The Experience of Female Veterans’ Transitioning to Post—Active— Duty Health Care

Sarah A. Bradwisch

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Molloy College
Barbara H. Hagan School of Nursing
PhD in Nursing Program

The Experience of Female Veterans’ Transitioning to Post—Active—Duty—Health Care

A Dissertation

by

Sarah A. Browne Bradwisch

Submitted in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy
MOLLOY COLLEGE
THE BARBARA H. HAGAN SCHOOL OF NURSING

The dissertation of Sarah A. Browne Bradwisch
Entitled FEMALE VETERANS’ TRANSITIONING TO POST ACTIVE DUTY HEALTH CARE in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

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Date: March 6, 2019
Abstract

**Problem Statement:** Female veterans are growing in record numbers and are the fastest growing segment of the veteran population in the United States (U.S.). After discharge from the military, female veterans face a difficult challenge in finding quality, efficient, and gender-specific health care following active duty. The growing number of female veterans in the Department of Veterans Affairs (VA) health care facilities has highlighted gaps in access to care and quality of care for female veterans.

**Methodology:** Interpretive phenomenology was used to better understand the meaning of 11 U.S. female veterans’ experiences. Semi-structured telephone interviews and the analytic approach of Martin Heidegger (1962) permitted the exploration of contextual aspects of participants’ lives and the in-depth meaning of their experiences.

**Results:** The results of this study reflect the needed areas for further health education and the advice from the participants for all female veterans to be advocates for themselves when attaining health care following active duty. The findings in this study have important implications for women’s health care providers and policy makers within both the VA and civilian health care systems related to screening, barriers to care and knowledge deficits of female veterans on how to attain post—active—duty health care.

**Conclusions:** The females in this study had varied reintegration experiences to both the VA and the American medical system. Although the VA offers a variety of services for transitioning veterans, this study promotes additional specific health programs before and after transitioning out of the military.
Dedication

To my father, Francis Thomas Browne,

My hero who inspired me to become a part of something bigger than myself.

I love you and miss you but carry you daily in my heart. Forever young in the town I love so well. Until we meet again, may God hold you in the palm of His hand.
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“Courage, sacrifice, determination, commitment, toughness, heart, talent, guts. That’s what little girls are made of.” — Bethany Hamilton

First and foremost, I want to give thanks to all the women who so valiantly served in the U.S. Armed Forces. It is because of you that I strive to be more than I ever thought was possible.

I would like to extend my sincere gratitude to Dr. Veronica Feeg, Associate Dean and Director of the Ph.D. nursing program at Molloy College. You believed in me from the very beginning of this process. You encouraged me and inspired me to recognize my military service and you enabled me to be a part of Jonas Philanthropy. I will proudly carry my Jonas Veterans Scholar honor and work diligently to make you proud, as you are my inspiration and I am humbly forever grateful.

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I want to sincerely thank Dr. Margaret Whelan as you have been there as my advisor since Day One of this program. You motivated me to uncover memories rooted deep in my heart and I will always be grateful for the diligence and the time you gave of yourself to help me accomplish my dream.

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To Genevieve, Rudd, Robert, Reilly, Mary and Annie, you light up my life and keep me smiling. Looking forward to many future adventures.

To my husband Troy, you are my sun, my stars, my rock, and foundation. Thank you for understanding my absence, and I look forward to many more memories to come. Forever love.

To my son Connor, my future Navy man, I am so proud of you and love you very much. I am so grateful for all your support and the young man you have become. I will miss you my Okinawa baby, but know you will be fulfilling your intended destiny. Fair winds and following seas.

My little girl, Amazing Grace Anna, when you dance, the heavens smile. I love you so very much and am so proud of all your dedication and hard work toward your studies. Never stop smiling, my beautiful girl. Mommy is back!
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Chapter 1: Introduction

Women have served in every military conflict in the history of the United States (U.S.), starting with the Revolutionary War. Women constitute 15% of U.S. active military forces and 19% of reserve units. There are currently 21.5 female veterans who have served in the U.S. military (Center for Women Veterans, 2016). Within the female population of veterans, there are unique stressors and threats that impact their health during and after leaving active duty. These stressors include but are not limited to: gender differences in combat, post-traumatic stress disorder (PTSD), sexual assault, interpersonal stressors, reproductive and gynecological health, and the homecoming readjustment period (VA, 2015a).

