone; we support you every step of the way. Thank you for your service.

I offer my deepest gratitude to everyone who contributed to my success, personally and professionally. All thanks and glory to God—because I followed His guidance, I stand at this point in my life content and with few regrets. God has given me a voice and the opportunity to help others, which I believe is His will for my life. I thank Him and commit to conducting His will at all times.

To my parents: you have been my greatest motivators and supporters. You taught me the value of hard work and that perseverance brings reward—principles that guided me through this journey. I owe my “go-getter” spirit and tenacity to you. I would not be who I am without your love and support. I love you both beyond measure.

To my husband, Javid Benson: you entered my life at the perfect time and gave me the encouragement I needed to move forward. You have been my steady point of reference in times of need, reminding me to write, stay focused, and keep going. You never left my side; you shaped me into the woman I am today. I love you unconditionally.

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Chapter 1: Introduction to the Study

Introduction

Both the Afghanistan and Iraq wars included many deployed U.S. female soldiers (Mattocks et al., 2012). Women who served in those conflicts were more likely than men to meet criteria for posttraumatic stress disorder (PTSD) after returning home (Lehavot, 2018). Notably, 18.7% of those women experienced significant depression, anxiety, and PTSD independent of their level of combat exposure (U.S. Department of Veterans Affairs, 2014).

The role of female soldiers has not always been direct fighting in combat, but female soldiers often took on stressful and dangerous missions during the war (U.S. Department of Veterans Affairs, 2014). As a result, women who returned home from combat faced both mental and physical health problems and sometimes struggled to adjust when back in the civilian world. Burkart and Hogan (2015) established that unique issues occurred for female soldiers returning home, particularly issues related to military sexual trauma and PTSD; however, gaps in knowledge of these exact issues remained.

Military sexual trauma (MST) was a term adopted by the U.S. Department of Veterans Affairs (2014) that applied standards to both men and women who reported rape, sexual assault, or sexual harassment during their military service. MST also included other experiences, such as unwanted sexual touching and threatening or unwelcome sexual advances. Wood and Toppelberg (2017) found it to be a realm between harassment and sexual assault based on military data. Still, the military needed

to improve its data collection methods for sexual assaults and sexual misconduct to fully understand the scope of the problem.

MST is not considered a formal mental health diagnosis but instead an experience that could lead to disabling conditions like PTSD (U.S. Department of Veterans Affairs, 2014). The U.S. Department of Veterans Affairs has seen cases of MST-related PTSD and addressed the concerns by allocating resources for women veterans to begin confidential counseling and treatment. One resource involved employing women veteran coordinators (WVCs) to look for signs indicating a traumatic event had occurred and to assist victims of MST submit applications for disability compensation to determine whether the PTSD was MST-related. However, gaps remained in the percentage of claims for MST-related PTSD compared to non-MST-related PTSD, and the need for further analysis was clear (U.S. Department of Veterans Affairs, 2014).

The U.S. Department of Veterans Affairs (2014) reported the percentages of PTSD claims granted for MST-related and non-MST-related cases. In its fiscal year (FY) 2011 data analysis, it found a substantial gap: 59.5% of non-MST-related PTSD claims were granted, compared to only 35.6% of MST-related PTSD claims—a nearly 24-point difference. By FY 2014, the gap had narrowed to less than 6 points, with grant rates of 54.1% and 48.5%, respectively. In the most recent fiscal year reported, the gap had narrowed to about 1 percentage point, with grant rates of 54.6% for non-MST-related claims and 53.4% for MST-related claims.

There had been a 24% gap between non-MST-related PTSD claims and MST-related PTSD claims approvals in fiscal year 2011 (U.S. Department of Veterans Affairs,

2014). Furthermore, for each fiscal year, the graph showed a 17–30% variance in approval rates between the two, raising questions about the reasons for the notable difference. Organizations that supported women with military experience had attempted to address the significant disparity (American Civil Liberties Union, 2013). In one particular case, the disparity was due to the amount of evidence required to establish service connection for MST-based PTSD.

In this chapter, I provide an overview of women's history, their roles in the United States military, and the status of women veterans seeking VA compensation and treatment. I will describe the problems encountered in the VA application process to better understand what was considered sufficient for application submission to avoid a denial rating from the VA, while identifying key issues that women veterans faced when submitting claims, particularly those related to mental health conditions such as PTSD and MST. By understanding these challenges, women veterans could better navigate the system and increase their chances of a successful application.

Background

The integration of women into the military and their roles have significantly increased in the United States since the early 1900s (U.S. Department of Defense, 2015). Female roles evolved from women initially accompanying men during combat as caregivers to women serving in various branches of the military by the end of World War II (Burkhart & Hogan, 2015). The military had not allowed women to fight in combat, but they had been permitted to be in war zones and serve in roles that supported the mission. Roles such as nurses, caregivers, and administrative assistants were essential to

supporting missions and ensuring that men had support during combat (U.S. Department of Defense, 2015). Pearl Harbor in Hawaii during World War II exposed the roles women had played during the war. The case of Honolulu's "sporting girls" revealed the arrangement of prostitution by nurses in the military in a temporary hospital, a prostitution house. The hospital was to take care of the injured men in all capacities, including sexually (Lewis, 2017). As with every war, there had been prostitution, and women occupied supportive roles with no power or ranking and little to no protection against sexual harassment. With the military stressing an environment of impartiality, no laws or official policies addressed sexual harassment, sexual discrimination, or sexual assault until World War II in 1939 (U.S. Commission on Civil Rights, 2016).

A pivotal shift occurred during World War II, when women were needed in greater numbers due to a shortage of male personnel. During this time, some women began receiving a status of relative rank after serving and fighting in combat (Burkhart & Hogan, 2015). Although these women could serve in distinct roles in the military, they did not receive the same benefits as male combatants (Miller, 2015). Explanations and limitations of women's roles in the military included soldiers serving overseas in the United States Army who did not gain military benefits and remained subject to court-martial and military regulations; Black women in the Nurse Corps who did not receive the same benefits as White women; and White women who served in other branches like the Navy, Coast Guard, and the Women Airforce Service Pilots who received only partial pay, rank, opportunities, and benefits (Segal, 1995).

When women lacked support or equity, the Women's Army Corps (WAC) was formed and subsequently fought the House of Representatives to secure competitive rank, pay, and benefits for women in the military (U.S. Army Center of Military History, 2016). President Dwight D. Eisenhower supported the WAC's efforts and women's right to serve in the military. Through Eisenhower's backing and the WAC's advocacy, Congress passed a bill in 1945 allowing women to pursue careers in the military. The law was not the final push needed to establish women's equality in the military (Holmberg & Alvinus, 2024).

In 1948, the Women's Armed Forces Integration Act was passed, allowing women of the Armed Forces to hold active or reserve status in all branches. Although the bill passed, women still faced restrictions on specific military jobs. For instance, women could not delegate duties to men or oversee men. They could not advance in rank, and if they became pregnant, they were subject to discharge from the military (Murdoch et al., 2006).

By the 1990s, women's roles in the military had become more diverse. Restrictions on women serving on the front line were lifted, allowing them to perform combat tasks (e.g., driving convoys, flying combat aircraft, directing artillery, and serving on ships) (U.S. Department of Defense, 2015). These newfound responsibilities exposed women to the additional stressors of combat and related traumatic events (Iverson et al., 2012). Although women had been active participants in both the Afghanistan and Iraq wars, the military had not updated its policies to include women assignments (Crum-Cianflone & Jacobson, 2014).

Women experienced captures, sustained wounds, and even lost their lives while performing combat duties despite military policies that traditionally kept them from being assigned to ground infantry roles (Cawkill et al., 2009). Historically, the primary role of female service members had been to support combat missions rather than engage directly in frontline duties. This distinction had been rooted in traditional views about gender roles within the military, which often limited women's responsibilities to logistical support, medical assistance, and administrative tasks. However, as conflicts evolved and the nature of warfare changed, the rigid boundaries separating combat roles became increasingly blurred. Military leaders faced growing pressure to reassess and update policies governing the assignment of female personnel, particularly as evidence mounted regarding their capabilities and contributions on the battlefield. The presence of women in combat-like scenarios raised important questions about equality, effectiveness, and the nature of combat roles. Consequently, the challenge for military officials was not only to integrate women more fully into combat positions but also to develop policies that acknowledged the complexities of gender dynamics in military operations. This evolution reflected broader societal change, recognizing the significant impact women had in various capacities during times of war and leading to discussions about equitable treatment and opportunities for all service members, regardless of gender.

In 2021, women comprised 17% of the active-duty force in the military (U.S. Department of Defense, 2022), and 2.7% of women in the military were stationed in direct combat roles. In both the Afghanistan and Iraq wars, more than 1,000 women had been wounded (U.S. Department of Defense, 2015). Despite the increasing number of

women in the military over the years, the issue of military sexual abuse had not received attention until the issuance of the National Defense Authorization Act (NDAA) in 2012. The NDAA was a U.S. federal law that addressed national security programs and healthcare costs for military service members. Section 579 of the NDAA of 2012 was enacted to assist with reducing cases of military sexual assault and to establish a policy and plan for the prevention of and response to sexual assault. The law shaped how the Department of Defense examined, investigated, adjudicated, and prosecuted sexual assault and related offenses of military sexual trauma (Kamarck & Salazar, 2021).

For years, the VA's outreach and benefit programs surveyed women veterans to identify their healthcare needs and determine how healthcare needs and barriers differ during military service. In the first commissioned survey conducted in 1985, the VA reported that 57% of women veterans were unaware of their eligibility for VA services or benefits (Washington et al., 2015). In 2009, this percentage dropped to 30%. Although this decrease in the rate was an improvement, the VA was aware of the need to address women's limited knowledge of their eligibility for VA benefits. Therefore, that same year, the VA began notifying women veterans about VA services and benefits for compensation and recommended that a full-time Women Veterans Coordinator (WVC) be available in all regional offices to communicate these benefits (U.S. Department of Veterans Affairs, 2015).

With the assistance of a WVC, women veterans have been able to submit claims for mental and physical health issues, especially those involving sensitive information (e.g., MST). Unfortunately, data gaps have hindered the VA's understanding of the needs

of women veterans and their use of VA benefits and services for these purposes (Stryczek et al., 2023). However, a VA analysis had found that women veterans should receive gender-responsive services and benefits, ensuring high-quality care delivered respectfully and sensitively (U.S. Department of Veterans Affairs, 2015).

The VA entitled any veteran of the United States Armed Forces who had a service-connected disability rated at 10% or higher to receive compensation as part of the benefits of military service, particularly for diseases or disabilities incurred during combat (U.S. Department of Veterans Affairs, 2015). This compensation played a decisive role in providing financial support to veterans as they transitioned back into civilian life, alleviating the economic burden often associated with service-related health issues and enabling them to access necessary medical care. Veterans were encouraged to apply for disability compensation not only for physical injuries but also for mental health conditions and other problems stemming from their military service. This included concerns related to MST, which had been recognized as a significant issue impacting many veterans, particularly women. However, women veterans faced limitations in the compensation structure; they did not receive direct compensation for MST itself, but rather for any health conditions that arose because of the trauma experienced. This distinction underscored an important gap in support for those who had endured MST and highlighted the need for a more comprehensive approach to address the unique challenges faced by women veterans. Furthermore, the existing policies did not always reflect the complexities of the long-term psychological and physical impacts of MST, prompting calls for reform to enhance the availability and scope of benefits for affected individuals.

As awareness grew about the prevalence of MST and its effects, there was increasing emphasis on the necessity for the VA to evolve its policies and practices to ensure equitable and effective care for all veterans, regardless of gender.

Problem Statement

Women veterans continue to suffer from MST-related PTSD and do not receive disability compensation from the VA (American Civil Liberties Union, 2013). The central problem was a lack of understanding of applicants' experiences during the claims process for MST-related PTSD and the reasons their claims were denied (Sayer et al., 2014). While a significant amount of data is available about women veterans' experiences of trauma resulting in PTSD, their experiences with the application process and applying for disability compensation due to an MST diagnosis are varied and undocumented as a group. Therefore, this area of concern remains in need of further examination to address issues that arise because of the VA's decision not to provide compensation to a woman veteran suffering from MST.

Purpose of the Study

The purpose of this research was to explore women veterans' experiences applying for disability compensation for MST-related PTSD. These female soldiers had experienced sexual trauma while serving in the military, which could affect their mental health and physical well-being for years. Therefore, this qualitative study was necessary and important for understanding the experiences of women veterans who had been denied VA compensation for MST-related PTSD.

Research Question

What are the experiences of women veterans who apply for VA compensation when they submit a claim for MST-related PTSD?

Conceptual Framework for the Study

Feminism is the belief that women should receive the same opportunities, power, and rights as men. It believes that one gender should not be raised above another in power (Faulkner, 2001). Feminism is centered on the experience of women's equality and being accepted before becoming a victim of gender stereotypes. Feminism, with a focus on equality, aims to ensure women's rights to self-determination and to make their own choices. To establish equal opportunities for women, advocates supported their rights and equality in education and employment (Sen, 2019). The feminist movement emerged to address women's social roles and experiences and to respond to issues of gender inequality, especially sexual objectification.

Mohajan (2022), a strong advocate for feminism, argued that women have little control over their bodies, with a woman's sexuality often defined by men in the vast number of patriarchal cultures seen in today's societies. With this viewpoint, the basis of sexual violence committed by men derives from the belief that women cannot reject a man's sexual advances; this notion holds that men, under the overarching patriarchy, are entitled to define sex on their terms, not a woman's terms. Although culturally determined, the role of sexual objectification of women becomes vital in understanding the views that women exist solely for a man's sexual pleasure.

Feminist theorists advocate on behalf of women to eradicate gender discrimination, but stereotypes remain. Women face disadvantages, such as men not appearing due to sometimes stark differences in unequal treatment (Williams & Neely, 2018). The goal of feminist theory is to give women the recognition they deserve and treat them with fairness, understanding, and, above all, equality. Therefore, the basis of women's equality and freedom is recognizing women as equal members of society and respecting them.

Nature of the Study

To address the experiences of women veterans who applied for VA compensation for MST-related PTSD, a generic, basic qualitative methodology was explored to clarify the women veterans' experiences in filing for an MST-related PTSD claim. The aim was to address the research question and bring awareness to the application process. Compared with other designs, a generic, basic qualitative design enabled understanding of the experiences of women veterans who had been denied VA compensation for an MST-related PTSD diagnosis. In contrast to a quantitative approach, a qualitative study gave meaning, enabled the discovery of the phenomenon, and provided individual participants' perspectives and interpretations. The primary method of data collection was semi-structured individual interviews guided by a set of questions.

Potential participants were recruited from an advocacy organization's social media page and website. The advocacy organization's sites were a member-driven community network that advocated for the individual and collective needs of military women by providing jobs, representing them against sex offenders in the military justice system,

eliminating barriers to disability claims related to MST, and providing reproductive health care services.

To facilitate participation recruitment for the study, a flyer was strategically posted on the advocacy organization's social media page, allowing interested participants to respond voluntarily by commenting on the thread. This approach leveraged the extensive reach and accessibility of social media platforms, which were increasingly used to connect individuals in targeted communities. By using this method, I engaged a diverse group of participants and fostered an inclusive environment where women felt comfortable sharing their experiences. Specifically, I planned to recruit 10–12 women diagnosed with MST-related PTSD who had applied for VA disability compensation.

The inclusion criteria for participants were designed to ensure that those who joined the study had firsthand experience with the challenges of MST and the disability compensation process, both of which were critical to an in-depth understanding of their lived experiences. Moreover, by focusing on women with MST-related PTSD, the study explored the intricate relationship between trauma, mental health, and the pursuit of equitable treatment within the VA system. The insights gained from these interviews illuminated the barriers and facilitators these women faced in navigating the complexities of applying for disability compensation. Ultimately, this research not only provides a voice for these individuals but also contributes valuable knowledge that could inform policy recommendations and enhance support services for women veterans experiencing the effects of MST. Through conscientious recruitment and data collection, the study aimed to enhance awareness and foster greater understanding of the unique needs of

women veterans regarding MST and PTSD, paving the way for meaningful changes in supporting systems.

The data were gathered through interviews conducted on a secure teleconferencing platform called Zoom, which were recorded for analysis. Each interview included semi-structured questions, enabling the participants to openly discuss the challenges and issues they encountered during the compensation application process. With the participants' consent, I audio-recorded the sessions and used Zoom's transcription feature to facilitate a thorough review and analysis of the interview data. This analytical review yielded insights into their experiences with the application process, which identified the limitations and barriers that may have contributed to lower compensation ratings for PTSD related to Military Sexual Trauma (MST).

Definitions

Combat-related: refers to conflict or fighting between armed forces or individuals. In a military context, it involves direct engagement between opposing forces, including ground, aerial, and naval battles. (U.S. Department of Veterans Affairs, 2015).

Women veterans' experiences: refer to the unique set of challenges, accomplishments, and perspectives that women who have served in the military encounter throughout and after their service (Pritchard, 2023). Women's understanding of the disability compensation process, including the challenges involved in applying and the denials received because their claims were deemed not to be non-MST-related PTSD (Department of Veterans Affairs, 2014).

Military Sexual Trauma (MST): MST is any sexual act performed against a service member's will, such as sexual assault, sexual contact, threatening or offensive remarks, and unwelcome sexual advances (Department of Veterans Affairs, 2014).

Post-traumatic stress disorder (PTSD): is an anxiety disorder that develops due to a physical injury or severe mental or emotional distress, such as military combat, violent assault, natural disaster, or any other life-threatening event (American Psychological Association [APA], 2013).

Relative rank: men and women who have enlisted in the military voluntarily in a position held in service or branch of the armed services (Mattila et al., 2017).

Assumptions

For this generic, basic qualitative research study, I assumed that participants would be open and honest, provide relevant information, and share diverse perspectives on their experiences with the disability compensation application process. Women veterans should not have participated if their primary motive were to have their claim reviewed (or re-reviewed) to obtain a favorable VA disability decision. The verbal consent process informed participants that the study would not provide any benefits or affect their compensation decisions and emphasized that the results would not be used to aid any service organization with current legislative issues. I assumed participants would be honest, providing truthful accounts essential to the study's credibility and validity. Also, I assumed their experiences were relevant to the research questions and would provide valuable insights into the application process. However, the sample encompassed

a variety of experiences that reflected different aspects of women veterans' application processes, thereby enriching the dataset.

Scope and Delimitations

This study's scope enabled a comprehensive understanding of the challenges women veterans faced when seeking compensation for MST-related PTSD, informing policy and improvements to support systems. In this study, I recruited potential participants via an advocacy organization's social media page and website. The eligibility criteria for inclusion consisted of female soldiers who had served in the US Armed Forces. The delimitations in this qualitative research were the population, type of trauma, and type of compensation. I focused exclusively on military sexual trauma, excluding other types of trauma that veterans might have experienced, which could have provided additional context on PTSD. I also focused exclusively on VA compensation (e.g., disability compensation) and excluded other forms of assistance, such as healthcare services or vocational rehabilitation. The study was restricted to women veterans, excluding men veterans and non-binary individuals, which may affect generalizability.

Limitations

The limitations affecting this qualitative study's findings, interpretations, and generalizability included sample size, subjectivity, and the exclusion of non-relevant experiences. A small sample size provided in-depth explanations and meanings for women veterans of MST, but may not have adequately represented diverse experiences. In qualitative research, subjectivity in interpretation could introduce researcher bias into data analysis and the conclusions drawn from participants' narratives. By focusing solely

on MST-related PTSD, I may have overlooked other relevant experiences and traumas that could have provided essential context for understanding overall veteran experiences. Therefore, I focused on women veterans with MST-related PTSD, and their VA application experiences (a) to increase awareness of this process and its outcomes and (b) to advocate for women and the push for equality in the military.

Significance

The significance of this problem lies in its potential to foster transformative change for women veterans. Recognizing and addressing their needs significantly enhanced their health, well-being, and social integration. Several factors underscore the importance of addressing this issue, including enhancing access to benefits, advancing policy development, and raising awareness of the unique challenges these veterans face. Additionally, incorporating social determinants of health—specifically, education access and quality, and health care access and quality—was important, as these factors profoundly influenced their overall health outcomes and social stability.

According to Nolo (2016), women veterans could not receive compensation for an MST diagnosis alone. Women had to have other health conditions the VA considered compensable, such as depression or PTSD. Often, women veterans developed PTSD because of retaliation that occurred after reporting a sexual assault. When women veterans submitted a claim for compensation related to MST, the decision for benefits was often denied due to issues related to the sexual assault.

In 2014, the Government Accountability Office report found that the VA had increased the number of PTSD claims filed by women veterans. Still, applications related

to sexual trauma were more likely to be denied than claims related to combat or other trauma. All veterans with issues related to MST could access counseling and medical care, regardless of whether evidence of trauma had continued during their military service. To file for VA compensation, veterans had to prove that they had a disability related to MST, such as depression or PTSD.