Approximately a half million female veterans returning from Afghanistan and Iraq have enrolled in the Veteran’s Administration (VA) health care system and are seeking medical care from providers that may not have adequate resources to deliver the care that they need (VA, 2015a). By 2015, women were eligible to serve in all military positions, including limited combat roles (U.S. Government Accountability Office, 2015). Female veterans may have faced life and death decisions while serving their country. Given that most empirical evidence is focused on male service members, women’s expanding roles in the military present both an opportunity and challenge to effectively capture how female veterans transition to health care outside the military (Street, Vogt, & Dutra, 2009).

During active-duty service, health care needs of women, as well as their family’s health care needs, are cared for by the military. However, once a military member transitions from active duty to civilian life, it is time to consider what health care they choose to receive. There are different options to consider for the female veteran when leaving active duty. Female veterans can receive life-long benefits from the military if they retire or have a service connected
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disability. These life-long benefits will allow them to be covered by the Transitional Assistant Management Program (TAMP) and Tricare, a health care program for uniformed service members, retirees, and their families around the world. If a female veteran has an injury or disability, she can be covered by the VA or TRICARE based on the coding of the disability or injury (Military Wallet, 2017). Females and males who have served in military conflicts can receive free medical care for any condition related to their service in the Iraq/Afghanistan operations for five years after the date of their discharge or release (VA, 2016c).

Female veterans have a decision to make about where to obtain health care following service to their country. Health insurance is a topic that most military members do not have to consider while on active duty. Following active duty, the Veterans Health Administration (VHA) and the American health care system are challenged with the delivery of quality health care to female veterans. In 2014, the VHA recognized that minimal services and a limited number of VHA providers with the necessary training and skills were available to deliver gender-specific care to women (VA, 2014). The VHA is faced with redesigning a healthcare system that accommodates women. To accomplish this goal, the VA has set forth policies to improve all aspects of primary care for female veterans (VHA Handbook, 2017).

Female veterans may choose, or be required to choose, a health care network outside the VA. Female veterans may have health care needs that differ from both male veterans and the general female population. For example, women veterans may need screening and treatment for specific issues that resulted from their service such as post-traumatic stress disorder (PTSD) and military sexual trauma (MST). Because many women veterans seek health care outside of the VA network, it is important that both their VA and non-VA care team members have the resources necessary to provide informed and comprehensive care (VA, 2017a).
Background

In 1983, women who served in the U.S. military had been referred to as “invisible veterans” because their service contributions went mostly unrecognized by politicians, the media, academia and the general public (Wilenz, 1983). In 1983, Congress granted veteran status to women who had served in the Women’s Army Auxiliary Corps (WAAC), starting with females who served in World War II. The early female pioneers in the military volunteered to wear the uniform, submit themselves to military rules, and risk their lives in service to their country, all without the same benefits and protections of the men with whom they served. Even though women have been officially serving in the military since the creation of the Army Nurse Corps in 1901, they have not always been considered qualified for veteran status in terms of receiving benefits from the Department of Veteran Affairs (VA, 2011).

Over the past 40 years, the VHA has introduced initiatives designed to improve health care access and quality of care for female veterans. In 2008, the VHA’s Women Veterans Health Strategic Health Care Group (WVHSHG) began a five-year plan to redesign the nation’s health care delivery system for women. A fundamental component of this plan was ensuring that all female veterans had access to comprehensive primary care from skilled women’s health providers. A major part of this redesign was identifying the need for detailed data on women veterans that could be used to inform policy and planning (Frayne et al., 2014).