If veterans submitted a claim for non-MST-related PTSD, the VA required details of their service and personal testimony; however, veterans with MST-related PTSD claims needed evidence validating their testimony. The VA required veterans who submitted an MST claim to have a formal PTSD diagnosis and to prove that the sexual assault occurred while they were in the military. Thus, an association had to exist between the sexual assault and their current symptoms for the VA to validate the claim (Bell et al., 2018).

Organizations that supported women with military experience had studied women's rights to disability compensation. Researchers confirmed the existence of discrimination toward women who submitted applications for disability claims due to MST (American Civil Liberties Union, 2013). Congresswoman Nikki Tsongas of Massachusetts questioned military leaders about their response to MST after reviewing the Department of Defense 2013 annual report (U.S. Department of Veterans Affairs, 2014). The annual report highlighted the increasing number of sexual assaults and misconduct in the military. As part of her mission to address this issue, she introduced new bills to fight for women who had experienced MST in the military. The goals of the bills were to (a) improve support for survivors of MST and (b) provide them with quality

services. Ultimately, the provisions required the Department of Defense (DOD) to change the military justice system and provide fair and equal treatment to women (Kamarck & Salazar, 2021).

In addition to Congresswoman Tsongas's efforts, VA staff in regional offices who reviewed claims continued to look for evidence to support disability claims. These markers included rape crisis center records, pregnancy or sexually transmitted disease tests, law enforcement records, and statements from friends, family members, and fellow service members (Bell et al., 2018). However, the regional officers interviewed by the Government Accountability Office described difficulties in standardizing their process for MST-related PTSD claims, even with training and guidance. The primary challenge was determining what constituted a marker.

Summary

In Chapter 1, I introduced the growing recognition of military sexual trauma (MST) as a significant issue for women veterans, who disproportionately experienced this form of trauma in the military. I established the connection between MST and the development of PTSD, outlining how these experiences impacted the mental health and overall well-being of women veterans, especially in receiving disability compensation.

The background in this chapter included a review of existing literature on MST and its effects on mental health, emphasizing the systemic challenges women veterans encountered when seeking compensation from the VA system. I discussed historical trends in military culture, the stigma surrounding sexual trauma, and the complexities of navigating the compensation application process, articulating a gap in understanding the

specific experiences of women veterans applying for VA compensation for MST-related PTSD. This underscored the need for comprehensive research to examine the barriers and challenges in the compensation process and their implications for access to care and support.

Overall, the purpose of this qualitative research study was to explore and document the lived experiences of women veterans as they applied for VA compensation for MST-related PTSD, identifying familiar challenges, perceived barriers, and areas for improvement within the VA system to contribute to the development of more effective support services. The significance of the study lies in understanding the unique circumstances faced by women veterans, with findings expected to inform policy changes, improve access to benefits, and enhance mental health support for veterans suffering from MST-related PTSD. The research question focused on participants' experiences, the challenges encountered during the application process, and the impact of those experiences on well-being and recovery. Further examination was required to investigate the disability application process and the VA's denial of disability compensation claims. In Chapter 2, I addressed the literature related to the application process for women veterans with MST-related PTSD claims, the VA's application process, and improvements in processing claims related to MST.

Chapter 2: Literature Review

Introduction

MST is a term used by the military to refer to sexual assault and harassment occurring during military service that includes any sexual activity taking place against the individual's will. It is considered a trauma that can negatively impact a person's physical and mental health for years after the incident. The U.S. Department of Veterans Affairs (2017) provides annual national screenings to each veteran seeking treatment and determines whether the veteran has experienced MST. The national screening program indicates that one in four women experiences MST; this estimate reflects only those who received treatment from the U.S. Department of Veterans Affairs. The VA's policies focus on the discovery of MST and treatment, but not every woman veteran seeks treatment.

The VA describes MST as an experience and not a diagnosis. PTSD is often associated with MST, and the VA regards it as a subset of PTSD personal trauma claims. There is a high percentage of female soldiers who present claims for MST, and this includes those considered mental health conditions (e.g., PTSD; Kimberling et al., 2007). The issue of women with MST-related PTSD not receiving VA compensation continues to be an alarming concern for the women serving in the military. In 1992, the government targeted women veterans' health as a research priority. They conducted several studies on their healthcare needs and benefits. It was not until 2007 that results were published showing that many women in the VA had physical and mental illness, as do men in the VA (U.S. Department of Veterans Affairs, 2019). Researchers have stated that the VA

has been slow to award women veterans with VA compensation for MST-related PTSD because they are unable to provide sufficient evidence to show that the sexual trauma occurred. Sexual assault is a sensitive, overwhelming, and personal experience that women do not report due to feelings of shame or guilt, lack of support from the military chain of command, and fear of retaliation (Bonnes, 2020). However, little to no research exists on women veterans' experiences with the disability compensation application process, including what is required to obtain an approval rating (U.S. Department of Veterans Affairs, 2015).

Organizations that support women with military experience have taken a stance to improve and address the enduring health consequences and bureaucratic battles faced by women veterans seeking to gain compensation for MST-related PTSD. Their reports have been the first opportunity for veterans, policymakers, and the public to see data that represents MST-related PTSD claims and the VA's disparate treatment of female soldiers who submit a claim for disability compensation. Their researchers state that the VA granting disability benefits for MST-related PTSD claims is at a significantly lower rate for female soldiers as compared to other claims unrelated to MST. Treatment of MST-related PTSD claims varies from one VA regional office (VARO) to another, and discrimination is evident (American Civil Liberties Union, 2013). As a result, recommendations from these organizations included a process to (a) reform VA regulations on disability claims for MST-related PTSD and (b) improve the training and oversight of VA offices while enhancing VA transparency and record-keeping of MST-related PTSD claims.

The purpose of this general qualitative research study was to explore the experiences of women veterans applying for disability compensation for MST-related PTSD. In this chapter, I include descriptions of what was then unknown about women veterans' experiences in the VA compensation application process for MST-related PTSD. Although some literature on women with MST-related PTSD was available, research and publications were limited.

Further, in this chapter, I provide a thorough, significant analysis of the current literature relevant to the VA's processes, policies, and proof needed to submit a claim for MST-related PTSD. The chosen literature included an in-depth examination of treatment plans, the access to care the VA provided for women veterans, and the improvements needed to ensure women received appropriate care while exploring future directions for MST-related PTSD issues.

Literature Search Strategy

Although several studies existed on women veterans who returned from combat with MST-related PTSD, researchers have examined the application process and policies for women veterans who submitted MST-related PTSD claims for compensation. Information regarding women veterans and MST-related PTSD claims was readily available but limited in scope, especially concerning the application process. The search for this literature review included CINAHL, Google Scholar, HeinOnline, SocIndex, the U.S. Court of Appeals for Veterans Claims, the U.S. Government Accountability Office, and the U.S. Department of Veterans Affairs. The keywords for the search included *combat/war, female soldiers, military personnel, military sexual trauma, post-traumatic*

stress disorder, sexual harassment, sexual abuse, women veterans, VA benefits, VA claims, VA compensation, and VA application improvements. I restricted the Google Scholar search to articles published between 2012 and 2024 and identified additional articles through the reference lists of previously gathered works. Subsequently, I found 15 articles on the study topic, and the findings provided further support for the current understanding of VA denials related to MST-related PTSD claims.

Conceptual Framework

Feminist theory is an extension of feminism that is used to understand gender inequality. Fraser (2017) examined the intersection of gender inequality and the construction of gender. Feminist theory is relevant to understanding social assessment and intervention, emphasizing the importance of personal and collective identity development (Turner & Maschi, 2014). The feminist movement dates to the mid-1970s, with key texts from the 19th and early-to-mid-20th centuries representing early feminist thought. Feminists and scholars divided the history of feminist theory into three waves, focusing on the intersection of gender, sex, and sex roles. The first wave began in the early 19th and 20th centuries with the women's suffrage movement and the right to vote. With this movement, women campaigned for equality and worked to secure sexual, reproductive, and economic rights as individuals, especially in the military. However, the movement's priority at that time centered more on women having a voice and on promoting equal contract and property rights. This wave marked the beginning of women serving as military helpers. Florence Nightingale, the founder of modern nursing in the military, established nursing as a well-respected medical profession with clear

responsibilities, rather than being seen solely as service work. Toward the end of the first wave of feminism, women were granted the right to vote in all U.S. states at age 21, thereby overturning one of the key obstacles to gender equality (O'Connor, 1996).

The second wave of feminism fought for women's legal and social rights to end discrimination against women (Fraser, 2017). It focused on domestic violence and marital rape, rape crisis services, battered women's shelters, and changes in custody and divorce law. During the second wave, activists pursued greater equality beyond suffrage, encouraging women to understand aspects of their own lives and the structure of power. Oral contraceptives were legalized during this period, allowing women greater control over pregnancy and reproductive choices. This second wave was weaker in some respects because it primarily comprised White, middle- to upper-class women and did not represent all racial groups of women (Browning, 2020).

The third wave of feminism emerged in the late 20th century, building upon principles established during the second wave (Harris, 2012). It included women from diverse groups with a range of identities. During this time, the National Organization for Women (NOW) was formed to secure women's political, professional, and educational equality. NOW fought to have the Equal Rights Amendment (ERA) added to the Constitution to ensure women and men had equal rights under the law. Although it failed, the movement achieved significant gains in reproductive rights, pay equity, sexual harassment law, and equality in women's sports programs in schools. Additionally, the Equal Employment Opportunity Commission (EEOC), like the military, defined sexual harassment as unwelcome sexual advances or sexual conduct, either verbal or physical,

that interfered with a person's performance or created a hostile work environment. Such gender-based discrimination was barred in the workplace by the Civil Rights Act of 1964 and in universities and colleges that received federal funds by Title IX. In a series of rulings, the Supreme Court held that employers were responsible for maintaining a harassment-free workplace. Legislation such as this protected the rights of women in the workplace and at schools (Kemp & Brandwein, 2010).

The feminist movement emerged to understand women's social roles and experiences and to respond to issues of sexual objectification. Feminism, at its core, promoted a woman's right to control her sexuality, and the treatment of women by men had not been equal or fair (Sen, 2019). According to work published in the Harvard Women's Law Journal, feminist jurisprudence, also known as feminist legal theory, held that the system of rules had historically been fundamental to women's subordination (Scales, 1997). The regulatory system played a significant role in women's subordinate status and was dedicated to changing women's status through a reworking of the rules and their approach to gender. In contribution to Scales' work, the Denver University Law Review noted that the law had long overlooked women because it was traditionally a male-dominated field, and feminist jurisprudence introduced women's experiences and voices (Henderson, 2014). In the effort to change sexist laws, feminists turned their attention to legal institutions and reshaped rules to become more woman-friendly. Therefore, feminist campaigns encouraged women to enter careers in law, politics, and the judiciary to raise women's public profiles and influence as policymakers (Baer &

Hartmann, 2014). Women in these roles would change how women were treated and how judges applied the law.

As the women's movement grew and more women entered law school, feminists argued that history had been written from a male perspective, perpetuating bias about gender roles, social arrangements, and human nature (Butler & Troule, 1990). As men held most of the economic, political, and social power, they used the system to subordinate women. Feminists explored gender law and relied on experiential discourse to evaluate gendered sexual objectification, gender hierarchy, and social structures (Goldstein, 1992).

Sexual assault survivors became targets of gender-based imbalance, and feminist theorists were committed to ensuring equal treatment and taking action to confront and alter oppressive and devaluing biases (McBride & Mazur, 2008). Importantly, to advance women's rights, feminist theorists devoted time to creating social change and to valuing women's perspectives. It was suggested that feminist theorists offered the best conceptual framework for understanding the symptoms exhibited by survivors of sexual trauma (Moor, 2009).

Literature Review Related to Key Variables and/or Concepts.

This literature review synthesized empirical and theoretical work on MST-related PTSD, treatment approaches, and VA disability processes to identify key findings, gaps, and implications for the study. It summarized prevalence estimates and clinical outcomes, evaluated evidence for trauma-informed and gender-sensitive interventions, and examined research on claims adjudication, documentation, and barriers to benefits. The

review highlighted methodological limitations (small samples, inconsistent measures, and limited qualitative inquiry), persistent service gaps (uneven access to gender-specific care and inconsistent screening implementation), and disputed evidence regarding treatment effectiveness and claims outcomes. These syntheses guided the study's questions, methods, and recommendations by identifying areas needing targeted research and policy reform.

Brief History of Military Sexual Trauma

The first reported case of MST occurred at the 35th Annual Tailhook Symposium in Las Vegas in 1991 when a young Navy lieutenant, Paula Coughlin, reported her sexual assault (U.S. Department of Defense, 2015). This incident became widely known in military history as one of the Navy's Tailhook scandals (D'Amico, 1998). The event prompted recognition of MST, and many traumatized women veterans began to tell their stories of sexual harassment and assault while on active duty. The episode led to more comprehensive care for women with MST.

The aftermath of the Tailhook scandal led the Department of Defense's military services to implement changes throughout the system, with all services reassessing their attitudes and policies toward women (D'Amico, 1998). Investigations were conducted, and some officers were formally disciplined or denied promotion. According to military critics, the scandal highlighted the hostile attitude in the United States military culture, especially toward women in the areas of sexual assault, sexual harassment, and equal treatment in career advancement and opportunity.

With changes in how the military addressed women in the service, the VA began to collect data on incidents of MST. After the scandals, the VA conducted a national cross-sectional, community-based telephone survey and found that 30% of female soldiers who served in the Vietnam era or later had been victims of sexual assault (U.S. Department of Veterans Affairs, 2019). In another VA study of 3,632 women veterans using VA services, 23% reported an occurrence of military sexual assault, and 55% reported a history of sexual harassment while on active duty (Pulverman et al., 2019). These rates reported by women who served in the military were higher than those for the general population of female soldiers who reported rape. These findings led to policy changes in the military (VA Health Initiatives, 2004).

MST: Mental Health Condition

The VA's designation of MST was derived from the definition of MST in federal law (Title 38 U.S. Code §1720D), which referred to experiences of sexual assault or repeated, threatening sexual harassment that occurred during military service (U.S. Department of Veterans Affairs, 2014). Data from the VA's national screening program showed that every veteran was asked whether they had experienced MST. The results showed that 1 in 4 women screened had experienced MST. With a 25% screening rate among women overall, MST-related services were essential (U.S. Department of Veterans Affairs, 2014).

MST was not a diagnosis; it was an experience, and each veteran's needs varied (U.S. Department of Veterans Affairs, 2015). With the increasing number of women in the military, accessing VA care was essential to understanding the stressors women

veterans experienced and to better prepare for their care. The VA provides evidence-based treatments for MST-related PTSD to improve veterans' quality of life and promote self-reliance (U.S. Department of Veterans Affairs, 2019).

The VA oversaw care and benefits for those who had served in the military, and the first step to receiving VA care for MST-related PTSD was to report the incident (Koo & Maguen, 2014). The results revealed that 31% of women veterans who served in Afghanistan or Iraq wars reported higher rates of PTSD compared to men veterans, with 1% related to MST. Additionally, MST-related PTSD correlated with higher rates of comorbid mental health diagnoses (e.g., depression, anxiety, and eating disorders) in returning veterans. These findings were significant, given that comorbid disorders resulted in poorer mental health outcomes (Maguen et al., 2012).

MST was also associated with physical health issues (e.g., hypothyroidism, obesity, and weight loss) as well as problems coping with society after discharge from the military (Drake & Burgess-Mundwiler, 2019). Additionally, with the increased risk for drug and alcohol problems, veterans found it difficult to find work, and disruptive relationships with family and friends often occurred. Therefore, treating MST-related PTSD conditions was critical to the overall health of women veterans, especially those actively seeking treatment with the VA, to improve their quality of life (Koo & Maguen, 2014).

Factors Contributing to Treatment

Despite attention to treatment for MST-related PTSD, many barriers remained when women needed services. Reports from victims revealed a reluctance to seek

treatment at the VA due to factors such as their relationship with the military and a perception that VA providers relied heavily on treating symptoms rather than examining the impact of the trauma (Kintzle et al., 2015). Other barriers (e.g., lack of knowledge and gender-related concerns from a male-dominated environment) evoked discomfort in requesting services and prevented some who needed treatment from seeking it.

Institutional factors, such as lower disability claim approval rates, also contributed to negative perceptions of the VA. These perceptions affected benefit-seeking behaviors for available free services (American Civil Liberties Union, 2013).

The NewGen study, a population-based research study, found that 51% of women veterans returning from the Afghanistan or Iraq wars had experienced some degree of deployment-related sexual harassment, compared with 11.2% of their male counterparts (Barth et al., 2016). The study included 30,000 veteran participants who recounted their experiences of MST during the war. The survey included an MST clinical screening questionnaire to identify sexual assault and/or sexual harassment experiences encountered by the veterans. The results showed that both men and women veterans experienced MST during and after deployment. The study found higher rates of MST among women soldiers who utilized Veterans Affairs healthcare services. Public awareness and ongoing research were necessary to fully understand the impact of MST (U.S. Department of Veterans Affairs, 2019).

Gender Differences: Combat-related vs. MST-related PTSD Claims

Many MST-related PTSD disability compensation claims were granted at marginally lower rates than VA claims for non-MST-related PTSD in fiscal years 2008–

2012 (Kimerling et al., 2007). Maguen et al. (2012) found that women sustained injuries of the same severity and complexity as those sustained by men. In their study, they examined PTSD overall, including MST-related PTSD, in both Afghanistan and Iraq veterans and compared mental health comorbidities in male and female soldiers with MST-related and non-MST-related PTSD. Their methodology included a retrospective analysis of VA data for over 200,000 veterans diagnosed with PTSD. Among women with PTSD, those with MST-related PTSD had more comorbid mental health diagnoses than those without MST-related PTSD. The results demonstrated that women were more likely to have comorbid anxiety, depression, and eating disorders, while men were more likely to have substance abuse disorders.

In another study conducted by the VA, differences in the characteristics and mental health needs emerged between men and female veterans seeking care for PTSD (Fontana et al., 2010). The findings highlighted the importance of better understanding the role of gender in PTSD and how it affected veterans' care-seeking. Gender differences in military trauma were linked to initial claim approval rate outcomes (Haskell et al., 2010). Thus, the VA acted to understand the complexity of the subject and initiated research studies to focus more on these issues. It was established that men were more likely to have experienced combat-related PTSD, whereas women were more likely to have experienced service-connected sexual assault (Sayer et al., 2014).

Sayer et al. (2014) were the first to examine the course of VA PTSD disability status and claim outcomes. Their study analyzed multiple data sets to explore gender differences in loss of VA disability status for PTSD. The findings indicated that women

veterans were less likely than men veterans to obtain service-connected disability for PTSD after the VA denied an initial claim. The study showed that differences in clinical factors by gender, with most initial claim differences attributable to combat exposure. Although veterans might have been expected to receive some benefit for service-connected PTSD, it was unclear why initial claims were denied. The evidence did not sufficiently support their conditions at the time the original claim was filed, and veterans or their advocates placed too much emphasis on evidence directly related to military service. The research revealed the need for the VA to implement methods to ensure high-quality and equitable disability evaluations for PTSD at the time of the initial claim. Additionally, employing a standardized disability evaluation with evidence-based assessment measures would have increased quality and reduced variability in PTSD disability evaluations.

Burns et al. (2014) found that the factors contributing to MST during combat fit primarily within three categories: (a) a lack of consequences, (b) deployment dynamics, and (c) military culture. Low reporting of MST contributed to adverse reactions, concerns about confidentiality, and humiliation. Unfortunately, there was a lack of qualitative exploration of women's experiences with MST and of service utilization. The perceived barriers and facilitators to reporting MST and accessing MST-related services required further examination.

Regarding the lack of consequences, women veterans perceived that military leadership had failed to address MST, and assailants rarely faced repercussions for their actions (Brown et al., 2021). In a tolerant environment, MST continued because there

was little risk of consequences and few deterrents for those committing assaults. Concerning deployment dynamics, long deployments contributed to and caused deprivation of sexual activity, especially amid the high stress of combat. Because of military culture, sexism became a concern due to the low ratio of women to men; men outranked women, which also contributed to a high incidence of MST among women (Burns et al., 2014).

A U.S. Court of Appeals case resulted in a judgment that the VA could not deny a service-connected PTSD claim without first advising the veteran that evidence from sources other than their service record or evidence of changes in their behavior was required to provide sufficient proof of a stressor. However, because sexual assault was involved, veterans claiming benefits for MST-related PTSD only needed to prove that they had served in the military (U.S. Department of Veterans Affairs, 2019). Under 38 C.F.R. § 3.304(f)(2), veterans bore the initial burden of proving combat engagement, and an actual encounter with a military foe or hostile unit established their service connection (U.S. Department of Veterans Affairs, 2015).