In 2006, Washington, Yano, Simon, and Sun suggested from research that female veterans who did not enroll in VA health care following active duty were women who were not familiar with the VA medical system and lacked knowledge to access their benefits. Their research indicated that educational campaigns were needed to fill the knowledge gap regarding women veterans’ VA eligibility and advances in VA quality of care. Perceptions of poor VA
quality of care and inconvenience of VA care may have been preventing female veterans from accessing VA health care (Washington, Yano, Simon, & Sun, 2006). Female veterans who did not use the VHA sometimes assumed the VHA system did not offer women’s health care. In addition, female veterans reported lower in-patient quality in VHA than men reported, after adjustment for transitions, physical comfort, involvement of family and friends, courtesy coordination, and access (Wright et al., 2006). It is important to understand the unique needs and experiences of women veterans as improvement efforts are being implemented, in order to ensure access to high-quality, patient-centered care when they transition to civilian health care or veterans’ health care.

Since 2007, the VA has been working to improve female veterans’ access and care satisfaction by mandating gender-sensitive primary care for women. These improvements have included separate comprehensive women’s primary care clinics or a separate provider/team for women veterans within mixed-gender primary care clinics, the availability of mental health services within primary care for women, access to female chaperones for women-specific exams, and efficient access to gynecology care (Department of Veteran’s Affairs, 2010a).

Data collected prior to and following the mandate of gender-specific care demonstrated that disparities in women veterans’ care have been reduced (Whitehead, Czarnogorski, Wright, Hayes, & Haskell, 2014). However, variability in the implementation of the policy may have resulted in uneven access to needed services and satisfaction in care across facilities (Yano, Haskell, & Hayes, 2014). What is not known is the women’s report of their experiences in accessing the health care they need and their choices in selecting health care services in various areas of the U.S.

Timely access to healthcare for female veterans is essential to ensuring optimal health
outcomes. While the VA has made improved access a priority, women veterans still underutilize VA healthcare relative to men. Eliminating access disparities requires a better understanding of the barriers to care that women veteran’s experience. Continued efforts are warranted to improve women veterans' knowledge of availability and affordability of VA healthcare to enhance the gender-sensitivity of this care. Female veterans who have used the VHA have improved perception. However, knowledge gaps in attainment of health care, and poor perceptions of the VA, suggest the need for more education for female veterans who do not use the VHA (Washington, Kleimann, Michelini, Kleimann, & Canning, 2007).

When a female veteran transitions out of the military, she may experience a myriad of health conditions. There is a need to understand the process by which the female veteran experiences these transitions. While on active duty, female veterans are cared for by the U.S. government. Health care is provided to them regardless of rank or position. When returning home from active duty or deployment, there is a transition to civilian life, and with that transition comes the choice for adequate quality health care. Washington, Yano, Simon, and Sun (2006) reported that early perceptions of VHA care were considered poor by the female veteran population. This perception may have hindered female veterans from attaining health care in the VHA. Since the 2006 study, there have been no other studies that have focused on the perception of VA health care when women veterans are transitioning to civilian life. However, improvements in gender gaps and a decrease in quality care for female veterans have been reported by the VA (VA, 2012a). In 2012, the VA reported that the quality of veteran health care for women and men was similar. The report issued by the VA stated that the quality of health care women receive from the VA is considerably higher than the care offered in the private sector. Studies that used accepted process of care measures and intermediate outcomes measures,
such as control of blood pressure or hemoglobin A1c for quality measurements almost always found that the VA performed better than non-VA comparison groups (VA, 2012a). Since the 2012 report, the VA has continued to recognize the limitations to access of quality care for all female veterans (VA, 2017a).

After leaving the military, female veterans reside in all areas of the U.S. Rural areas may pose barriers to the veterans, including limited access to quality care and a knowledge deficit about receiving health care. As of a 2017 report, more than half of rural veterans enrolled in VA health care were 65 years or older. In addition, 6% of rural veterans were women and 9% reported being members of racial and ethnic minorities. Nearly 435,000 rural veterans reported being in military conflicts in Iraq and Afghanistan and 44% of rural veterans have one or more service-related disabilities. Rural veterans were noted to have lower average household incomes than other veterans. They often faced long driving distances to access quality health care. There were also fewer VA health care providers and nurses reported per capita in rural areas (VA, 2017d).