Numerical data from the VA showed a breakdown of MST-related and non-MST-related PTSD claims by gender, and women veterans were disproportionately affected, with a higher percentage reporting MST experience since 2011 (U.S. Department of Veterans Affairs, 2019). Men and women saw substantial increases in the percentage of PTSD claims granted due to military sexual trauma; the grant rate for men lagged significantly behind at 44.7 percent, compared to 57.7 percent for women. Overall, the effort was largely successful in reducing the gap: PTSD claims granted for military

sexual trauma–related causes climbed twenty points in seven years, from 35.6 percent in 2011 to 56.6 percent in 2018, while the rate for non–military sexual trauma causes hovered around 54 percent for several years. Changes were instituted to reduce stark disparities identified between the rates of claims granted when the cause of PTSD was military sexual trauma compared to other precipitating events (e.g., combat). Reviewing the data by gender showed clearly that the grant rates had not benefited men and women equally.

In 2018, the VA’s Inspector General found that thousands of military sexual trauma survivors may have been incorrectly denied benefits due to paperwork and procedural mistakes (Drake & Burgess-Mundwiller, 2019). A series of corrective recommendations included that the Veterans Benefits Administration (VBA) employ specialized raters for MST claims, require additional review of denied claims, and develop a processor checklist to improve the process. The Office of the Inspector General (OIG) further recommended that the VBA update training for military sexual trauma claims and monitor its effectiveness.

In an exploratory study, Hyun et al. (2012) investigated organizational factors associated with veterans who received MST screenings. Research on these screenings revealed that policies related to screening and support increased veterans' engagement in screening. Given the high prevalence of MST high prevalence of MST and the sensitivity of related issues, women veterans were more likely to use women’s health clinics or specialized PTSD programs. Providers in these types of programs were sensitized to the problems of the MST-related PTSD population and saw these patients at a rate three to

four times higher than in the general veteran population. Thus, most specialized PTSD programs had more information available concerning women veterans suffering from MST-related PTSD than the military.

As a result of these data and conclusions, the VA reconsidered the delivery of services to women veterans suffering from MST-related PTSD. One area of focus for change involved the legal and medical assistance needed to establish entitlement to disability compensation benefits (Drake & Burgess-Mundwiller, 2019). Understandably, the women veteran had to verify that she had a service-connected disability, and a medical diagnosis was required to substantiate the disability claim. The standard to receive approval for disability ensured that competent medical evidence or a medical expert provided comprehensive data supporting women veteran's claim.

The VA faced several challenges in effectively providing compensation benefits to women veterans. Many claims were delayed or denied due to difficulties encountered by those who processed VA claims (Drake & Burgess-Mundwiller, 2019). Ambiguities in eligibility criteria and confusion among medical service providers contributed to the problem. Administrative guidelines were subject to specific regulations, with claims for trauma that were not combat-related receiving stricter scrutiny (Marrero, 2014). VA standards supported soldiers injured during combat under the law and those who qualified for disability compensation; however, those who had not been wounded in battle were more likely to receive denials. The law did not distinguish between combat and non-combat wounds; nevertheless, trauma events such as MST-related PTSD were subject to administrative procedures for compensation.

Overall, the value system and culture of the military presented a woman veteran with MST-related PTSD as a classic victim, and these women could be subjected to further trauma because of the administrative procedures or administrative decisions involved in the application process. Marrero (2014) reported that the administrative procedures for applying for disability compensation subjected a woman veteran with MST-related PTSD to even greater scrutiny if the claim failed to meet the standard notion of military trauma, which caused further harm to the woman veteran.

VA Benefits

Military veterans were among the first groups to receive state social welfare benefits (U.S. Department of Veterans Affairs, 2015). Veteran benefits were introduced in the 19th century, initially covering medical and hospital care. To be eligible for most benefits, veterans had to have received an honorable discharge for a minimum period specified by law. The benefits and services provided after their discharge from the military were intended to assist them in readjusting to civilian life (American Professional Society on the Abuse of Children – Global Organization Against the Sexual Abuse of Children [APAGOA], 2013). The benefits included disability compensation, survivor's support, healthcare services, educational assistance, and training. As relates to disability compensation, two major cash programs existed for veterans: (a) benefits for service-connected disabilities and (b) benefits for veterans with nonservice-connected disabilities. The U.S. Department of Veterans Affairs determined disabilities; if a disability was related to military service, this could lead to monthly non-taxable compensation and other benefits.

In 2012, the VA awarded \$50 billion in disability and death benefits to veterans and their families. Recipients received these benefits when a veteran's service connection was related to an accident, injury, or death. Historically, the judicial system did not review VA benefit decisions for veterans until 1988. The Veterans Judicial Review Act (VJRA) changed that practice by establishing the United States Court of Veterans Appeals, which enabled veterans to appeal VA decisions denying benefits. This change marked a significant shift in the judicial system, providing veterans with recourse to ensure they received the benefits to which they were entitled. Due to the procedural aspects of obtaining VA disability benefits, circumstances related to combat, compared with those involving MST, made sustaining benefits for PTSD harder for women veterans than for men veterans (U.S. Department of Veterans Affairs, 2014).

Veterans could apply for disability compensation for service-connected MST difficulties that occurred during their military service. A service connection could also be established for any diagnosis received after discharge, provided that sufficient evidence supported the claim that the illness or injury had occurred while the individual was in service (U.S. Department of Veterans Affairs, 2019). For each woman veteran diagnosed with MST, coordinators at local Veterans Affairs offices were available to assist with the application process and other treatment services (U.S. Department of Veterans Affairs, 2015). The Veterans Benefits Administration within the Department of Veterans Affairs (VA) was responsible for processing claims. In recent years, over 29,000 veterans have filed for disabilities related to MST (U.S. Government Accountability Office, 2014). These claims may be difficult to validate because individuals are reluctant to file formal

complaints at the time of the incident while still in service. Because there was no formal complaint, additional documentation was often required to support the claim. Notably, the Veterans Benefits Administration implemented additional steps to improve decisions for all applications submitted for MST-related PTSD, specifically after concerns were raised about inaccurate and inconsistent evidence adjudicating MST-related PTSD claims (U.S. Government Accountability Office, 2014).

VA Application Process

Kintzle et al. (2015) reported that MST was a pervasive problem in the military. The study focused on the relationship between PTSD and mental health utilization and differences in pre- and post-9/11 veterans who had experienced sexual assault in the military. After reviewing 2,583 online and in-person surveys completed by veterans, forty percent of the women reported experiencing sexual assault during their military service. The research further indicated that a history of MST could be a substantial contributor to PTSD among those sexually assaulted during their military service. Additional findings revealed that significant barriers existed for women when disclosing a sexual assault incident and seeking support. Women assaulted during active duty were often required to file a formal report.

Moreover, accessing immediate care for the assault required additional effort, prolonging the time before women received treatment for MST-related health problems (Holland et al., 2015). These findings required further review of the military's prevention programs for MST victims. Nevertheless, some research focused on access to and use of MST-related treatment specific to the military (Turchik et al., 2014).

Per the American Civil Liberties Union (2013), women veterans diagnosed with MST-related PTSD suffered from invisible wounds. Many women veterans were affected both mentally and physically, which ultimately had dire consequences for their work, relationships, and overall quality of life after service. Despite efforts to prevent and address MST-related PTSD, high occurrence and low reporting persisted, with limited data on MST incidents because only 3,374 out of 26,000 active-duty members who reported unwanted sexual contact had come forward (Burns et al., 2014). Research and literature on the prevalence of MST-related PTSD provided few qualitative studies of women veterans' experiences with MST and the outcomes of their attempts to obtain disability compensation to improve their quality of life. Additional reviews were required to examine the VA compensation application process to close the literature gap. The policies the VA employed for vetting these claims on behalf of women veterans with MST-related PTSD required further analysis (Kintzle et al., 2015).

The disability compensation claims application process consisted of eight steps, each of which varied and depended on several factors, including the complexity of the claim, the amount of evidence needed to support the allegation, and the type of proof available (U.S. Department of Veterans Affairs, 2015). The process was streamlined, helping veterans effectively access their benefits, from eligibility determination to implementation. The entire process varied based on several factors and the applicant's state of residence. An applicant could check the status of a claim by registering for benefits on the VA benefits site or by visiting the VA's ASPIRE website, which provides

the average processing time for claims that require a disability rating (U.S. Department of Veterans Affairs, 2019).

Standard Claims

To receive disability compensation from the VA, veterans had to complete the standard application, which included submitting medical documentation of their physical and mental health (U.S. Department of Veterans Affairs, 2015). There was no time limit for a veteran to apply for disability compensation after service. Most applied for disability compensation after returning to civilian life. As previously stated, one in four women veterans of the U.S. Armed Forces had experienced MST (U.S. Department of Veterans Affairs, 2014). Women had been fearful of reporting MST while in the military, and they had faced challenges in attempting to obtain disability compensation from the VA for MST-related PTSD. However, disability compensation eligibility required a veteran to establish a currently diagnosed service-connected physical or mental health condition.

Required Forms

As part of the process, veterans received a percentage rating, or VA disability rating, which determined the amount of compensation and eligibility, using VA Form 21-526, the Veteran's Application for Compensation and Pension (U.S. Department of Veterans Affairs, 2015). However, veterans who submitted a claim for MST-related PTSD had to complete VA Form 21-0781a, a "Statement in Support of Claim for Service Connection for Post-Traumatic Stress Disorder (PTSD) Secondary to Personal Assault." For this form, women veterans provided personal information and details regarding the

date, location, and description of the claimed in-service assault, along with a nexus letter signed by a physician. The nexus letter was a doctor's or clinical note in the medical record that stated the reason the veteran's disability resulted from an event that occurred during their service. According to Zaleski (2018), an example of a nexus letter involved a statement similar to the following:

After a review of the veteran's medical records, it was my professional opinion or diagnosis that, more than likely, the veteran's PTSD was a direct result of the military sexual trauma she experienced while serving on active duty (p.101).

Both national and state veterans service organizations (VSOs) played a significant role in assisting veterans with the application process and completing VA Form 21-526. While veterans could apply independently, it was best to have a VSO serve as their legal representative. VSOs also provided training on their services, enabling veterans to learn about disability compensation and the associated process (Serota & Singer, 2011). About 85% of veterans received VSO assistance when applying for or appealing disability compensation (Taylor, 2016). Veterans could also obtain legal representation from private firms, and the VA had accredited at least 3,200 firms to provide such representation (U.S. Department of Veterans Affairs, 2015).

According to Meshberg-Cohen et al. (2013), veterans did not fully understand the eligibility requirements for disability compensation and needed assistance when submitting a claim. In research conducted on veterans with substance abuse, applicants received guidance and insight on obtaining disability compensation if they continued to work. Most participants surveyed reported that working would negatively affect their

medical benefits with the VA, despite working being allowable while receiving disability compensation.

Evidence Needed

Women veterans who had suffered from MST-related PTSD were highly unlikely to have formal documentation establishing that their sexual assault or harassment had occurred. Many women felt significant humiliation in reporting such assaults (Kimerling et al., 2017). Because the veterans did not report the assaults when they occurred, the military took no disciplinary action, and no record of the assault existed. Nonetheless, the VA understood that this lack of documentation was an issue given the circumstances and did not require women veterans' service medical records as proof of the assault or harassment. Per Zaleski (2018), women seeking to substantiate incidents of military sexual trauma (MST) could submit various forms of evidence. Common types of substantive evidence included documentation showing that the incident was reported to authorities or support services, testimonies from individuals who were aware of the incident or its aftermath, and entries in a journal, notebook, or other personal records recounting the event.

Results of VA Compensation Claims for Women Veterans with MST

Far too many service members and veterans had survived military sexual trauma and were re-victimized by the ineffective and discriminatory claims-review process of the U.S. Department of Veterans Affairs (Kintzle et al., 2015). In an Office of Inspector General report (2018), veterans who submitted complaints about sexual assault received little attention, and the process required further review. The House Report 114-102 and

the National Defense Authorization Act of 2017 found that of 498 non-disability mental condition (NDMC) records, 67% were completed and processed with the DoD 1332.14 application for military separation, while 22% had incomplete or missing information and could not be processed (Office of Inspector General, 2018).

More than 125,000 veterans who had served in Afghanistan and Iraq wars had incomplete paperwork with insufficient evidence and, as a result, received denials for VA benefits (U.S. Government Accountability Office, 2014). While a veteran could appeal board decisions through federal courts, only a handful did so because of the emotional and financial stress involved. In the civilian world, the perception was that people received protection against unfair situations, whereas in the military, veterans underwent extensive review and scrutiny (Huskey, 2017). These findings led to recommendations for policy updates to ensure that veterans received counseling upon separation from the military and that all service records were available, accurate, and complete. Human Rights Watch (2016), a non-governmental human rights organization, also recommended changes in how the military processed separations, including providing hearings where veterans could recount their experiences.

Improvements to the Application Process

Establishing that a woman veteran had experienced MST was a prerequisite to approving a claim (U.S. Department of Veterans Affairs, 2015). Although challenging, many service members were unwilling to file complaints or seek disability compensation because of the burden of proof. In 2002, the VA allowed evidence for MST-related claims to include other indicators, such as behavioral changes. However, the VA had

broadened the scope of its process in 2001 to enable additional steps that clarified the changes made in 2002. Those steps included improvements to MST-related decisions, results, and evaluations of the quality of claim determinations (U.S. Government Accountability Office, 2014). To improve the application process, the U.S. GAO reviewed relevant federal laws, guidance, and regulations and analyzed MST data from the VA for 2010–2013. The U.S. GAO’s recommendations to improve training included greater outreach to veterans and enhancements to VA review processes for MST-related cases. To date, the VA has complied with all of the GAO’s recommendations.

With training, the VA took several steps to improve MST claim processing by providing training for adjudicators. In 2011, the VA directed regional offices to designate MST specialists to process complex claims (U.S. Department of Veterans Affairs, 2019). These specialists compiled evidence for MST-related claims, identified markers, ordered medical exams, and, with the additional information available, made final decisions on whether to approve or deny claims. Further, the specialists received 1.5-hour and 4-hour training sessions on how to process PTSD claims related to MST. The training curriculum included cases in which the VA’s 2011 quality reviewers had identified missed indicators that should have triggered a medical examination (U.S. Government Accountability Office, 2014).

The medical examiners, who also evaluated veterans for PTSD, received a 1-hour certification course on how specific markers should be used to assess the likelihood that an MST incident had occurred (U.S. Department of Veterans Affairs, 2019). However, because the training was separate from the formal curriculum, it was optional for in-

house medical examiners and unavailable to contractors who conducted MST-related examinations. The VA saw this difference as a potential issue and developed more formal training on conducting MST-related examinations. Beginning in September 2014, the VA provided training for in-house examiners and contractors (U.S. Government Accountability Office, 2014). Consequently, through these changes, VA approval rates for MST-related PTSD claims increased. One significant action the VA took was to have those denied before the 2011 changes reapply for disability. As a result, the total number of military sexual assault reports increased because those who had received a denial reapplied (Bell et al., 2018).

Although changes had occurred nationally, a report by the American Civil Liberties Union and Service Women's Action Network (SWAN) found that a veteran's location and the site where the claim was submitted significantly impacted whether the claim was approved or denied (American Civil Liberties Union, 2013). Since many sexual assaults were unreported or underreported, evidence was often lost or insufficient when a veteran applied for a claim. Moreover, the Department of Defense contended that, because underreporting was a problem in the military, the VA also needed to improve regulations and processes for obtaining and substantiating evidence for MST-related PTSD claims to resemble the process used for other PTSD applications. Recognizing that denied MST-related claims resulted from a lack of staff training and insufficient evidence, the VA sent letters to 2,667 veterans whose claims had been denied, notifying them to resubmit; however, their efforts resulted in only 150 overturned denials (Bell et al., 2018).

MST: Future Directions

The future for addressing MST involved implementing multiple strategies for prevention, response, policy improvement, and comprehensive support for survivors. Over the years, the VA made significant strides in enhancing the processing of MST-related PTSD claims for all veterans, acknowledging the unique challenges faced by those who had experienced such trauma (U.S. Department of Veterans Affairs, 2014). However, despite these improvements, many veterans continued to struggle to obtain the benefits they deserved. Ensuring that survivors of MST received the care and compensation they needed was not just a matter of policy; it required ongoing outreach efforts to connect with veterans and raise awareness about available resources. Furthermore, it was essential to monitor MST-related screening and treatment practices within the VA system to ensure they were practical and accessible. This necessitated continued training for healthcare providers on the nuances of MST and its long-term effects, as well as fostering an environment that encouraged survivors to come forward and seek support without fear of stigma. By prioritizing these initiatives, the future of supporting those who experienced MST could be more proactive, ensuring veterans receive holistic care tailored to their specific needs and experiences.

Advocacy organizations that supported women with military experience continued to serve as a voice for women veterans across all branches of the U.S. Armed Forces. Mental health remained one of the top challenges women veterans faced, with gender bias continuing to be a significant problem (American Civil Liberties Union, 2013). Despite the noted challenges, public awareness remained at the forefront of

shifting perceptions of women in military culture, the media, and women's rights overall, as they continued to progress. In line with this, organizations that supported women with military experience and goals to educate and build a stronger community on behalf of women veterans.

Partnering with Cornell Law School's Gender Justice Clinic enabled service organizations and other advocacy groups to refine the VA's MST guidelines (SWAN, 2017). In 2016, Cornell Law School's Gender Justice Clinic submitted a report on sexual violence in the military to the United Nations Committee to push for justice and to investigate and prosecute sexual abuse against service members. Surveys were administered to thousands of service members to assess their challenges and preferred solutions. In 2017 and thereafter, the resulting survey data were used to set programmatic and policy agendas, broaden the community, and tailor efforts to ensure that the voices of all women veterans were recognized (American Civil Liberties Union, 2013).

Summary and Conclusions

Researchers needed to explore the needs of women veterans who had experienced sexual assault in the military. Advocacy organizations that supported women's military experiences had provided data that enabled the VA to improve processes and policies for handling MST-related PTSD compensation claims. However, Congress needed to enact legislation to address transparency and discriminatory acts toward MST survivors who had waited a long time to obtain benefits due to problems with the application review process. In this chapter, I critically analyzed the current literature on MST, treatments,

the VA application process, study outcomes, improvements, and the future direction of MST. Chapter 3 focused on this research study's methods and strategies.

Chapter 3: Research Method

Introduction

The purpose of this research was to explore women veterans' experiences applying for disability compensation for MST-related PTSD. These women's claims highlighted ongoing issues of equality and justice within the military. The application process and subsequent denials often subjected women veterans to additional humiliation and resentment (Dyer et al., 2019). Providing guidance on correctly submitting the required supporting documents was essential for increasing approval rates (American Civil Liberties Union, 2013).

In this chapter, I presented a generic, basic qualitative methodology and design for case interviews with women veterans who had applied for VA compensation due to MST-related PTSD. In the interviews, I examined the VA MST-related PTSD disability compensation claim process and the reasons women veterans received denial ratings. Understanding the application process and its challenges in securing compensation was essential for supporting women veterans effectively. In this research, I primarily examined the process of applying for benefits related to MST-related PTSD, conducting a detailed analysis to uncover the challenges women veterans faced and the issues that contributed to denials.

Research Design and Rationale

The research question for this study was: What were the experiences of women veterans who applied for VA compensation when they submitted a claim for MST-related PTSD? Women veterans often faced significant challenges in the complex application

process, making it difficult to gather the necessary documentation and evidence. This process was fundamental to understanding their experiences with MST-related PTSD claims.

A generic, basic qualitative research approach was particularly well-suited to this study, as it offered insights into the personal and contextual factors affecting these veterans. Using a generic, basic qualitative methodology, primarily through in-depth interviews about MST-related PTSD, resulted in a more nuanced exploration of personal experiences, emotions, and beliefs tied to MST and PTSD. With this approach, I achieved research flexibility and contextual understanding using thematic analysis (Braun & Clarke, 2022). I used the generic, basic qualitative methodology to capture rich narratives that quantitative methods would not have included. A generic, basic qualitative design allowed for examination of the complex contexts surrounding MST-related PTSD, including key themes such as gender differences, the benefits application process, and factors influencing women veterans' experiences. Through interviews, I highlighted the subtleties of their experiences and the barriers they faced, allowing them to articulate their stories in their own words. The flexibility of semi-structured interviews facilitated exploration of emerging topics. Given the sensitive nature of MST-related PTSD, the participant pool was limited, making qualitative interviews a suitable method for gathering detailed information from a smaller group while still producing valuable findings. I used interview data as a primary source of evidence (Malterud et al., 2016).

Qualitative methods provided rich, contextual data on women veterans' experiences with VA compensation claims for MST-related PTSD, documenting

challenges, emotions, and insights. Findings informed recommendations for improvements to support systems, policies, and resources to better assist women navigating the claims process.

Role of the Researcher

As the researcher, my primary responsibility was to gather qualitative data through methods such as interviews, which were essential for understanding the experiences of women veterans applying for VA compensation for MST-related PTSD. I conducted in-depth interviews to create a space where participants felt comfortable sharing their narratives. The method allowed the collection of rich qualitative data, capturing the nuances of participants' experiences. The questions (see Appendix B) were designed and structured to elicit comprehensive and detailed responses from the selected participants. This involved asking open-ended questions and encouraging participants to elaborate on their feelings, challenges, and insights throughout the claims process. This responsiveness was important because it enabled the exploration of unexpected themes and insights that emerged during the discussion.

Guided by feminism, I strove to eliminate bias and ensure that the results accurately reflected participants' experiences. This approach emphasized empowerment and agency, treating participants as co-contributors to the research rather than mere subjects. I recognized the importance of transparency in the research process and, to establish rapport, informed participants that I was a military child and a military spouse. This self-awareness was essential for assessing my capacity to conduct the research and helped build trust with participants (Fink, 2000).

As a researcher, my responsibilities went beyond documenting the experiences of women veterans; I also raised awareness of the challenges they faced during the application process. By sharing their stories, I hoped to foster systemic change that enhanced support and resources for this group. Throughout the research process, I engaged in reflective practice, concentrating on key aspects vital for understanding the inquiry. This reflection occurred before and during data collection, contributing context and insights that strengthened the analysis and validity of the findings (Sutton & Austin, 2018). Additionally, I acknowledged the real and perceived power dynamics in the researcher-participant relationship, addressing these concerns to facilitate open and meaningful interactions that honored participants' voices (Råheim et al., 2016).

Methodology

In this section, I outlined the methodology that explored the experiences of women veterans applying for VA compensation for MST-related PTSD. The chosen research approach emphasized qualitative methods to capture the depth, nuance, and complexity of participants' experiences. By using qualitative approaches, I provided a rich, detailed understanding of the personal narratives of women veterans, allowing their voices to be heard concerning their experiences with MST and the subsequent processes involved in seeking compensation for PTSD. This qualitative framework revealed unexpected themes and patterns in the discussions, providing a holistic view of the barriers that women veterans face in pursuing compensation. Ultimately, the selected methodology documented the experiences of women veterans, contributing knowledge about MST-related PTSD and informing future VA policies and support systems.

Participant Selection Logic

The population of women veterans needed to include those with a history of military service in any branch of the armed forces. Participants were selected based on specific characteristics or criteria relevant to the research question. Therefore, purposive sampling ensured participants met selection criteria and provided rich, relevant data on the research topic (Nyimbili & Nyimbili, 2024). This method captured rich, detailed information from individuals with specific experiences or knowledge and ensured the sample was free of bias, thereby increasing the reliability and trustworthiness of the findings.

The selection criteria for participants in this qualitative study included (a) being a veteran, (b) being female, (c) having been diagnosed with MST-related PTSD, (d) having previously sought professional help for MST-related PTSD, and (e) having applied for VA disability compensation. Participants were identified as meeting the selection criteria through self-identification by responding to a social media flyer distributed by an advocacy organization for women veterans.

I used a generic, basic qualitative approach, focusing on depth rather than breadth, and interviewed 11 women veterans. Because purposive sampling was carefully selected, fewer life-story interviews provided the necessary research information (Bekele & Ago, 2022).

I identified, contacted, and recruited women veterans who had experienced MST-related PTSD, ensuring a diverse and relevant participant pool for qualitative research. To achieve this, I collaborated with and obtained permission from an advocacy organization

focused on women veterans who had submitted disability claims to identify eligible participants. Recruitment material, including the social media flyer (see Appendix A), provided clear information on the study's purpose, eligibility criteria, and benefits of participation.

By posting the recruitment flyer on these organizations' social media platforms, I effectively targeted women veterans. Interested individuals can reach out directly via email to express their willingness to participate, which will allow me to provide a brief overview of the study. Potential participants were emailed the informed consent form. Participants emailed the words "I consent" to confirm their consent. Then, an interview was scheduled with each participant.

Instrumentation

In this study, I shared the experiences of women veterans during the VA compensation application process and provided detailed information for those seeking to apply. I used a series of open-ended questions (see Appendix B) to elicit comprehensive responses about their compensation application process. The semistructured format allowed for flexibility in follow-up questions based on participants' replies.

The interview guide facilitated in-depth responses from women veterans, enabling them to share their personal experiences, feelings, and challenges in their disability compensation application process. By examining specific aspects of the application process, this instrument provided rich qualitative data from participants that directly addressed the research question.

The interview guide began with four demographic questions to determine the branch of the armed forces the women veteran had joined, her age, marital status, and rank. The semistructured interview guide provided to participants included two questions on feminist theory and six questions derived from the themes of the literature review.

Procedures for Recruitment, Participation, and Data Collection

Key personnel at the advocacy organization received the recruitment flyer after the Walden University Institutional Review Board (IRB) approved the study. The recruitment flyers were posted on the advocacy organization's social media and website. Participants could reach me via the email provided on the flyer. The recruitment flyer summarized the study, stated that participation was voluntary, outlined inclusion criteria, explained the risk–benefit ratio, and detailed compensation (see Appendix A). Upon expressing interest, I sent participants a digital copy of the informed consent form. To confirm participation, participants replied with “I consent” via email.

Once I received consent from a participant, an interview was scheduled via email, allowing each participant to choose preferred time slots. Interviews were conducted via Zoom, audio-recorded, and transcribed using its built-in features. Each interview was expected to last 30 to 45 minutes via Zoom at the scheduled date and time. Both participants and I were virtual in locations free of noise and distractions, and I asked questions from the interview guide. Zoom transcribed the conversation's dictation from the audio recording. All participants were asked the same questions about their VA compensation application process. If any participant showed signs of distress during the interview, I provided contact information for the VA Crisis Line at 1-800-273-8225,

which offered confidential support 24/7, and I stopped the interview immediately, as stated in the informed consent.

At the end of each interview, I expressed my gratitude to the participants and invited any final questions. I emailed each participant a \$25 Visa e-gift card as a thank-you for their time and effort. I also informed them that no follow-up interviews would be conducted and reassured them that all data would be anonymized to protect their confidentiality.

Data Analysis Plan

The analysis followed Braun and Clarke's six-phase thematic analysis approach, providing a structured yet flexible framework for identifying, analyzing, and reporting patterns (themes) within the Zoom recordings. First, I listened to the audio recordings and read the transcriptions to familiarize myself with the content and ensure accuracy. I immersed myself in the transcripts, reading and re-reading them to understand participants' experiences and identify preliminary themes, notable quotes, and significant patterns. I organized and described the data using NVivo software. The raw interview data were imported into NVivo to further organize and analyze them for management and coding (Lumivero, 2023). However, the transcriptions had to be completed verbatim to ensure they could be easily analyzed before data analysis began (Sutton & Austin, 2015).

A thematic analysis was used, involving repeated cycles to deepen understanding and ensure the reliability of the identified themes in this research through a six-step analysis, which included:

Familiarization With The Data

I practiced active listening and took notes on my initial reactions and observations to capture my thoughts in real time (Clarke & Braun, 2017). To become acquainted with the data, I read the transcriptions to familiarize myself with the content and ensure all transcriptions were correct. I immersed myself in the transcripts by reading and re-reading them to understand participants' experiences and identify preliminary themes, notable quotes, and significant patterns.

Generating Initial Codes

I grouped the initial codes into broader themes, examined how they combined to form overarching patterns, and developed thematic tables to visually represent the relationships between codes and themes (Clarke & Braun, 2017). I also systematically identified and categorized interesting data features.

Searching for Themes

I prepared detailed descriptions of each theme, including the data scope and insights into women veterans' experiences (Clarke & Braun, 2017). For each theme, I wrote a clear definition outlining what it encompassed and how it related to the broader context of women veterans' experiences. I also organized the themes into a hierarchy, categorizing them into main themes and subthemes to show how they were interconnected and contributed to the overall experience of women veterans.

Reviewing Themes

To ensure alignment, I systematically reviewed each theme and cross-checked it against the coded extracts to ensure sufficient data supported it (Clarke & Braun, 2017). The themes were reviewed to accurately reflect the coded extracts and the dataset. Some

themes required refinement, splitting, or combining to finalize a coherent and meaningful representation of participants' experiences.

Defining and Naming Themes

I compiled the dataset, systematically coded it, and identified relevant text segments related to the research questions (Clarke & Braun, 2017). Both inductive (data-driven) and deductive (theory-driven) coding were used to create a comprehensive list of codes reflecting the experiences of participants with MST-related PTSD and the VA compensation application process.

Producing the Report

I compiled the findings into a written report that presented the themes, supported by participant quotes to illustrate key points (Clarke & Braun, 2017). This included using data examples to illustrate themes, discussing the implications of the findings, and situating them in the context of existing literature. Additionally, I included a discussion section that interpreted the findings in relation to the existing literature, outlined implications for practice, identified potential areas for further research, and reflected on how the themes enhanced understanding of women veterans' experiences.

In completing my analysis, I encountered outliers in the research data, and I needed to maintain the integrity and validity of my analysis. According to Gibbert et al. (2020), recognizing discrepancies provided valuable insights into the variability of human behavior, and a systematic approach to pursuing a deeper theoretical understanding of these interesting outliers was important. Therefore, I examined these outliers with curiosity rather than dismissiveness, using a theory-building technique. I did

this by assessing the outlier to determine whether it resulted from data entry, validating the data point, and deciding whether to retain or remove it. Ultimately, thoughtfully addressing outliers ensured my analysis was comprehensive, robust, and reflective of the data's inherent complexities.

Issues of Trustworthiness

Once the data had been processed, analyzed, and interpreted, evaluating the trustworthiness and rigor of qualitative research involved assessing four main criteria: credibility, transferability, dependability, and confirmability. Credibility referred to the confidence that could be placed in the accuracy and truthfulness of the findings, which was strengthened through techniques such as data triangulation, including interviews. Transferability pertained to the extent to which the research findings could be applied or generalized to other contexts or settings, often achieved by providing detailed descriptions of the research context and participants. Dependability related to the consistency and stability of the research process over time, which was ensured through thorough documentation. Confirmability ensured that the results were shaped by participants' responses rather than researcher bias or subjective influences, typically supported by audit trails and reflexivity. Assessing the research based on these four criteria ensured that my findings were credible, reliable, and applicable (Lewis, 2015).

Credibility

To ensure and demonstrate credibility, I kept a detailed record of the decisions made during data collection, coding, and analysis. This served as an audit trail of all raw data, enabling transparency so others could follow my research process. Additionally, I

regularly engaged in reflexivity to recognize and address my biases. I also obtained member validation by sharing preliminary findings with participants to confirm that my interpretations reflected their experiences (Ahmed, 2024).

Transferability

To ensure the transferability of the study findings, I contextualized the data by describing the environmental, social, and cultural factors that may have influenced the results, enabling their relevance to be reviewed. Additionally, I provided rich, detailed descriptions of the participant characteristics, settings, and the research process, enabling readers to assess the applicability of the findings to other contexts. Maintaining transparency and thorough documentation throughout the study further supported the transferability of the results (Drisko, 2025).

Dependability

To ensure the dependability and reliability of my research findings, I used an interview guide (see Appendix B) as a standardized instrument to ensure uniformity across all interview data. This provided consistency in the data collection regarding the MST-related PTSD disability application process. Additionally, I maintained an audit trail documenting all methodological decisions and modifications throughout the research process. I also engaged in peer review by having colleagues review my interview procedures and coding strategies to verify consistency and mitigate researcher bias. Regularly reflecting on the data collection process and comparing ongoing findings further supported the study's dependability (Ahmed, 2024).

Confirmability

To establish confirmability in this study, I kept detailed documentation of all raw data, analysis notes, coding procedures, and decision-making processes to ensure transparency regarding how I arrived at my findings and conclusions. The goal was to ensure that my research findings were linked to the data. Additionally, I engaged in reflexive journaling to acknowledge and reflect on my potential biases and influences throughout the research process. These steps strengthened the confirmability of my study by establishing an objective, transparent link between the data and the conclusions (Nassaji, 2020).

The final aspect, which aligned with confirmability, was synthesizing meanings derived from the analysis because it emphasized interpretation grounded in data and differentiation from existing literature. This study differentiated its findings from existing literature and explored implications for future research, theory, and practice (Drisko, 2025). Improved data interpretation enhanced understanding of participants' experiences, potentially leading to new theoretical developments and better practices for addressing challenges faced by women veterans applying for MST-related PTSD compensation.

The goal was to deepen the understanding of how these female participants navigated civilian life, revealing new dimensions beyond their military backgrounds. By exploring their experiences, perspectives, and strategies, the study uncovered detailed insights that could challenge or expand existing perceptions. This process encouraged rethinking established views and highlighted the importance of approaching the research with an open mind, allowing unexpected themes to emerge. Moreover, it underscored the

researcher's need to be transparent about their assumptions, biases, and interpretative frameworks, ensuring the findings were credible and trustworthy. Maintaining such transparency not only strengthened the research's validity but also fostered a more comprehensive and authentic portrayal of participants' lived experiences (Adler, 2022).

Ethical Procedures

Ensuring ethical conduct was fundamental to producing credible and responsible research, as it established a foundation of trust and integrity between the researcher and participants. Adhering to ethical principles such as honesty, transparency, and respect safeguarded participants' rights and well-being while maintaining the study's credibility and validity (Kang & Hwang, 2021). Ethical research practices involved obtaining informed consent, ensuring confidentiality, minimizing potential harm, and securing approval from relevant review boards or ethics committees. By prioritizing ethics throughout the research process, researchers demonstrated their commitment to social responsibility and academic integrity, ultimately advancing knowledge in a respectful, accountable, and trustworthy manner (Resnik, 2011).

Informed Consent

To clearly state the study's purpose, procedures, potential risks, and benefits to participants, the consent form (see Verbal Consent) informed participants of the study's purpose, procedures, potential risks, and benefits, as well as their rights as participants. The verbal consent process addressed these risks by informing participants and giving them time to consider their involvement before participation (Nusbaum et al., 2017). Participants were explicitly informed that their participation was voluntary and that they

had the right to decline or withdraw at any time without penalty. A detailed discussion confirmed their understanding and agreement, allowing them a chance to ask questions.

Confidentiality and Anonymity

Participants' identities were safeguarded by anonymizing data and ensuring that all sensitive information remained secure, with access limited to authorized personnel (Resnik, 2011). Throughout the study, confidentiality and privacy were prioritized, and data were managed with care to protect participants' identities. Additionally, all procedures adhered to institutional and national ethical guidelines, with oversight from the Walden Institutional Review Board (IRB) to safeguard participants' well-being and rights at every stage of the research process.

Before agreeing to participate, participants needed to fully understand the purpose, procedures, risks, benefits, and their rights. Personal data and responses were kept confidential, and data were anonymized to protect identities. All information was stored securely in password-protected files, and access was limited to authorized research personnel to prevent unauthorized access (Pascale et al., 2022).

Respect for Participants

Informed consent was obtained, ensuring that participants understood that participation was voluntary and that they could withdraw without penalty by notifying the researcher via email or during the interview session, if applicable (Resnik, 2011). The study was designed to minimize potential physical, emotional, or psychological harm by carefully framing questions and maintaining a supportive environment. The interview guide (see Interview Guide, Appendix B) was used as a template to facilitate consistent

data collection, ensuring that questions were clear, respectful, and focused on pertinent topics.

Minimizing Harm

The study was designed to minimize potential physical, psychological, or social harm and to provide support or resources if distress arose. Participants were monitored throughout the interview for signs of distress or discomfort, and immediate support was offered when needed. If a participant exhibited significant distress, they were provided with appropriate resources, such as a crisis line or a mental health referral. They also had the option to pause or terminate their participation at any point without penalty.

Ethical Approval

Permission had been granted to authorize the recruitment flyer (see Appendix A) on a service organization website, allowing potential participants to voluntarily participate, understand the study, and acknowledge their rights. Additionally, I obtained ethics approval from the Walden University IRB before posting the flyer to ensure that the study adhered to ethical standards and safeguarded the well-being of this vulnerable population. I also ensured that all recruitment materials and procedures complied with organizational policies and ethical guidelines to protect participant confidentiality and rights throughout the research process.

Transparency and Integrity

Being honest about the research purposes, methods, and potential conflicts of interest and reporting findings truthfully and accurately were recognized as essential for conducting a rigorous qualitative study of MST-PTSD among women veterans.

Transparency in outlining the specific objectives of the research ensured that participants and readers understood the study's scope and purpose, fostering trust and credibility (World Medical Association, 2013). Clearly describing the methods used for data collection and analysis allowed for evaluation of the study's rigor and provided a basis for replication or further research. Disclosing any potential conflicts of interest safeguarded the integrity of the findings by addressing possible biases. Moreover, reporting findings truthfully and accurately, even when they challenged preconceived notions or revealed uncomfortable truths, was critical in accurately representing the experiences of women veterans dealing with MST-PTSD. Such transparency and honesty upheld ethical research standards and contributed to the development of a trustworthy body of knowledge that could inform reasonable interventions and support strategies tailored to this population.

Data Management

Ensuring proper handling, storage, and disposal of data in accordance with ethical guidelines and legal regulations was recognized as essential for effective data management (NIH, 2019). Data was collected by removing identifiable information to protect participants' identities, especially when sharing or publishing findings. The data were organized systematically using secure storage methods such as password-protected files and encrypted drives, and were coded to ensure confidentiality. All coding schemes and analysis procedures were documented thoroughly to facilitate transparency and reproducibility. The data were analyzed in accordance with ethical standards, maintaining objectivity and integrity throughout the process. Findings were reported accurately, with

Careful attention to avoid data manipulation or misrepresentation, and in a manner that upheld confidentiality and respected participants' rights. Additionally, all data handling and reporting procedures complied with Walden's IRB guidelines and relevant legal or ethical requirements, ensuring responsible information stewardship at every stage.

Other Ethical Issues

Participation in this research could have involved emotional distress, particularly when discussing the military application process, which could have occurred during or after the interview. Maintaining confidentiality was also a key ethical concern; while it could not wholly prevent privacy risks, researchers avoided requesting unrelated private information. Using an interview guide minimized this risk by keeping discussions focused on relevant topics (Sanjari et al., 2014).

Summary

In summary, Chapter 3 outlined the study's methodological framework, employing a generic, basic qualitative approach to analyze data obtained from participants. These participants were recruited through collaboration with a designated service organization specializing in MST-related PTSD disability applications for compensation. The chapter detailed the research design, participant recruitment process, data collection methods, and analytical procedures used to explore and interpret participants' experiences related to the disability application process. It laid the foundation for understanding how qualitative insights were generated to inform the organization's broader research objectives.

Building on the practical framework outlined in Chapter 3, the subsequent chapter presented a detailed analysis of the data collected from participants. The analysis uncovered themes and insights related to their experiences with the MST-related PTSD disability application process, providing a deeper understanding of their perspectives and challenges.

Chapter 4: Results

Introduction

The purpose of this generic, basic qualitative study was to explore women veterans' experiences applying for disability compensation for MST-related PTSD. I designed the study to gather data from women veterans in the U.S. Armed Forces about their experiences in filing for an MST-related PTSD claim to bring awareness to the application process and to provide suggestions for improvements in processing claims related to MST. In this chapter, I describe the setting, demographics, data collection, data analysis, evidence of trustworthiness, results, and summary.

Setting

The research setting was a virtual environment: I was in my home office with the door closed, and the participants were in private, quiet locations of their choosing, participating remotely via Zoom on the researcher's laptop. The recruitment settings produced a self-selected, convenience sample in which participants' access to technology and internet connectivity, their ability to secure a private space, scheduling constraints, and privacy or comfort concerns (opting out of video) affected the remote setting and, at times, the timing or quality of the interviews. The participants were recruited from an advocacy organization for women veterans via a flyer posted on the organization's website. Applying purposive sampling approaches, I recruited 11 female participants who were 18 years and above, victims of MST-related PTSD in the U.S. Armed Forces, and who have sought VA disability compensation. The participants expressed their interest in the study by contacting me at the email address provided on the flyer. I then sent them an

informed consent form via email, to which they responded with “I consent,” confirming their willingness to participate in the study. The interviews were audio-recorded, and transcripts were generated using the Zoom platform on my laptop. I asked participants to be in a quiet location where they could openly share their experiences in response to questions from the interview guide, and I informed them that the interviews would be recorded and that they did not have to appear on camera. The setting was changed for scheduling and logistical reasons to allow participants to complete the interview remotely, based on their accommodations.