In 2017, the VA conducted health care inspections to evaluate the VHA’s standards and care for female veterans. The VHA has identified the limitations of quality health care to female veterans and has set forth on a mission to redesign a medical system that recognizes the unique health needs of female veterans. The VHA has recommended that the Acting Under Secretary of Health ensure that the Office of Women’s Health Services routinely reviews, and when appropriate, strengthens the requirement for women’s health providers (VHAH, 2017). Recent initiatives by the VHA include programs to provide comprehensive primary care, enhanced mental health services for women, and the creation of better education programs in women’s
health for physicians. The VA is also supporting a multifaceted research program on women’s health (VA, 2016a).

**Problem Statement**

The proportion of female service members and veterans is at its highest point in history, with projections for continued growth. As those active and reserve service members transition into veteran status, females make up the fastest growing cohort within the veteran community (VA, 2012b). As of a 2007 report, there were 1.8 million female veterans of the 22.2 million veterans in the U.S. (Department of Veterans Affairs, 2007). As the numbers of female veterans increase, the VA continues to prepare for their health care needs. Over the past decade alone, the number of female veterans in the VA health care system has nearly doubled. While the attention and effort to serve the female veteran population has been in place for decades, there have been renewed efforts to understand the current population dynamics and needs. Eligibility for VHA health care is not automatic. Basic eligibility is determined by types of service and discharge status (Women’s Veteran’s Report, 2017). Female veterans have numerous options for health care following their separation from active military duty. They may be able to attain VA health care (VHA) or Military Health Service (MHS) benefits if they retire. Some female veterans might choose to pursue health insurance through new employers or a spouse. In the case of a transition from MHS to VHA, female veterans still encounter a federal, military-oriented health care system, but one that supports a different mission and different health programs than those intended to equip active military members (Military Wallet, 2017). No matter what choice the female veteran decides upon, they are required to adapt to different norms when they leave the active duty military structure of required preventive screening, weight and fitness management, and prevention of certain health risk behaviors, such as smoking. Unlike the MHS, which has
programs and facilities to promote health and fitness for all military members and their families, the VHA has traditionally focused on the treatment of disease and illness among aging veterans. Both the MHS and the VHA have struggled with institutional stressors from the increase in female-oriented services needed to address women’s health care needs (Batuman et al., 2011). This study aimed to explore and understand the transitional process of the unique culture of female veterans and their experiences attaining health care following active-duty service to their country.

**Research Questions:**

The research question for this study was, “What is the lived experience of female veterans transitioning to post-active duty health care?” This study focused on female veterans who have been discharged from active duty between 1990 and 2017. Several probes or sub-questions helped the researcher gain an understanding of this phenomenon as follows:

- What were your experiences transitioning to post—active—duty health care?
  - What educational resources were you provided to transition to a health care system following active duty?
  - What supported or hampered your transition?
  - What would have helped you make a better transition?

- What have your experiences been attaining health care outside the military?
  - Have any military experiences affected your health since your discharge?
  - Have any health conditions affected your life since discharge from the service?

- How would you describe the culture of the health system in the military? (What was it like, and how did it affect you?)
How would you describe the culture of the health system where you are currently receiving care?

Is there anything else you would like to share about transitioning to post—active—duty healthcare?

Probes:

Think back to the time when you were discharged. What were your experiences of re-integrating back to family, friends and the civilian community?

Think of any physical, emotional, or even spiritual aspects of your journey from back then until now.

Describe any challenges you have faced since discharge related to your healthcare or that of your family.

What should nurses and healthcare providers be aware of when providing care to female veterans?

What health-related advice would you have for a woman about to be discharged related to her health?

Purpose of the Study

The purpose of this phenomenological study was to understand and explore the female veterans’ experience transitioning to health care following active duty in the U.S. military. In addition, the data collected may reflect the needed areas for further health education.