Demographics

I used the interview guide (Appendix B) to collect data from participants. Participants were women veterans aged 18 or older, ranging from 30 to 41, from different branches of the U.S. Armed Forces, and with varying relationship statuses. Each participant applied for disability compensation but received different ratings. The following summarizes the basic demographic information for each participant.

Participant 1 (P1) was in the Air Force and was 27 when she enlisted. She experienced MST-related PTSD at age 32, received a denial rating, and she was married at the time of collecting data.

Participant 2 (P2) was in the Army and was 25 when she enlisted. She experienced MST-related PTSD at age 30, received a denial rating, and she was married at the time of collecting data.

Participant 3 (P3) was in the Army and was 22 when she enlisted. She experienced MST-related PTSD at age 32, received a denial rating, and was married at the time of collecting data.

Participant 4 (P4) was in the Army and was 20 when she enlisted. She experienced MST-related PTSD at age 39, received a denial rating, and is currently separated.

Participant 5 (P5) served in the Marine Corps and was 21 when she enlisted. She experienced MST-related PTSD at age 35, received a denial rating, and is currently separated.

Participant 6 (P6) was in the Navy and was 21 when she joined. She experienced MST-related PTSD at age 38, received a denial rating, and was married at the time of collecting data.

Participant 7 (P7) was in the Army and was 18 when she enlisted. She experienced MST-related PTSD at age 34, received an approval rating, and is currently divorced.

Participant 8 (P8) was in the Air Force, 18 years old, experienced MST-related PTSD when she was 33, received an approval rating, and is currently married.

Participant 9 (P9) was in the Marine Corps and enlisted at 19 years old. She experienced MST-related PTSD when she was 43, received an approval rating, and is currently engaged.

Participant 10 (P10) served in the Navy and joined at age 18. She experienced MST-related PTSD at age 41, received a denial rating, and is currently married.

Participant 11 (P11) was in the Air Force and enlisted at age 19. She experienced MST-related PTSD at age 37, received a denial rating, and is currently divorced.

Table 1

Demographic Summary

Participant	Age (Years)	Military Branch	Disability Claim Status	Current Relationship Status
P1	32	Air Force	Denied	Married
P2	30	Army	Denied	Married
P3	32	Army	Denied	Married
P4	39	Army	Denied	Separated
P5	35	Marine Corps	Denied	Separated
P6	38	Navy	Denied	Married
P7	34	Army	Approved	Divorced
P8	33	Air Force	Approved	Married
P9	43	Marine Corps	Approved	Engaged
P10	41	Navy	Denied	Married
P11	37	Air Force	Denied	Divorced

Data Collection

The recruitment of 11 participants was conducted through an advocacy organization that supports women veterans, using flyers posted on its website. The data collection process involved conducting interviews with each recruited participant using the interview guide. Data collection took 3 weeks, during which each participant was allocated a day and time of their preference. I requested that participants be in a quiet location during the interview, where they could openly share their experiences in response to the interview guide's questions. These interviews were conducted virtually via Zoom, with audio recorded and transcribed. For each participant, data was collected

once. However, one interview was briefly interrupted when a participant became distressed by the questions, but it resumed and was completed. After completing the interviews, I thanked each participant for their participation and for sharing their experiences. I also provided each participant with the crisis line to contact if they needed to speak with someone after the interview; however, a follow-up interview was not required. I informed the participants that they would receive the preliminary data coding via an encrypted email, allowing them to verify its accuracy and relevance to their experiences. Additionally, I reminded them that a \$25 Visa gift card had been sent to each participant via email as a token of appreciation for their participation in the study. The participants remained confidential, and each participant's data was anonymized using unique identifiers, namely participant numbers ranging from P1 to P11. The collected data was stored on my computer in a folder protected by a password known only to me to ensure its security. There were no physical copies of the data collection.

Data Analysis

I analyzed the collected data using thematic analysis to identify meaningful themes and patterns. This involved transcribing the interviews and coding the data to familiarize myself with the material and identify potential codes. The first coding cycle was line-by-line coding in an Excel spreadsheet, in which each line from the transcribed interviews for each participant was reviewed and assigned a code to represent its meaning (see Braun & Clarke, 2022).

Following initial coding, I analyzed the codes for patterns, similarities, and discrepancies. Related codes were organized into broader categories, thereby yielding

preliminary themes (Braun & Clarke, 2022). A table was employed to arrange and visualize the emerging themes and their interconnections. The initial themes were then reviewed against the coded data and the complete dataset to confirm that they accurately reflected the participants' experiences and perspectives. Some themes were merged, refined, or discarded based on their clarity and relevance. This phase also involved ensuring that each theme was distinct and supported by meaningful quotations from the transcribed interviews. From this process, I identified and defined six themes and wrote descriptive summaries for each, explaining how they addressed the research questions. There were also 21 categories and 155 codes that aligned with the interview questions. The themes developed for this study are military challenges, coping mechanisms, MST treatment, gender treatment differences, VA benefit process, and VA benefit application improvements. Each theme also included several categories and subthemes. Under Theme 1, there are four categories: discrimination, limited representation, sexism, and gender bias. These categories are supported by 45 codes and nine coded references. Under Theme 2, there are three categories: counseling, support networks, and mentorship. These categories are supported by 10 codes and three coded references. Under Theme 3, there are three categories: therapy, integrated healthcare, and medication. The categories were 5 codes and three coded references. Under Theme 4, there are five categories which include sexual trauma group, fair treatment or no difference, education, combat counseling, or no support. These categories are supported by 18 codes and five coded references. Under Theme 5, there are nine categories: mental support, financial support, injustice or entitlement, online application, medical records

documentation, therapy session, witness statements, denial rating, and approval rating. These categories are supported by 39 codes and nine coded references. Under Theme 6, there are four categories: online guide or portal, accessible support, AI tools for guidance or support, and a checklist. These categories are supported by 21 codes and four coded references. No discrepancies were observed in the analysis of these data, and no inconsistencies or unexpected patterns were identified in the participant data.

Theme 1: Military Challenges

Within this theme, the individual challenges faced by military personnel and the experiences of women veterans were highlighted. There are four subthemes associated with this theme: discrimination, limited representation, sexism, and gender bias (see Table 2). The subtheme of discrimination captures the experiences of women veterans. This subtheme includes code gender discrimination. The second subtheme focuses on the limited representation of support within the military, thereby highlighting the impact of military challenges on women veterans. The codes in this subtheme include psychological impact, barriers to retention and advancement, and gender representation. The third subtheme concerns sexism and its impact on women veterans, particularly their experiences within the military, and highlights how they felt. The codes supporting this subtheme include sexual harassment and assault, gender bias in promotions, and impact on mental health. The fourth subtheme under this theme is gender bias, which tries to show how the women veterans felt about the treatment they were receiving in the military. This subtheme includes codes such as microaggressions and gender stereotypes.

Table 2*Theme 1: Military Challenges*

Subthemes	Subtheme description	Total # of Codes	Codes (Coded references)
Discrimination	Captures the perspective of women veterans on their military experiences.	3	Gender Discrimination (3)
Limited Representation	Highlighting the impact of military challenges on women veterans.	5	Psychological Impact (2) Barriers to Retention and Advancement (2) Gender Representation (1)
Sexism	Highlights the impact of women veterans, particularly their military experiences and their feelings.	26	Sexual harassment and assault (11) Gender bias in promotions (4) Impact on Mental Health (11)
Gender Bias	Captures how women veterans felt about the treatment they received in the military.	11	Microaggressions (4) Gender stereotypes (7)

Theme 2: Coping Mechanisms

In this theme, the coping strategies used by women veterans to address their unique experiences in the military were highlighted. This theme had three subthemes: counseling, support network, and mentorship (see Table 3). The first subtheme on counseling highlights their experiences, needs, and outcomes, which differ from those of men. Different exposures to combat shaped how the military provided counseling services to the veterans, but a lack of trauma-informed therapies was not provided for MST-related PTSD women veterans. The second subtheme, support networks, provided social connections and access to community resources that guided and shaped women

veterans' health and resilience. The impact on their mental health improved with strong social support to reduce PTSD triggers, depression, and lack of substance use. The codes in this subtheme include peer support, family support, and friendships. The third subtheme is mentorship, which can serve as a code to support a subtheme network, but it is presented differently in this theme because the guidance is provided by experienced veterans or mentors who have been diagnosed with MST. This subtheme captured the peer-to-peer guidance that shapes trust, recovery, and reintegration to their military experience.

Table 3

Theme 2: Coping Mechanisms

Subthemes	Subtheme description	Total # of Codes	Codes (Coded references)
Counseling	Highlights the experiences, needs, and outcomes of women veterans compared to those of their male counterparts.	3	Combat Exposure (1) Non-Combat Exposure (1) Informed Therapies (1)
Support Network	Captured the types of support relevant to the women veterans.	9	Peer support (2) Family Support (4) Friendship (3)
Mentorship	Emphasizes the impact of ranked women veterans who shared the same diagnosis.	26	Sexual harassment and assault (11) Gender bias in promotions (4) Impact on Mental Health (11)

Theme 3: MST Treatment

In this theme, the treatment of women veterans with MST is discussed. This theme had three subthemes: therapy, integrated healthcare, and medication (see Table 4). The first subtheme on therapy captures how formal mental-health treatment affects the women veterans' recovery and service use. Systematic barriers, stigma, and negative encounters shaped their access and retention in the military, but again, the lack of informed therapies, such as trauma-focused therapy, was provided to men counterparts and not women. The second subtheme of integrated healthcare involved multidisciplinary care to ensure a coordinated approach to the outcomes of women veterans' treatment plans. This is the only code in this subtheme, as integrated healthcare facilitates shared guidance for their treatment, care coordination, and management. The third subtheme is medication and how pharmacologic treatment affects MST women veterans' symptom management, functioning, and care experiences. The codes in this subtheme are side effects and medication adherence, which captured the importance of medication as a standalone treatment that requires management and monitoring of dosing and side effects.

Table 4*Theme 3: MST Treatment*

Subthemes	Subtheme description	Total # of Codes	Codes (Coded references)
Therapy	Addresses the treatment of trauma-specific symptoms for a favorable outcome.	2	Perceived therapy effectiveness/outcomes (1) Crisis management/recovery (1)
Integrated Healthcare	Captured how coordinated treatment with multidisciplinary care.	1	Integrated Care Coordination (1)
Medication	Emphasizes the impact of pharmacologic treatment on managing care.	2	Side Effects (1) Medication adherence (1)

Theme 4: Gender Treatment Differences

Gender differences in treatment care indicate that male and female soldiers received different treatment for MST in this theme. This theme had only one subtheme: differentiated treatment (see Table 5). The subtheme of differentiated treatment encompasses services, policies, interventions, and care pathways tailored by gender, and how these differences affect veterans' needs and outcomes. Some codes for this subtheme refer to the use of combat counseling, education, and sexual trauma groups.

Table 5*Theme 4: Gender Treatment Differences*

Subthemes	Subtheme description	Total # of Codes	Codes (Coded references)
Differential Treatment	Addresses the treatment of trauma-specific symptoms for a favorable outcome based on gender.	3	Combat Counseling (1) Education (1) Sexual Trauma Groups (1)

Theme 5: VA Benefit Process

Under the fifth theme, the VA benefit process for MST needs, and the decision is captured to address the requirements for seeking MST benefits. This includes the benefit need, the benefit process, and the benefit rating. Therefore, there are five subthemes: financial support, injustice/entitlement, medical records documentation, witness statements, and benefit rating (see Table 6). The subtheme on financial support captures how monetary resources, benefits, and material assistance affect MST women veterans' stability, treatment, and overall health outcome and had codes such as financial security and stability. The subtheme injustice/entitlement captures an actual unfair treatment, which entitles them to the benefit for their service as a deserved resource. The codes referenced in this subtheme are benefit, knowledge, and compensation. The third subtheme is medical record documentation, indicating the need for VA benefits as evidence in the application process. Codes such as documentation for benefits and completeness of records provided accurate, sensitive documentation of the MST diagnosis, care, and treatment. Witness statements were the fourth subtheme that

supported the women veteran's VA benefits application process by validating MST reporting and investigation. There was only one code in this subtheme: witness presence/knowledge of the MST. The last subtheme, benefit rating, examined how the VA determines disability compensation (ratings) to support VA women veterans' access to resources, financial stability, and treatment, and had codes such as denial or approval ratings.

Table 6

Theme 5: VA Benefit Process

Subthemes	Subtheme description	Total # of Codes	Codes (Coded references)
Financial Support	Captures the reason for applying for a VA benefit rating.	5	Financial Security (3) Financial Stability (2)
Injustice/Entitlement	Highlights perceptions of injustice and entitlement to VA benefits.	3	Benefit (1) Knowledge (1) Compensation (1)
Medical Records Documentation	Emphasizes the need for documentation as evidence for the VA benefit application process.	14	Documentation (11) Completeness of records (3)
Witness Statements	Highlights the importance of witness statements to validate MST.	4	Witness presence/knowledge (4)
Benefit Rating	Captures the decision of the VA application for compensation (rating).	11	Denial (8) Approval (3)

Theme 6: VA Benefit Application Improvements

In the last theme, improvements to the VA benefit application indicate the improvements needed to the application process to support better ratings and approval times. This theme had four subthemes: online guides/portal, accessible support, AI toolkits, and a digital checklist (see Table 7). The first subtheme, online guides/portal, captures how digital tools support women veterans' access to information in a centralized location for tracking and management. Codes such as integration with VA electronic health records (EHR) and a portal for resource hub use were discussed. Accessible support is the second subtheme that captures the need for the availability and usability of VA documents for VA benefit applications, as they affect MST women veterans' ability to engage with services and resources. The codes referenced in this subtheme were digital access and women-only services for people with MST. The third subtheme is AI toolkits, which are current decision aids that support women veterans' care navigation and improvements to the VA benefits compensation (rating) system. Chatbot, predictive tips/responses, and documentation automation were code-referenced in this subtheme. The last subtheme highlights the use and value of a structured, step-by-step digital list to guide women veterans through the online application process for disability claims and compensation appeals. The only code in this subtheme mentioned was a digital checklist.

Table 7*Theme 6: VA Benefit Application Improvements*

Subthemes	Subtheme description	Total # of Codes	Codes (Coded references)
Online guide/portal	Highlights the need for important documents to be available in a centralized portal with digital access.	4	VA EHR Integration (2) Resource Hub (2)
Accessible support	Captured the need and use of VA benefit documents	6	Digital access (3) Women-only services (3)
AI toolkit	Emphasizes the impact of advanced technology on rating decisions and on navigating the application process.	7	Chatbot (2) Predicative tips/responses (3) Automated documentation (2)
Digital Checklist	Captured the need for a checklist as guidance for completing an online application.	10	Checklist (10)

Evidence of Trustworthiness

Evidence of trustworthiness for qualitative research with women veterans who had MST-related PTSD meant demonstrating that findings accurately reflected participants' experiences, were produced through careful, transparent procedures, and protected participants' safety and privacy. Because this population was trauma-exposed and vulnerable, establishing trustworthiness also required trauma-informed, ethical, and culturally competent practices throughout the study. The key factors in trustworthiness were credibility to accurately represent women veterans, transferability to ensure

contextual fit, dependability to confirm transparency, and confirmability to minimize bias.

Credibility

Credibility, which parallels internal validity in this conceptual framework, was demonstrated by the findings to accurately reflect participants' perspectives and experiences of applying for VA disability compensation. I enhanced credibility through data triangulation, conducting one recorded interview per participant, generating Zoom transcripts, and coding themes and subthemes to confirm consistency across sources. Peer debriefing and reflexivity were employed to identify and reduce misinterpretations and researcher bias. Although this was planned to allow participants to review transcripts and interpretations, participants were ultimately unwilling or unavailable to complete that step. Together, these measures supported the trustworthiness of the study's findings by aligning analytic procedures with the goal of accurately representing the 11 women veterans' experiences with MST-related PTSD.

Transferability

To ensure transferability, the study's findings can be generalized to other contexts or settings, often achieved by providing detailed descriptions of the research context and participants, as stated in Chapter 3. This includes research strategies to support implementation and the mechanisms underlying the details, not just the outcomes (Drisko, 2025). Providing a detailed description of the participant characteristics, settings, and the research process enabled me to access the findings with other contexts on MST-

related PTSD. Maintaining transparency and thorough documentation enhances the transferability of results.

Dependability

Dependability was supported by systematic reflection on the data collection process and ongoing comparison of emerging findings. I used a standardized interview guide for all interviews, documented each research step from recruitment through reporting, and applied manual coding techniques to the transcripts. These procedures created a clear, replicable audit trail and reduced procedural variability, while manual coding increased consistency and accuracy in theme identification. Together, these measures strengthened the study's dependability by ensuring that the research process and findings could be traced and replicated. Coding techniques improved the accuracy of my findings, enhancing the reliability of the data on their experiences.

Confirmability

Confirmability was achieved by establishing a transparent, objective link between the data and the study's conclusions. I differentiated findings from existing literature, used reflexive journaling to document researcher decisions and potential biases, and maintained an audit trail linking raw data, codes, and themes. Reflexive journaling and the audit trail enabled systematic scrutiny of how interpretations were derived, thereby reducing the researcher's influence on findings and improving the credibility of data interpretation (Nassaji, 2020). These steps supported confirmability by demonstrating that conclusions were grounded in participants' data and contributed new theoretical

insights and practical recommendations for VA disability compensation processes for veterans with MST-related PTSD.

Results

The purpose of this generic, basic qualitative study was to explore women veterans' experiences applying for disability compensation for MST-related PTSD. This study collected information from women veterans diagnosed with MST-related PTSD who served in any branch of the U.S. Armed Forces. Participants were those who sought support by pursuing VA benefits compensation. In this study, I identified barriers, facilitators, and perceptions of the VA disability compensation application process.

I presented the results of the data analysis and the interpretive synthesis for the study. I began with a brief descriptive summary of the sample—key demographic and service-related characteristics of the women veterans (age ranges, branches of the U.S. Armed Forces, disability claim status, and marital status)—to contextualize the findings. I then organized the findings thematically around the study's research questions, reporting each theme in turn with subthemes where appropriate (Braun & Clark, 2022). For each theme, I provided a clear analytic statement supported by multiple verbatim quotations from the interview transcripts that illustrated participants' perspectives, experiences, and interpretations of seeking VA benefits; quotations were identified with non-identifying pseudonyms and basic participant characteristics (e.g., "Participant 1/P1, Army veteran") to preserve anonymity while retaining analytic clarity.

Methodologically, I described the thematic coding process, how codes were developed and refined, and steps taken to move from descriptive codes to higher-order

themes and interpretations. I noted strategies that enhanced credibility and trustworthiness—such as member checking, audit trails, and reflexive journaling—and report any analytic divergences and how they were resolved. In the findings, I also addressed both differences and challenges encountered when seeking VA benefits (for example, knowledge gaps about eligibility, perceived gender bias, supportive peers, and effective advocacy strategies).

Each thematic section concludes with an interpretive summary that links the empirical evidence back to the research questions and to pertinent literature, identifying how these findings confirm, extend, or challenge existing knowledge about women veterans' experiences with the VA. The chapter closes with a concise synthesis of key findings and a transition to the next chapter, which discusses the implications for policy, practice, and future research.

Theme 1: Military Challenges

In this theme, the individual challenges faced by military personnel and the experiences of women veterans were highlighted. There are four subthemes associated with this theme: discrimination, limited representation, sexism, and gender bias (Table 2). The findings are that women veterans in this study reported persistent gender-based discrimination and sexism in the military marked by limited support and representation, barriers to retention and advancement, sexual harassment, assault, microaggressions, and gendered stereotypes, which collectively contributed to negative psychological outcomes, stalled career progression, and feelings of marginalization. Therefore, these subthemes show how structural factors (representation/support, institutional bias) and interpersonal

harms (discrimination, sexism, microaggressions) interact to produce negative mental health outcomes, pointing to targets for policy, training, and clinical/benefits interventions.

Subtheme 1: Discrimination

This subtheme captured the perspective of women veterans' military experiences. It comprised one code with three references: gender discrimination. P7, P9, and P11 experienced discomfort and discrimination while in the military, particularly from their superiors. This appeared to be a familiar feeling among the women veterans who loved the military and serving their country, as evidenced by a statement from P7, "It was overall a good experience, and an honor to serve my country in the Navy. However, I could not stay any longer because I suffered a lot of discrimination and trauma, especially as a woman."

Also, P9, correspondingly stated;

It was quite an experience; being in the military has its good parts and bad parts. My grandfather was in the military, so I just thought maybe I could do this, but the sexual harassment, discrimination, and abuse of women by men is unreal.

Similarly, P11 mentioned the enjoyment of serving her country, stating:

I enjoyed the military. There were hard times and difficulties, but overall, I was happy to have served my country. However, at times it was challenging because I experienced some difficult things, like sexual assault and discrimination. This made it difficult for me as a female.

These three participants offered rich, firsthand perspectives that illuminate both the structural and interpersonal challenges female service members encounter. Their accounts reveal that while military service can be rewarding and sustainable for female soldiers, pervasive obstacles undermine that sustainability and shape daily experiences. Importantly, their insights identify actionable areas for improvement to make military service more equitable and sustainable for female personnel.

Subtheme 2: Limited Representation

In this subtheme, the limited representation was described as highlighting the impact of military challenges on women veterans. The codes in this subtheme are 5, with three coded references, including psychological impact, barriers to retention and advancement, and gender representation. Several participants reported an impact on their representation as being limited in the military from P1, P3, P7, and P10, who all equally stated, “I did not have the right to speak up or have the right to anything because my colleagues were all guys. They did not listen to me, probably because I am a woman. I felt bad at times because I feel everyone should be treated equally.” While P5 also shared separately that:

Men would treat women as if they were only good enough for sex and did not feel like they should be in the military. Often, it affected our advancement because male superiors had the upper hand, so you had to do what they said.

Also, P5 separately discussed how ranks do not matter in the military and stated:

As a woman in the military, you really have to learn how to navigate because men do not respect you. You have to find your voice because to

them, it does not matter your rank; you are beneath a male.

Similarly, P9 stated the following:

The entire field was male-centered, and male soldiers were treated as superior to female soldiers. As a woman, I was treated like a board, and when I was assigned tasks beyond my capabilities and failed, I was mocked. This was mentally draining.

The participants' responses indicated that women's representation in the military had been limited, and many reported being treated as inferior to their male counterparts, which in turn hindered career advancement. Several participants described how disrespect and exclusion damaged their professional credibility and opportunities. Psychologically, participants reported lasting effects, including diminished self-confidence, heightened anxiety, and persistent vigilance stemming from discriminatory treatment and MST experiences. Over time, these participants regained their confidence through coping strategies, seeking support, and gradually finding their voice to advocate for themselves and challenge the institutional barriers they had faced.

Subtheme 3: Sexism

In this subtheme, sexism highlights the impact of women veterans, particularly their military experiences and their feelings. There are 26 codes and three coded references that are sexual harassment and assault, gender bias, and impact on mental health. Each participant in the study spoke about sexism on some level, while certain statements related to sexual harassment and/or assault. P1 stated, "I also experienced

sexual harassment. Since I am a woman, it was kind of hard for me. But I just had to continue because it is my only source of income.”

While P11 shared a different perspective and stated, “No major struggles, but if you are a woman, you are treated like a woman. You were sexually harassed and assaulted at times. Again, it is a world of structure and sacrifice.”

Similarly, P7 stated, “I struggled with being assaulted. I was an officer and a soldier. I had to deal with anything that came my way, so it was really stressful.”

P4 and P6 stated similar accounts about sexism, which were;

Well, it was sexism in the military, and because I am a woman, many men do not believe in equality. You do not really matter to them in the military, and well, yes, I am going to say I experienced much sexism, and, uh, misogyny from high counterparts, and I also, um, suffered sexual abuse.

All participants experienced sexism in the military, manifested as gender-based discrimination tied to sexual harassment or assault. These behaviors compounded the trauma of harassment or assault, contributed to long-term psychological effects, and often limited access to career opportunities. Collectively, these experiences reflected institutional patterns rather than isolated incidents, underscoring a need for stronger accountability, supportive reporting mechanisms, and cultural change.

Subtheme 4: Gender Bias

In this subtheme, gender bias is shown as a systematic preference and captures how women veterans felt about the treatment they received in the military. There were 11

codes, and two coded references: microaggressions and gender stereotypes. P2

summarize the following statement:

I struggled with not being treated equally. I did not get to assign duties to people, and they did not assign any to me because I was a female soldier. I had to take what was thrown my way. In addition, something happened at my workplace that created a rift between my male colleague and me. So, um, when I reported the issue to my superior, they did not take it seriously. They felt the male soldier was right and I was wrong. They did not give me a listening ear.

P11 stated the following regarding gender bias:

It is kind of unusual. The military teaches discipline, patience, and courage. Yet it is not a place for the weaklings; it is not a place for people who are weak-minded, and the male soldiers make you feel like you are less than, with no mindset, because you are a female soldier.

Additionally, P5 stated:

I was under a lot of stress while in the military. It left me with PTSD, where I could not sleep, thinking about all the abuse and assault I experienced. Being treated like I did not belong, and seeing opportunities pass me by because I was a woman and was treated as less than. There were many microaggressions in my unit.

Participants in this subtheme described how gender bias shaped their military experiences, portraying women as a marginalized group who routinely faced abuse, discrimination, and unfair treatment. They reported behaviors that were directed at them

specifically because of their gender, ranging from subtle exclusion and microaggressions to overt harassment and unequal access to assignments or promotions.

Theme 2: Coping Mechanisms

In this theme, the coping strategies women veterans used to address their unusual experiences in the military are highlighted. There are three subthemes associated with this theme: counseling, support network, and mentorship (Table 3). The results indicated that counseling for women veterans emphasized validating emotional experiences and teaching skills for emotion regulation and problem-solving, contrasting with male-oriented treatments that more often concentrated on combat-related issues.

Correspondingly, support networks reflected the specific kinds of assistance women veterans needed for their military-to-civilian transition, physical and mental health, social reintegration, and access to services. Mentorship highlighted the influence of senior women veterans with the same diagnosis who provided guidance and support to those coping with MST-related PTSD.

Subtheme 1: Counseling

Under this subtheme, participants reported therapeutic approaches for women veterans prioritized creating a validating, trauma-informed space where clinicians acknowledged and normalized complex emotional responses. Interventions frequently incorporated approaches to assist with applying for VA disability compensation. By contrast, counseling targeted to men veterans tended to focus more directly on combat trauma, exposure-related symptoms, and threat-based behavioral responses. This divergence reflects gender-differentiated clinical needs that will be discussed in Theme 4:

Gender Treatment Differences. P3 discussed the struggles of seeking treatment when she stated:

Seeking counseling really was not easy. Things that most people would not open up about, I had to explain to a therapist. I mean, my family did not know. So, seeking treatment was kind of difficult, because I had to think and relive those sexual moments all over again while opening up to a stranger.

However, P11 stated, “The VA provided counseling and medical visits. The journey to seek help was not easy, but I had to take that step forward, especially for my family. Because of the emotional trauma, I decided to get some help.” Whereas P10 mentioned, “The VA provided counseling services and paid my medical bills.”

There was one participant who was currently being seen by the VA, and P5 stated, “My incident occurred recently, and I visited the VA for assistance. They provided great counseling sessions to assist me in applying for benefits because it was hard for me to work.”

All participants reported that counseling assisted with bill payments, medical costs, and the navigation of benefits. Counselors provided practical case management support by connecting clients to emergency pay-for-care funds and medical assistance programs and guiding them through VA and public-benefit applications, appeals, and documentation to reduce barriers to care, stabilize basic needs, and improve treatment engagement.

Subtheme 2: Support Network

Under this subtheme, support networks were documented to illustrate the types of assistance available to women veterans and how those supports addressed their specific needs. These supports came from family, peer mentors, veteran service organizations, health-care providers, and community agencies, each addressing gaps unique to women veterans such as childcare, gender-sensitive medical and mental-health care, and recovery from military sexual trauma. P9 mentioned,

“I felt like I was not in the right place mentally. Like, I was not mentally okay at one point, but I am just so grateful for the partner I have. I do not know where I would have been without them.”

Oddly, P6 stated, “I got to a point where I would trust strangers instead of my friends, because the men who assaulted me were my colleagues. I was stressed every day and knew I needed help.”

However, P2 did something different than the usual VA contact and instead mentioned, “I would talk to my friends about the undue treatment, but I just had to deal with it. I never contacted the VA about my work issues; only when I was seeking disability compensation.

Overall, P4 summarized it all as it related to support networks,

I went to them as things brewed with my superior, and they were good to talk to and help with some things like childcare, how to emotionally deal with issues, and how to apply for VA disability compensation due to my MST-related PTSD diagnosis.

The participants' data described networks that delivered instrumental, emotional, informational, and appraisal support. By combining practical resources, specialized knowledge, and relational validation, these networks reduced access barriers, promoted benefit-seeking, and strengthened veterans' capacity to manage health, employment, and social reintegration.

Subtheme 3: Mentorship

Under this subtheme, mentorship was emphasized, with senior women veterans who shared the same diagnosis providing guidance to others. One participant specifically highlighted a mentorship relationship in which higher-ranked, or more experienced, women veterans with the same diagnosis offered practical guidance, emotional support, and role modeling. P1 stated:

What motivated me was telling one of my colleagues about what I am facing, and she was like, "I should seek support and disability compensation, because I've been through it too. She was a high-ranking official, and I could not imagine it happening to her. She mentioned that it was going to really help me in my daily activities, with my trauma, my stress, and how I feel. I said, "Enough is enough," and I am tired of feeling this way. So, I encouraged myself to seek support, which is going to help me with my sexual life, reduce the trauma, and the stress I face. I believe anything I feel is going to work for me, I will go for it and seek disability compensation. She instantly became my mentor and my support system.

In mentorship, mentors supported mentees in navigating medical and benefits systems, sharing coping strategies and recovery resources, and advocating gender-

sensitive care. By normalizing symptoms and modeling successful management, mentors reduce isolation and stigma, boost confidence in seeking treatment, and improve service engagement. Their support gives participants the chance to see situations through the eyes of respected role models. Seeing how others, who are respected, interpret challenges, make decisions, and apply strategies fosters observational learning.

Theme 3: MST Treatment

This theme highlighted MST treatments pursued by women veterans, with three subthemes: therapy, integrated healthcare, and medications (Table 4). Observable improvements for veterans receiving MST treatment were consistently shown. Functionally, veterans reported better sleep, stronger relationships, and greater community participation. Gains were observed across treatment modalities and were strengthened by case management and peer support that reduced access barriers. While individual responses varied, outcomes were most durable when care included relapse-prevention planning, ongoing supports, and coordinated, multimodal services.

Subtheme 1: Therapy

Under this subtheme, therapy for trauma-specific symptoms is presented as a favorable outcome, reflecting both clinical improvement and everyday functional gains. For women veterans with MST-related PTSD, evidence-based trauma-focused therapies reduced symptoms and restored functioning, while supportive practices like peer support, stabilization skills, and case management reinforced gains. Therapists also taught cognitive and behavioral strategies to improve sleep, concentration, work, and relationships, and navigated practical barriers such as benefits, childcare, and medical

care. These interventions made it easier for veterans to tolerate reminders, sleep better, and engage in relationships and work. According to P1:

What influenced me was when I started having sleepless nights, as it was affecting my daily life. So, I decided to seek support from my healthcare professional to improve my daily activities, because it was hard. I also went for therapy, and that influenced me to continue seeking help.

Similarly, P2 mentioned:

The process I went through to seek treatment was visiting my healthcare professional. They took me to a room where I could discuss all that, so it was a step-by-step process. I was also given a referral for therapy, which had assisted me in addressing some of the traumas I did not want to face. At my third therapy session, they gave me assistance for MST, like stuff like anxiety meds and therapy group sessions. So, they assisted me in so many ways that I cannot explain.

However, P10 stated:

I was not financially stable enough to go on my own; I just needed support and money. I discussed my issues with my healthcare professional, who suggested I speak with a therapist. I started seeing a therapist who improved my nightmares and focused daily on my priorities, which were my daughter. The therapist also suggested group therapy and provided resources for childcare, since I am a single mom.

As it relates to suggested improvements, P11 stated:

Because of the emotional trauma, I decided to get some assistance. Therapy was a lifesaver. I learned to be more open and advocate for myself. I also learned the importance of applying for benefits. I needed assistance, and there was a program that helped me get it, so I applied.

Participants described a common care pathway involving a healthcare professional who referred the women veterans to a therapist who taught coping strategies for MST-related PTSD, while concurrent case management removed practical barriers (childcare and benefits navigation) that supported engagement and follow-through. This coordinated approach stabilized symptoms and increased readiness for trauma processing and translated therapy progress into everyday life by combining treatment with practical support (like transportation, childcare, or benefits support). Overall, integrating clinical referrals, trauma-focused therapy, and active case management enhanced engagement, treatment adherence, and functional outcomes.

Subtheme 2: Integrated Healthcare

Under this subtheme, integrated healthcare was captured, and how treatment was coordinated with multidisciplinary care. This approach combined medical, mental-health, and social services so women veteran's needs are treated together rather than separately. As with subtheme, therapy, integrated healthcare provided team-based care comprised of primary care providers, mental-health clinicians, therapists, and specialists who collaborate to address women veterans' concerns related to MST-related PTSD. This provided better detection and treatment of comorbid conditions like PTSD, which was documented in their medical records. P7 stated:

It was time, after all I had been through; it was my own willpower that told me it was time to seek benefit compensation, but I needed relief mentally. I talked to my primary care provider about my issues, and she referred me to a psychologist, who also referred me to an ongoing therapist.

Equally, P11 mentioned:

I could not manage it anymore. I just needed service with my emotional and sexual trauma, so I contacted the VA. I was not in a good mental state and needed bad support with the emotional trauma, so they suggested I speak with a healthcare provider who could provide a referral to a mental-health counselor and a psychiatrist. The treatment provided care, with both in constant communication to ensure I received the proper care.

Lastly, P2 said:

The main reason I sought assistance with MST is that it was affecting my mental health. To get better, I had to take action to address the issues I faced, so I contacted the VA. A therapist was assigned, and during those sessions, I was able to talk about my problems in a comfortable setting. A social worker was a part of my mental health treatment, and I was provided with resources to support me daily, like finding a job outside the military. Both facilitated me getting back on my feet.

Coordinated, female-focused care that combined medical care, mental health support, and assistance with practical needs made it easier for women to get care, stay in treatment, and address other health or life problems. This led to a longer-lasting recovery

and a better quality of life, as well as to the documentation needed for the benefits application process.

Subtheme 3: Medication

Under this subtheme, the impact of pharmacologic treatment (medication) is emphasized for its role in managing symptoms and supporting overall care. A form of pharmacotherapy, such as antidepressants, sleep agents, or antianxiety medications, provided relief when experiencing symptoms of suicidal or intrusive thoughts, depression, and anxiety. These medications are enhanced when combined with psychosocial interventions. All participants in this study experienced sleepless nights due to their trauma. Statements from P3 and P6 stated equally:

There were several instances, but specifically, it was when my husband (or another family member) noticed me sitting in my room for hours, not talking to anyone, which prompted me to get assistance. I could not sleep at night; I was having nightmares. After seeing my doctor, I was prescribed sleeping pills.

Similarly, P8 mentioned:

My sister, specifically, told me I needed to get aid. It was not easy for me. I get nightmares, I cannot function at work, and I do not like to be around people. I was prescribed antidepressants and sleeping pills to help me sleep at night. Both keep me functional.

Also, P4 cited:

There were several instances, but specifically, it was when my husband noticed me sitting alone in my room for hours and not talking to me anymore, which

prompted me to get aid. My primary provider prescribed me an antidepressant and a sleeping medication. We had to adjust my meds several times as certain dosages made me feel worse. However, we finally got the right dosage, and I am doing a lot better.

Participants described how awareness of their support systems helped them seek care and how medication management supported their treatment. They reported that medications often reduced core symptoms (sleep problems, anxiety, mood symptoms), which made it easier to engage in therapy. Effective medication management included monitoring side effects, adjusting dosages over time, and close coordination between primary care and mental-health providers to manage drug interactions and overall health.

Theme 4: Gender Treatment Differences

This theme addressed gender differences in treatment, showing how men and women received different care for trauma when seeking assistance from the VA. There is only one subtheme associated with this theme: differential treatment (Table 5). Tailored health care and services were provided to both men and women who experienced trauma that addressed distinct needs or experiences. Men veterans' treatment was tailored to combat-exposure or threat-based situations, whereas women veterans' treatment was tailored to MST, childcare and safety concerns, peer mentorship from other women, and screening for reproductive or gender-specific health needs. When discussing the treatment for men vs. women, it was evident that several participants discussed a specific program for only men, which was named "Warrior Transition Unit." P1 stated:

There is a program for men, like the Warrior Transition Unit, and for women, they have a survival military sexual trauma group. So, um, it is different from the men. They both required support from the healthcare practitioner. For women, the practitioner took their time, teaching us how to address our issues, unlike what they instruct men.

Equally, P2 mentioned, “For men, support focused on combat-related issues, and they received counseling through the Warrior Transition Unit. For women, we were offered counseling and therapy, especially if it was related to MST.”

Another female soldier, P4, confirmed:

Generally, women have an advantage in terms of receiving support in the military compared to men. The women may get more services that support them, like childcare services and mentorship, while the men may only receive treatment related to PTSD or combat-related issues.

In contrast to P2, P3, and P4, all other participants felt there were no major differences between the men and women and that men would receive better treatment anyway because they were men. This is evident when P5 stated, “There were many differences between men and women. Men were superior. Our high officials are all male soldiers; what they say goes, and they receive better treatment.”

Equally, P7 said,

“I cannot really say if there were differences, but I feel like men and women were treated the same because we were all in the military. However, I thought that women should have been treated more softly due to our issues, but we were not.”

Confirmed by P11, “I probably ignored the differences, but men always had the upper hand. It was a man’s world in the military.”

Participants reported two perspectives on gender and military trauma care. Some described VA services as adapted by gender to address different trauma experiences and service barriers, while others felt no real difference, stating that men historically received preferential treatment. In practice, programs were often gender-differentiated, where women received MST-focused support groups, while historically male-oriented services like combat-rehab units remained common.

Theme 5: VA Benefit Process

In this theme, the VA benefit process is captured to understand the reason for seeking benefits for MST, the requirements of the VA in the process of applying for VA benefits, and the decision on the application status. There were five subthemes associated with this theme: financial support, injustice or entitlement, medical records documentation, witness statements, and benefit ratings (Table 6). Getting a favorable VA decision usually means the veteran’s reasons for applying and the documents they provide must meet the VA's requirements for proof. When records were missing or the women veterans did not report what happened, the VA had to rely on other evidence, such as statements from friends/family or later medical notes. That makes claims harder to prove and can slow the decision.

Subtheme 1: Financial Support

In this subtheme, women veterans applied for disability compensation primarily for financial support. Veterans often applied for benefits to pay for housing, education,

medical care, and everyday living expenses. When benefits were denied, or the payment is too small, money worries push them to appeal or try again. According to P2:

The VA supported and motivated me to seek benefits. It was during a primary care visit that they noticed my difficulty thinking and keeping a job since leaving the military. They suggested disability compensation would be the best source of financial support.

P4 mentioned that “I decided to apply for benefits after retirement because I had flashbacks of horrible days, and I needed advancement and compensation for everyday living.”

Similarly, P7 stated:

There was no specific situation that made me realize I needed to seek benefits, but it was time to get support because I needed assistance financially. I could not focus on simple tasks day to day. It was affecting my life.

Overall, the participants in this subtheme had both practical and long-term needs. Disability compensation would provide monthly revenue to cover daily expenses (rent or mortgage, utilities, food, and other living expenses) to stabilize their household since their mental health condition limited them by not being able to get a job or focus on a job. Because money and access to services directly affect day-to-day survival, financial need is a strong motivator for filing an initial claim.

Subtheme 2: Injustice or Entitlement

Under this subtheme, participants defined their claims as seeking the opportunity to correct an injustice or to recognize an entitlement to compensation. Doing so reflected

their need to be believed and cleared of blame, and they wanted the VA to take responsibility for the harm that happened during their service in the military and cause for their current mental health condition, MST-related PTSD. Participants summarized that “the need for moral vindication shaped both how they presented their experiences and how long they fought for benefits.” This drive influenced how veterans interacted with the VA and clinicians. This made women veterans push harder to give more details and restate their trauma again (which could be painful) and apply for disability benefits. P5 mentioned, “I saw the injustice in the military (especially for women) and how women were treated, so that prompted me to seek benefits. I was tired of how women were treated, and they owed it to me to make it right. I was denied several times, but I kept fighting until I received 80% rating.”

Contrary to P5, P6 mentioned:

Others thought people applying felt entitled, but for me, I really needed the support. While I did not like how we were treated in the military, I felt the need to seek benefits because it was a part of my benefits as a soldier.

These participants offered a different perspective on the need for disability compensation as a given right, having served in the U.S. Armed Forces. The benefits for military service members include education and training, healthcare, mental health, and rehabilitation services (PTSD treatment, counseling), long-term insurance, legal protections and advocacy resources, family support, and childcare programs, transition assistance (such as job placement), and VA disability compensation and pensions for VA service-connected conditions.

Subtheme 3: Medical Records Documentation

Under this subtheme, medical record documentation captures the requirements of the VA process for applying for benefits and the evidence needed to justify disability compensation. Medical evidence for the VA, which included VA and civilian treatment notes, mental health diagnoses, and documented symptoms, was central to proving both the existence and ongoing impact of MST-related conditions like PTSD or depression. Gaps in documentation, overdue treatment, or records lost during service would delay the claims process when applying for disability compensation. This is evident in several participants in this study. For instance, P2 stated:

When I applied for VA compensation, I was initially denied due to a lack of medical evidence. I did not know why it was like that, but after they denied it, I had to go back again, because I really needed the compensation. I told myself I was going to gather more medical history as evidence, then bring it to them to see if they would accept it.

Subsequently, P4 stated;

The entire process of applying for disability compensation is unsettling. I submitted a disability claim that required me to provide substantial evidence. I was denied, and I was shocked. How was I going to feed my family if I could not function in the military and had to get out?

Furthermore, P5 mentioned;

“I was rejected because I did not submit enough evidence. They wanted to know about behavioral changes, my medical reports, and statements from family and

friends. I did not see a physician immediately after the rape happened. It was not until I left the military that the VA questioned me. Currently, I am appealing to the application and am hopeful of a good rating to receive compensation. But getting the evidence and telling the story were both very, very, very, very difficult.”

In addition to providing medical information, P9 stated, “First, they have to confirm your eligibility. Then, you must start gathering all your documents, such as your DD-214, driver’s license, a utility bill confirming your name on the housing bill, and proof of the MST. Next, you will go for an interview, or they will call you.”

Additionally, P10 said, “They asked for my driver’s license, my DD-214, and proof of documented MST-related PTSD. Although I had everything I needed, I was still denied because I uploaded the incorrect paperwork.”

According to P1:

When I applied for VA compensation, I was initially denied for lack of medical evidence. I did not know why it was like that, but after they denied it, I had to go back again, because I really needed the compensation. I told myself I would gather more medical history as evidence, then bring it to them to see if they would accept it.

Per P11, who stated:

The hardest evidence to gather was the sexual incident documentation. I had no record of it. You do not know you are going to get raped, so there is no evidence. This information gap made it hard to prove it was service-connected.

The participants had to provide medical records from the VA and civilian providers, as it was a significant piece of evidence when applying for disability compensation, especially for MST-related PTSD. Clear, consistent medical documentation makes it much easier for the VA approvers to link the claimed in-service event to current disability. When records are incomplete, missing, or delayed, it breaks that chain of evidence. If women veterans did not seek care right after the incident, later treatment can still support the claim, but it may raise questions about how the condition began and whether it was service-connected.

Subtheme 4: Witness Statements

Under this subtheme, witness statements also captured the requirements needed when applying for VA disability compensation. Just as medical records, witness statements played a vital role in documentation. When official records were unavailable, statements from fellow service members, family, or others who witnessed what happened or noticed changes in the veteran's behavior were used instead. The details, credibility, and consistency of these statements strongly influenced the VA's decision when rating the women veterans for disability compensation. However, it affects women veterans, as they may not have shared some details with their witnesses. This made it very difficult to use as proof. This is evident by P3 stating, "First and foremost, not everyone knew I had been assaulted, so opening up about it was not easy. Obtaining witness statements as evidence from family and friends was the most challenging, but I had to do it."

Additionally, P4 stated, “I had almost all the documents, except for witness statements, like proof from others. That was probably the only difficult thing, especially since I had not shared it with many people. Only my sister.”

P7 mentioned that, in addition to providing medical record documentation:

The challenge was providing personal evidence and documents about the assault because I did not go to a military doctor. I had to gather witness statements from friends, family members, and peers. This was quite humiliating because I had to share it with people that I did not want to know. But it was the only way to get the application in with all the required information.

Also, P7 stated, “Also, I had to provide documentation on my therapy sessions, and when I found them, it triggered me all over again. I had teared up every night, and I was afraid of reliving it all over again.”

Last, P6 stated, “Finding witnesses was the most challenging aspect to gather because no one else was present when it happened. I felt like they thought I was lying, but I was not.”

Overall, the participants explained that witness statements are needed to fill gaps when official records are missing or incomplete. For women veterans reporting MST, these statements would provide independent confirmation of the incident and establish the veteran’s credibility. Witness statements also reinforce medical documentation by recording observed symptoms, behavioral changes, and the event timeline. When an initial claim is denied or appealed, newly collected, or more detailed witness accounts

can provide clearer, corroborating evidence of what happened and how it affected the veteran, improving the chances of a successful decision.

Subtheme 5: Benefit Rating

Under this subtheme, the outcome of the VA compensation rating application is highlighted. Of the 11 participants in this study, 8 received denials on the initial application, and 3 received approvals. Ratings determined compensation levels and are based on severity and functional impairment. Veterans can dispute ratings by submitting supplemental evidence or appealing when ratings do not reflect symptom severity. Ratings also affect eligibility for supplementary benefits, such as Special Monthly Compensation (SMC), an extra tax-free payment for severe disabilities, loss of use, or the need for aid and assistance. The VA ratings quantify disability severity and determine compensation amounts. Disputes are common, and veterans can contest a low rating by submitting additional medical evidence or appeal arguments. P1 shared, "At first, my application was denied, but when I appealed, it was approved on my second try." Since I only provided documentation regarding the assault, they asked me to submit further information about my medical history and witness statements."

P5 stated:

I was really sad about the denial, like why would I lie about being sexually assaulted, but I appealed and was interviewed about the incident. It was like they needed to read my nonverbal cues or something to see if I was lying.

Like P2, P3, P4, and P10 all applied initially and were denied; however, they all reapplied. P10 mentioned, "I applied twice and got denied. I lost hope because I did not understand why I did not get approval the first time."

Additionally, P6, P10, and P11 were initially denied but subsequently appealed the rating decision.

However, P11 stated:

Although my request was initially rejected, I submitted an appeal. They said it was deferred. Since they used the word deferred, I was not qualified or something like that. When I read my denial rating, it stated I needed my psychological evaluation to be higher to qualify for PTSD. It made me feel sad because I was so close, as I received a high rating, like 65%, but I had to have another psychological evaluation to get a higher rating. Getting a 100% rating from the VA can lead to higher pay and better benefits.

Yet P7, P8, and P9 all received approval on the first try. The difference between these participants and those who received an initial denial was either being a high-ranked officer or knowing the process of someone who had been through it before. This is evident when P7 stated, "I was accepted on the first submission. I was excited because, as an Officer, I knew what to provide to the VA for approval."

As for P8 and P9, they both knew someone who applied before they did and informed them of what to provide to the VA for approval. P8 stated, "My sister had a friend who went through the process before me. Since my sister's friend told me everything about it, I was pretty prepared." While P9 stated that:

I was approved for the first time. I am not sure how, but I was eligible and reviewed all the documents needed to apply. The application does tell you everything you need to provide, but depending on your situation, you may not have all they need. I provided all medical records, therapy records, including a Nexus letter (medical documentation from a qualified healthcare professional), witness statements, and police reports. I had all the proof they needed due to having MST-related PTSD, so I was happy with the final rating.

Analysis of these statements shows that veterans' claims require stories supported by documentation that meets VA standards—such as medical diagnoses, evidence of events, and clear causal explanations. Gathering supporting materials like witness statements and nexus opinions adds complexity and emotional strain, especially for those with trauma histories, but they are necessary as the burden of proof. Accurate ratings are essential, as they determine both income and access to services, making precise documentation of limitations vital.

Theme 6: VA Benefit Application Improvements

In this theme, future recommendations include requirements to support veterans in successfully applying for and receiving VA MST benefits. There were four subthemes associated with this theme: online guide or portal, accessible support, AI toolkits, and a digital checklist (Table 7). Altogether, these recommendations were meant to support more veterans to win their claims, make it less painful to recount experiences that can be retraumatizing, and make it easier to follow the process when applying, especially for people without service records or who were afraid to report what happened. Suggestions

include straightforward, trauma-informed guidelines about eligibility and required paperwork, along with simpler methods for submitting and monitoring those documents. Also, having ready access to trained VA representatives, such as a claim processor or case manager, helps gather records and prepare statements.

Subtheme 1: Online Guide or Portal

Under this subtheme, a centralized portal with digital access to support key documentation is highlighted. Centralizing records would make it easier for women veterans or their witnesses to find and submit required evidence without having to search through multiple offices or paper files. Additionally, it reduces delays caused by lost, duplicated, or hard-to-locate records, speeding up the decision process, as evidenced by P4, who stated:

It should automatically generate a list of items to upload to an online portal and provide immediate feedback on what is missing. This way, you will proceed to the next step without having to wait to be informed that you were missing something.

Similarly, P11 mentioned:

A guideline to help people fill out the form, as I did not know what I needed to provide, would be helpful. An online platform could provide detailed information on how to apply and what is required, minimizing back-and-forth with the VA on appeals.

Unlike those who were denied, participants who were approved on their first attempt also highlighted how helpful online information and guides would be in

simplifying the process. This is evident when P9 mentioned, “The application process went smoothly for me. But having more awareness online and providing an online portal for veterans to place all information in one location when they apply would be easier.”

However, P7 suggested that “Because we have to supply a lot of information from our medical records, they should connect the application to the VA EHR, so it's automatically imported.” Integrating women veterans' medical records into the application process would provide a cohesive view of their medical history.

Participants in this theme described specific needs for a secure, easy-to-use online portal to store, locate, and manage key documents related to MST claims. They said the portal should hold all the information needed for a claim in one place. They expected these features to reduce delays, especially by avoiding duplicate requests, enabling faster evidence assembly for initial claims or appeals, and reducing the frequency with which survivors must retell traumatic events. Finally, participants noted that the portal should be paired with human support and clear guidance so that technology can aid with the process.

Subtheme 2: Accessible Support

Under this subtheme, the need for accessible, easy-to-access support to help veterans gather and use VA benefits documentation is emphasized. Easy access to trained VA claims representatives, case managers, or mental health clinicians can assist women veterans in gathering evidence by coaching them through interviews or accompanying them through the appeals process.

P1 stated:

They should be able to provide accessible support for people. There were times when I was confused about what they were asking, and if someone had been available to ask questions, I could have figured out what they needed. Even a bot would have helped out.

P2 mentioned:

Some steps to simplify those applications: a form for what you need, issued before a letter of denial. The form could provide guidance on how to apply for what you need, so people know in advance what they need and avoid delaying the process. If there were a VA representative available during the application process to call and ask questions, it would help us.

However, P6 stated, “online communities are great resources that can benefit women, especially like SWAN, when filling out the application. Having someone guide you along the way alleviates the traumatic episodes while completing the application.”

P10 had an interesting thought for assistance, and she stated, “I think physical centers where people can apply and ask questions before applying would be really great. You can get immediate support and assistance instantly.”

Reviewing participant feedback showed that offering multiple ways to get relief makes the disability compensation application process easier for women veterans. This means providing phone support, video calls, in-person meetings, secure chat, and email so people can choose what works best for them. Offering multiple channels of assistance and desirable times can reduce missed deadlines, lower barriers for those with childcare

or work constraints, and support veterans who are uncomfortable with digital tools or who find it too painful to repeat their story in person.

Subtheme 3: AI Toolkits

Under this subtheme, the impact of advanced technology on rating decisions and on navigating the application process is highlighted. Secure online systems can quickly gather service records, medical notes, and witness statements, so claim reviewers see the full picture sooner to provide a rating for disability compensation. AI tools can spot missing papers, gather medical histories, create timelines, flag inconsistencies or gaps, and help claim reviewers make clearer, fairer decisions. P10 was the primary participant who mentioned the use of advanced technology, stating, “AI tools can assist people with navigating the online world more effectively.” While the other participants felt a human factor was needed to ensure efficiency and consistency in the application process. They felt AI would assist the claim approvers more than the veteran. Overall, using automated tools can speed things up, but also cause problems, as P7, who was approved the first time, stated:

First of all, for anyone who has been involved in trauma, it is essential to take charge of your situation by getting some support. Trauma is a lot to deal with, and you will need to work through it. You must understand the application, provide as much information as you can, and, if needed, overshare your interviews with the physician to ensure you get approved the first time. You have to ensure there are no gaps in therapy or in seeking help.

Also, P7 mentioned:

As an officer, I knew what was needed because I had assisted others. However, better guides can be offered to women who suffer from MST to ensure they get approved the first time and do not delay the process for compensation.

Participants emphasized the need for a strong online presence and digital tools, noting that AI toolkits could provide secure software to help veterans and staff prepare, organize, and review evidence for MST claims. They described AI toolkits as capable of automatically sorting and tagging records, making claim preparation faster and more complete. At the same time, participants said that current VA chatbots and virtual agents are useful for answering common questions and guiding users, but stressed that they are not replacements for the human decision-makers who evaluate claims. They noted that the VA is piloting and using automated and AI systems for parts of claims processing and customer service, but these tools are not yet widely available for end-to-end claim development or final determinations.

Participants stated that relying too much on poor automation can cut out needed human review, repeat mistakes, or introduce bias into the records, and hurt people applying for benefits. They think AI can assist, but only as a tool that supports privacy protections, which requires human checks and has clear limits on what AI can do.

Subtheme 4: Digital Checklists

Under this subtheme, a checklist is needed to guide completion of an online application. Such a checklist reduces missed items, delays, and repeated disclosures, improves veterans' ability to submit stronger claims the first time, and makes the online process less overwhelming. The benefit of an interactive online electronic checklist that

guides veterans through each step of the VA disability application is that it reduces emotional burden by organizing the process and minimizing the need to retell it. In addition to providing an online portal, P4 also stated, “A digitalized checklist would be great for people like us that tend to get confused, maybe along with a visual or audio guide, so we do not have to keep retelling the same story over and over again.”

Additionally, she mentioned:

Veterans need to be taken care of because some of them have a lot of trauma from being in the military. Most are not mentally cared for. More are afraid to ask for support, but they need a good support system, like the right friends around to help them get through things.

Participants felt that online sessions for people who have served in the military, regardless of service, and a digital checklist of what is needed before applying for a disability claim would benefit applicants seeking VA disability compensation. P5 stated:

Create a community to support one another and address their issues, learn how to access available support, and take the steps needed to apply for a disability claim using a digital checklist.

However, other participants believed that an online portal could assist and also felt that a digital checklist would be beneficial. P9 stated,

I believe they could provide a digital checklist of all information needed at the time of the application. I had to go back several years to provide them with details. A more digitalized online checklist will guide you through each question, making the process faster and increasing the likelihood of a favorable rating.

Participants agreed that a digital checklist would guide veterans through MST claims by listing required documents, steps, and deadlines, and by enabling secure sharing with VA claim reviewers. Benefits include fewer missing or incorrectly submitted items, faster processing, less emotional strain from repeated retelling, and better-coordinated, more complete evidence packaging, making claims easier to prepare and increasing the chance of a favorable decision.

Summary

In this chapter, I described the study setting, participant demographics, and the data collection process. I then explained the data analysis methods in detail and presented the study findings. These results are important in answering the research question of the study as they provide insights and more information to understand the experiences of women veterans with MST-related PTSD seeking VA disability compensation.

This chapter presented six themes detailing women veterans' experiences applying for VA disability benefits for MST-related PTSD. The themes described service-time conditions that shaped exposure and reporting, the range of coping strategies veterans used after service, their experiences with diagnosis and clinical care, how gender influenced recognition and treatment, the specific steps and hurdles of the VA application process, and veterans' suggestions for improvement. Together, these themes showed how military experiences, post-service coping, clinical interactions, gendered dynamics, and bureaucratic procedures interacted to influence whether and how veterans pursued and obtained benefits. They also identified concrete targets for policy and practice change with clearer evidence pathways and better support during the claims process. In Chapter

5, I interpret these findings in relation to existing research, outline the study's limitations, and offer recommendations and implications for clinical practice, VA policy, and future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this generic, basic qualitative study was to explore the experiences of women veterans applying for disability compensation for MST-related PTSD. In this study, I documented women veterans' experiences during the VA compensation application process and provided detailed information for prospective applicants. Using semistructured interviews with 11 participants and thematic analysis (Braun & Clarke, 2006), I identified key challenges in the application process and their effects on veterans' well-being and recovery, and recommended changes to make benefits easier to obtain and to cover more needs.

The analysis yielded six themes, 21 sub-themes, and 155 codes. The themes included military challenges, coping mechanisms, MST treatment, gender treatment differences, VA benefit process, and VA benefit application improvements. These themes described women veterans' experiences applying for VA disability compensation for MST-related PTSD. Participants reported military barriers that harmed their well-being; experiences, interactions, and bureaucratic obstacles influenced how they obtained assistance and benefits, highlighting the need for cultural and systemic change. They also reported low awareness of, and limited access to, services and resources tailored to their needs.

Within this chapter, I present a detailed interpretation of the study's findings, explaining how the themes, subthemes, and codes related to the research questions and to existing literature on MST-related PTSD and VA disability processes. Based on the

findings, I offered specific recommendations for VA administrators and policymakers designed to improve access, screening, clinical care, and the claims process for women veterans with MST-related PTSD. I also identified priorities for future research to fill gaps and test proposed interventions. Here, I concluded with a concise summary that synthesized the key findings, reinforced the call for targeted reforms, and reiterated the study's contribution to understanding and improving support for women veterans with MST-related PTSD.

Interpretation of the Findings

The feminist framework supports women veterans' experiences seeking VA disability compensation for MST-related PTSD and connects them to existing literature. Participants reported gender bias and discrimination during their military service that affected their self-image and relationships afterward, consistent with prior research on military sexual trauma and social and psychological effects. They faced many barriers to benefit-seeking and accessing resources, yet those who engaged in treatment generally reported improved coping behaviors, health management, employment, and social reintegration, aligning with evidence that appropriate therapies can support recovery. The interpretations are based on the six themes identified from the analyzed data, which include military challenges, coping mechanisms, MST treatment, gender treatment differences, the VA benefit process, and needed improvements to the VA application system, which together extend and reinforce current literature on barriers, treatment benefits, and policy implications for women MST survivors.

Interpretation of the Theory

Feminism served as the conceptual framework in Chapter 2 to examine gender inequality and sexual objectification; its core concepts inform the analysis of women veterans' experiences with MST-related PTSD and VA disability claims. Central constructs include equality and justice (the principle that women should have equal rights and access); patriarchy and power relations (how social systems privilege men and reproduce hierarchies); objectification and sexualization (the reduction of women's bodies and sexual autonomy to targets); institutional critique and structural change (the need for systemic reform); agency and empowerment (supporting survivors' autonomy and participation); and representation and leadership (increasing women's decision-making roles to address policy and service gaps). This framework promotes equal rights and fair treatment and guides efforts to improve healthcare, challenge harmful norms, build support networks, and address women's underrepresentation and everyday sexism.

Fraser (2017) characterized feminism as multidimensional, linking these constructs across successive waves. The first wave (late 19th–early 20th century during World I) focused on legal equality and suffrage, securing formal rights and removing legal barriers to civic and political participation. The second wave (1960s–1980s during World War II) expanded attention to patriarchy, workplace equality, and sexual objectification, and it fostered organizational responses such as the formation of NOW, which advanced legal protections against sexual harassment and reproductive-rights initiatives. The third wave (1990s–2000s, during the Gulf War) addressed the second wave's limitations by centering on diversity, identity, and intersectionality, showing that

discrimination is intersectional rather than merely additive (Crenshaw, 1989), and by prioritizing difference and representation. The current, fourth wave (2010s–present during Afghanistan and Iraq Wars) is characterized by digitally driven activism (e.g., #MeToo), which amplified survivor voices, increased public attention to sexual violence, and stimulated dialogue about consent, power, and institutional accountability.

Throughout these waves, feminism has consistently advocated for women’s control over their bodies and for greater equity in how women are treated (Sen, 2019).

Overall, feminist theory identifies the structural factors underlying the problems women veterans encounter when applying for VA disability compensation. Although women have served in increasingly official military roles since the early 20th century and in larger numbers on the frontlines by World War II, sexual harassment and assault remain persistent institutional problems. Feminist analysis shows how gender bias, sexism, and unequal power shape women’s military experiences and how institutions such as the VA can reproduce those inequities. Feminist advocacy legitimized MST as a serious issue and raised awareness of the need for trauma-informed care. Many participants reported that the VA’s evidentiary rules and claims processes make it harder for women to obtain benefits, indicating a need for policy reform and improved application procedures.

This section presents the study results in plain terms and compares them with earlier research on MST-related PTSD, treatment, and VA disability claims. I note where my findings agree with, extend, or differ from past studies and show how gaps in research and VA systems shape participants’ experiences. The goal was to place the

results in a broader context, recommend practical and policy changes, and identify topics for future research.

Theme 1: Military Challenges

Researchers noted that military challenges for women persist, tracing back to the 1991 Tailhook scandal, which fostered hostile attitudes toward women regarding sexual assault, harassment, and unequal career opportunities (D'Amico, 1998). While several participants identified that the military can be rewarding and sustainable for women, obstacles undermine their daily experiences and sustainability. Consistent with this history, women veterans in this study reported ongoing gender-based discrimination and marginalization, including limited support and representation, barriers to retention and advancement, and frequent sexual harassment. These combined factors increased stress, discouraged reporting, and reinforced feelings of isolation and helplessness. In response to mounting evidence of MST, the VA revised its policies after a VA study documented high rates of MST (VA Health Initiatives, 2004) to improve its attitudes and policies toward military women. Those revisions required routine MST screening in primary care and mental health settings with trauma-informed guidelines for PTSD and other comorbidities.

The findings showed high levels of reported pride in military service and generally positive service experiences among women veterans. However, experiences of MST, sexism, and limited representation diminished that enjoyment and created additional challenges. Each women veteran had varying needs, so tailored policies and services were necessary. MST affected their military service and was linked to physical,

psychological, and financial difficulties, with many veterans continuing to face challenges reintegrating into civilian life after discharge (Drake & Burgess Mundwiler, 2019). To respond effectively, the interventions needed should include routine trauma-informed screening, accessible and gender-sensitive clinical care, case management and benefits advocacy, peer support and vocational services, and policy changes to reduce administrative burdens and stigma.

Theme 2: Coping Mechanisms

Women participants reported receiving different treatment and support from men veterans, with services often focused on symptoms rather than trauma. Participants indicated that VA counseling validated emotions and taught emotion-regulation skills, while men treatment focused more on combat-related issues. Kintzle et al. (2015) noted that the VA emphasized symptom treatment over examining trauma impact. The NewGen review (U.S. Dept. of Veterans Affairs, 2015) assessed physical and mental outcomes and found coping supports (counseling, support groups, mentorship) but a lack of trauma-informed therapies. Differential treatment approaches reflected gendered assumptions about causes and expressions of PTSD, producing care that addressed immediate symptoms but often failed to target underlying trauma. The absence of trauma-informed interventions limited long-term recovery and reinforced reliance on nonclinical supports and coping strategies. Future policy and research should promote trauma-informed, gender-sensitive interventions within the VA, ensure parity in treatment focus across genders, and evaluate whether such changes improve recovery and functional outcomes for women veterans.

Social support from family, friends, and senior women service members was the primary factor associated with health improvements among women veterans with MST-related PTSD. Participants said listening, practical service, advocacy, and modeling coping strategies eased symptoms and encouraged benefit-seeking. Findings indicate that trauma-focused treatments developed for men could benefit women if adapted to address sexism and safety concerns. Research has linked systemic problems and lower claim-approval rates to negative perceptions of the VA (Kintzle et al., 2015), and the American Civil Liberties Union (2013) reported that these perceptions reduced VA service use, leading veterans to seek informal supports. Strengthening peer and family networks, expanding gender-sensitive, trauma-adapted treatments, and reforming claims processes could rebuild trust and increase VA service use.

Theme 3: MST Treatment

Women veterans pursued varied support for MST-related problems, and MST itself was not a compensable diagnosis. They had to demonstrate a related condition (usually depression or PTSD) to obtain VA disability benefits. Treatment approaches described in this study included therapy, coordinated/integrated health care (combined physical and mental services), and medication for MST-related PTSD (Nolo, 2016). Requiring a compensable diagnosis pushed veterans toward clinical pathways that produced medical records, therapy, integrated care, and pharmacotherapy, which aided both symptom management and claims evidence. Integrated care addresses comorbid physical and mental health needs, while medication often reduces acute symptoms enough to enable engagement in therapy. Future research and policy should support

integrated treatment models and documentation practices that both improve outcomes and strengthen veterans' evidence for disability claims.

The VA gets many PTSD claims from women veterans, but some claims are denied when the injury is not tied to combat. The Government Accountability Office (2014) has noted that counseling and medical care are the appropriate responses to sexual harassment complaints. To receive VA compensation, women veterans must demonstrate that they have a disability connected to their MST, typically by documenting a diagnosis like PTSD or major depression and showing it resulted from their military experience.

The participants in the study reported seeking support from the VA for depression and PTSD due to being sexually assaulted or harassed, which affected their ability to function in daily tasks and activities. However, the VA required evidence to support their depression or PTSD encounter to substantiate the need for compensation. Per the VA (2017), trauma-focused therapy produced favorable outcomes; all participants received therapy to cope with their symptoms, which entered their medical records and supported disability compensation claims. Also, the Government Accountability Office (2014) noted that sexual assault had to occur while they were in the military. Each person in this study was considered a veteran and was living in the civilian world. They had to provide medical records documentation to prove that the sexual encounters occurred during military service to validate their claim.

Integrated healthcare, including therapy and medication, supported symptom management and overall care for women veterans with MST-related PTSD. Participants received antidepressants, sleep agents, and antianxiety medications that relieved suicidal

ideation and improved sleep; all participants reported trauma-related sleeplessness that medications addressed. Koo & Maguen (2014) emphasized the importance of integrated physical and mental healthcare for improving quality of life. Combining psychotherapy with pharmacotherapy and coordinated medical care addressed both psychological symptoms (PTSD, anxiety, suicidal thoughts) and physical sequelae (sleep disruption, somatic complaints), producing more comprehensive symptom control than isolated treatments. Medication reduced acute distress and enabled engagement in therapy, while integrated care facilitated continuity, side-effect monitoring, and management of comorbid conditions. Future interventions and evaluations should prioritize integrated, coordinated treatment models (therapy + appropriate medications + primary care integration) to improve outcomes and quality of life for women veterans with MST-related PTSD.

Theme 4: Gender Treatment Differences

MST-related PTSD disability claims were granted at lower rates over time. Kimberling et al. (2007) documented declining grant rates. These declines reflected persistent evidentiary and procedural barriers—stigma, inadequate documentation, inconsistent nexus determinations, and adjudicator misunderstanding—that disproportionately affected MST survivors. Evidence showed MST-related PTSD treatment improved over time, but confusion and fear about filing (PTSD vs. MST-related PTSD) continued to reduce care-seeking. Haskell et al. (2010) linked gender differences in MST and treatment to initial claim approvals; in this study, 64% of

participants' initial ratings were denied, usually for lack of treatment records or other supporting evidence, and many subsequently appealed.

Due to the lack of treatment therapies for women veterans, evidence was often misrepresented because it addressed more of their depression and less of the actual assault or harassment. Men received approvals of their claims faster than women because combat-related PTSD was more significant. Not much has changed in the treatment differences between men and women since Sayer et al. (2014) first examined them. The study examined gender differences in VA disability compensation rates for PTSD. Findings indicated women veterans were less likely than men veterans to receive initial approval of disability claims when conditions were not attributed to combat exposure. Compared to this study, the initial claims are still being denied because the evidence did not support their condition, which is non-combat-related PTSD.

Theme 5: VA Benefit Process

The participants in this study reported mixed experiences applying for VA disability compensation benefits. This was evidenced by 64% of the participants receiving a denial on their first application submission, while the other 36% received an approval on their first try. From their experiences, the need for VA compensation contributed to their inability to perform daily tasks or activities and re-living the trauma with sleepless nights. Some even reported not being able to keep a job due to their traumatic symptoms and needing financial support.

The application process needed an overhaul to prevent women veterans from being delayed in receiving VA disability ratings due to a lack of knowledge, insufficient

evidence, or inadequate medical documentation. The American Civil Liberties Union (2013) noted that women veterans with MST-related PTSD experienced invisible wounds that affected them physically and mentally, impairing work, relationships, and quality of life. Existing literature on MST-related PTSD included only a few qualitative studies on outcomes of applying for disability compensation. The application process was described, with recommendations to integrate medical records for documentation and to upgrade submission technology to reduce delays and simplify applications.

Findings supported a favorable VA decision on the disability compensation application. Participants stated that if you do not know of a higher-ranking official to guide you through the process, be sure to meet the VA's minimum qualifications as proof. Missing information will automatically delay the process, and if there are gaps in the assault or harassment timeframe, fill them with supporting documentation. You must have a timeline of the encounter with no gaps. If so, explain or have someone to corroborate your story, such as statements from friends, colleagues, or family members. Documentation is key to the incident, and the effects it has had on your daily life and overall well-being are crucial to receiving an approval rating.

Theme 6: VA Benefit Application Improvements

The application process for VA disability compensation requires an overhaul. Historically, the judicial system did not review VA decisions on veterans until 1988. VA researchers (U.S. Department of Veterans Affairs, 2014) changed the process to include appeals, providing veterans with recourse for denied ratings. In their review, procedural aspects made it harder for women veterans than men veterans. Women who had MST-

related PTSD were provided a local VA coordinator and offered other treatment services to address the symptoms they were experiencing, but not the formal complaint of sexual harassment or assault.

The participants in this study reported that the application process needs a better tool to gather information, ensuring women veterans do not forget specific documentation or details the VA is looking for to approve the application. Doing so would support that application time and minimize delays. Several of the participants indicated that a digitalized checklist that provides each requirement would be helpful for gathering information and providing guidance along the way. The benefit of an interactive online checklist using AI tools would guide women veterans through each step of the application, assisting those who get confused and minimizing the need to retell the assault to someone over and over for clarity. This is evident from participants noting that a digitalized checklist would make the process faster, increase the likelihood of a favorable rating, and, most importantly, enable secure sharing with VA claim reviewers.

Limitations of the Study

Through this study, I illustrated aspects of women veterans' experiences when applying for VA disability compensation for MST-related PTSD. Nevertheless, several limitations may have affected the study's trustworthiness and validity. Most noticeable is the small sample size despite the targeted recruitment and efforts to maximize diversity among participants who met the dual criteria of veteran status and an MST-related PTSD diagnosis; the number of respondents was limited. This constraint reduces the study's representativeness of the broader population of U.S. women veterans with MST-related

PTSD seeking VA compensation and limits the generalizability (transferability) of the findings. A small sample also limits the range of validating evidence available to adjudicators and researchers. This limitation weakens the ability to characterize symptoms, severity, and the variety of claim experiences, all of which are central to establishing credibility in claims-based research.

As Marshall et al. (2013) noted, inadequate or poorly justified sample sizes pose threats to transferability and credibility because they make it difficult for readers to determine whether results apply in other contexts or are sufficiently robust. To lessen these limitations in future work, larger and purposively stratified samples, clearer justification of sample-size decisions (including procedures used to assess saturation or information power), and triangulation with documentary or clinical records would strengthen confidence in the conclusions.

Another important limitation is subjectivity. Participant self-reports of trauma and symptoms are central to understanding MST-related PTSD, yet they are inherently subjective and may be perceived as biased, inconsistent, or insufficiently detailed. That same subjectivity operates on the adjudicative side, where clinicians, C&P examiners, and adjudicators bring their own perspectives, training gaps, and framing choices to intake interviews and medical opinions. Poorly worded questions, inconsistent clinical interviewing, or cursory nexus statements can produce variable records that either understate symptom severity or fail to link current diagnoses to in-service MST. These reciprocal subjectivities pose multiple risks, including variability in how evidence is documented, differential weighting of lay testimony versus clinical findings, and a

greater likelihood of denial or under-compensation when statements are interpreted skeptically.

However, Braun and Clarke (2022) acknowledged subjectivity as both an inherent feature and a potential limitation of qualitative inquiry, and they recommend explicit strategies to manage and report on the influence of researchers to bolster trustworthiness. Key techniques included reflexivity (documenting the researcher's positionality and assumptions), triangulation (using multiple data sources, methods, or analysts), thick or rich description (detailed contextual reporting so readers can judge transferability), audit trails (clear records of decisions from raw data to final themes), and peer debriefing (independent review of methods and interpretations).

As noted in Chapter 4, member checking was planned to allow participants to review transcripts and preliminary interpretations. However, participants were unwilling or unable to complete this step. This omission affected the study's trustworthiness in two ways. First, the opportunity to verify factual details, clarify ambiguous statements, and confirm the researcher's interpretations was lost, increasing the risk that participant meanings were misrepresented or incompletely captured. Second, without participant feedback, the study relied more heavily on the researcher's analytic judgments, increasing concerns about interpretive bias and limiting external corroboration of the thematic findings.

Recommendations

The recommendations for future research were drawn from this study's strengths and weaknesses, as well as from existing work on women veterans applying for VA

disability benefits. Both our results and prior studies showed problems with MST screening, uneven access to women-focused care, and inconsistent treatment outcomes for MST-related PTSD. To address these problems, the study calls for rigorous VA research on MST screening and treatment to assess whether services are trauma-informed, clinically effective, and accessible. Such research should identify barriers to improved care and test solutions (for example, standardized screening tools, staff training, and expanded programs for women). Evidence from that research would have informed VA policies and services, making it easier for women veterans to obtain the care and benefits they need.

Specifically, a systematic evaluation of screening practices is needed to assess consistency, timing, and sensitivity across VA facilities. Further study is needed to examine when and how MST screening is offered (intake, primary care, mental-health visits, claims processing), whether standardized, validated instruments are used, and how screening results are documented and communicated. The VA (2015) recommends a trauma-informed approach, conducting screening in private, supportive settings to reduce re-traumatization and increase disclosure. Such evaluations can identify missed opportunities for disclosure, procedural barriers to accurate identification (e.g., inconsistent protocols, inadequate training, documentation gaps), and subgroups who are less likely to be identified, including by race/ethnicity, sexual orientation, service era, or rural/urban residence.

Recommended methods include facility-level audits, clinician and veteran surveys, chart reviews, and qualitative interviews with veterans and providers to

triangulate and validate findings. Outcomes of interest should include screening uptake, disclosure rates, time from disclosure to referral, and linkage to evidence-based MST-specific care (Proctor et al., 2013). Identifying these process failures will inform interventions, such as standardized screening protocols, provider training, documentation practices, and trauma-informed screening environments that can increase accurate identification and timely access to treatment and support.

Participants reported that societal and cultural factors shape benefit-seeking and access to resources for women veterans with MST-related PTSD. To investigate these dynamics, I recommend a generic, basic qualitative study that explicitly centers ethnicity and examines how cultural identity and related structural factors influence disclosure, treatment engagement, claims navigation, and outcomes. The sampling would be more purposeful, stratified recruitment to ensure representation of major racial/ethnic groups (e.g., Black/African American, Hispanic/Latina, Asian/Pacific Islander, Native American/Alaska Native, multiracial), with attention to intersectional factors (age, sexual orientation, service era, rank, rurality). The goal is to recruit enough participants in each group to reveal meaningful within-group variations and support valid cross-group comparisons, ensuring that diverse experiences are captured rather than assumed to be similar.

Implications

Results from this study have implications for individual veterans, community wellbeing, and the institutions that deliver human services. Clarifying how women veterans navigate VA claims and how providers perceive them can inform clinical

practice, claims adjudication, and outreach to improve access to care and benefits. The changes were designed to simplify veterans' access to care and benefits, ensure continuity of treatment, reduce stigma, and strengthen coordination between the VA and community services.

Improving how women veterans are identified, treated, and supported through the claims process, especially those with MST-related PTSD, yields clear, measurable benefits. Early detection and timely, evidence-based treatment reduce PTSD symptoms, depression, and substance use, and improve physical health. Effective care and stable compensation support veterans to keep jobs, maintain housing, repair relationships, and pursue education or training. Trauma-sensitive claims procedures lower stress and encourage engagement with services. Together, these changes reduce homelessness, unemployment, and suicide risk, cut emergency-service use and costs, and strengthen families and communities through greater economic and social participation.

Evidence also indicates that policy and system reforms could produce positive social change. Policy improvements can be guided to ensure fairer, trauma-informed claims processes and equitable access to evidence-based MST care. Tailoring services to gender-specific needs and explicitly addressing the social determinants of health (education, socioeconomic status, geographic access, and quality of care) will reduce disparities, improve outcomes, and promote a more inclusive VA system that supports long-term well-being for women veterans.

Conclusion

The study examined women veterans' experiences applying for VA disability compensation for MST-related PTSD to clarify barriers, procedural dynamics, and opportunities for policy and practice change. Using qualitative methods, the data documented how underreporting, evidentiary gaps, subjective adjudication, institutional bias, procedural complexity, and social determinants shape disclosure, treatment access, and claims outcomes. Participants reported re-traumatization within systems, inconsistent Compensation & Pension (C&P) practices, and structural obstacles that disproportionately affected marginalized subgroups.

Key contributions include empirical findings from the study. The analysis presents detailed, first-hand accounts of what women veterans experience when applying for VA disability, documenting the steps they take, the emotions they feel, and the decisions they make, and shows how denials, long delays, and missing documentation harm their lives. The study identified immediate barriers that hinder claim success, including inconsistent screening, incomplete or weak records, variability in examiner practices, and a lack of trauma-sensitive procedures. Finally, data indicated that sexual orientation, service era, and socioeconomic status intersect with gender to impede disclosure of MST, access to appropriate care, and receipt of benefits for some veterans. These patterns demonstrated the need for targeted outreach, culturally responsive screening, and policies that address these specific disadvantages.

Improving identification, treatment, and adjudication for women veterans with MST-related PTSD is both an ethical obligation and a practical opportunity to reduce

harm and close equity gaps. The study identified concrete failures, including sporadic screening, incomplete documentation, inconsistent examiner practices, and poor care coordination, that undermined outcomes. Priority actions included standardized, trauma-informed screening; improved training for clinicians and C&P examiners; streamlined, less re-traumatizing claims processes; and policies addressing social determinants that hinder access. With sustained funding and rigorous evaluation, the VA can convert procedural fairness into measurable gains in health, housing, employment, and community reintegration for women veterans. Doing nothing will cost lives and money; fixing these problems honors their service and restores dignity.

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Appendix A: Social Media Recruitment Flyer

Social Media Invitation



There is a new study about the VA application experiences of MST-PTSD women veterans who have sought disability compensation that could help other women veterans better understand their application process. For this study, you are invited to describe your experiences in the disability application process.

About the study:

- One 30- 45-minute interview will be audio recorded (no video recording).
- You will receive a \$25 Visa gift card as a thank you.
- To protect your privacy, the published study will not share any names or details identifying you.

Volunteers must meet these requirements:

- A veteran.
- A female.
- Diagnosed with MST-PTSD.
- Have previously sought professional help for MST-PTSD.
- Applied for VA disability compensation.

This interview is part of the doctoral study for Bridget Strong, PhD, at Walden University. The interviews will take place in June 2025.

Please email me privately at the flyer's email address to let me know if you are interested.

Appendix B: Interview Guide

Thank you, [State Name], for meeting with me today. I appreciate your willingness to participate in answering questions regarding your application experience applying for VA benefit compensation. Every story is unique, and there is no right or wrong answer to any of these questions. This is an opportunity to share your story, and I am interested in learning more about your experience.

It is acceptable to need a break or pause during our interview. If you would like to stop the interview at any time, please let me know, and we will do so.

Interview Questions:

To get started, let me tell you a little bit about myself. I come from a military family. My father was in the Army, my sister was in the Navy, my brother was in the Air Force, and my husband was in the Navy.

Demographics

- Tell me which military branch you served in (i.e., Army, Air Force, Navy, etc.).
- How old are you?
- What is your marital status?

Literature/Theory

- Describe your experience in the military. [**Feminism Theory**]
- In theory, feminists have made significant contributions to the fight for women's rights in the military. Describe any struggles you experienced in the [State military branch].
 - Explain how the VA resolved your struggles.

Themes: **Factors Contributing to the Treatment of MST**

- Can you describe your journey in seeking treatment for MST?
 - i. What specific factors or events influenced your decision to seek treatment?

 Gender Difference

- Have you observed differences in how male and female servicemembers receive support for mental health or other issues?
 - i. Can you provide specific examples of how the support received varies between male and female servicemembers?

 VA Benefits

- What motivated you to seek VA benefits after experiencing MST?
 - i. Were there any specific events or realizations that prompted you to take action and apply for these benefits?

 VA Application Process

- Can you describe the application process for VA benefits concerning MST? What challenges did you face?
 - i. What documentation or evidence did you find most difficult to gather during the application process?

 Results of VA Compensation

- Describe the results of your rating letter.

- i. What specific benefits and compensation were outlined in your rating letter, and how do you feel about those outcomes?

Improvements to the Application Process

- o In your opinion, what steps could be taken to simplify the application process for MST-related benefits?
 - i. Are there specific resources or tools (such as online platforms, checklists, or guides) that you believe would help applicants navigate the process more easily?

Closing question:

Wow, you have shared valuable information about the VA disability compensation application process. I genuinely appreciated the discussion and your story.

- Before we close the interview, is there anything else you want to share that we have not discussed that you feel will help support others seeking disability compensation?

Closing:

Thank you again for sharing your story with me. Your experiences could also help support others applying for disability compensation. Sometimes, memories can trigger powerful emotions. Remember that we provide all participants with information on helpful resources that may be needed, as part of your consent form.

My next step is emailing you a copy of the transcript for accuracy verification within 24-48 hours.