Significance of the Problem

Transitioning to health care presents many challenges to the female veteran including, but not limited to attainability, privacy issues, gender-specific care and perception and lack of knowledge of veteran health care benefits (VA, 2015b). Delivering comprehensive care to
female veterans has posed significant challenges in a system that has been predominated by men. The shortage of gynecologists in the VHA health system to provide gender-specific care has produced concerns within the female veteran community and has led female veterans to seek care outside the VA (VA, 2016d). All female veterans return home to a civilian culture unlike the military and are in need of health care. It is imperative that health care providers both in the civilian sector and VHA provide appropriate care measures and continue to improve health care for female veterans.

**Definition of Terms**

Most of the terms used in this study are either self-explanatory or defined within the body of the document. The following terms are used repeatedly in this research, so they are defined here:

*Gender differences in combat.* In 2016 females were given permission to serve in combat roles which include serving as Army Rangers, Green Berets, Navy SEALs, Marine Corps infantry, Air Force para-jumpers, and all roles that were only previously open to men (Rosenberg & Phillips, 2016).

*U.S. military discharge.* There are two types of military discharge, administrative and punitive. The majority of veterans receive administrative discharges: Honorable, General Under Honorable Conditions, and Other Than Honorable Discharge. Only a few veterans receive punitive discharges (Miller, 2015).

*Honorable discharge from U.S. military.* If a military service member received a good or excellent rating for their service time, by exceeding standards for performance and personal conduct, they will be discharged from the military honorably. An Honorable Military Discharge is a form of an administrative discharge (Military Wallet, 2017).
**General discharge from U.S. military.** A General military discharge is a form of administrative discharge. If a service member’s performance is satisfactory but the individual failed to meet all expectations of conduct for military members, the discharge is considered a General Discharge, Under Honorable Conditions. To receive a General Discharge from the military there has to be some form of non-judicial punishment to correct unacceptable military behavior or failure to meet military standards. The discharging officer must give the reason for the discharge in writing, and the military members must sign paperwork stating they understand the reason for their discharge. Veterans may not be eligible for certain veteran’s benefits under a General Discharge, including the GI Bill (Military Wallet, 2017).

**Other than honorable conditions discharge.** The most severe type of military administrative discharge is the Other Than Honorable Conditions. Some examples of actions that could lead to an Other Than Honorable Discharge include security violations, use of violence, conviction by a civilian court with a sentence including prison time, or being found guilty of adultery in a divorce hearing (this list is not definitive; these are only examples). In most cases, veterans who receive an Other Than Honorable Discharge cannot re-enlist in the Armed Forces or Military Reserves, except under very rare circumstances. Veteran’s benefits are not usually available to those discharged through this type of discharge (Military Wallet, 2017).

**Bad conduct discharge (BCD).** The Bad Conduct Discharge is only passed on to enlisted military members and is given by a court-martial due to punishment for bad conduct. A Bad Conduct Discharge is often preceded by time in a military prison. Virtually all veterans’ benefits are forfeited if discharged due to bad conduct (Military Wallet, 2017).

**Officer discharge.** Commissioned officers cannot receive Bad Conduct Discharges or a Dishonorable Discharge, nor can they be reduced in rank by a court-martial. If an officer is
discharged by a general court-martial, they receive a dismissal notice which is the same as a Dishonorable Discharge (Military Wallet, 2017).

**Entry-Level Separation (ELS).** If an individual leaves the military before completing at least 180 days of service, he or she receives an entry level separation status. This type of military discharge can happen for a variety of reasons (medical, administrative, etc.) and is neither good or bad, though in many cases, service of less than 180 days may prevent some people from being classified as a veteran for state and federal military benefits (Military Wallet, 2017).

**Coded Conclusion.** Coded conclusion is the section of a code-sheet of a rating decision that contains a summary of information on the status of benefits and all decided issues (Military Wallet, 2017).

**Military Transition Post-Active Duty.** A change in oneself and the world around that requires a change in behavior and relationships with others. The transitions related to events denoted as anticipated, unanticipated, and non-events (Wilson, 2015).

**Military Health Care System (MHS).** In 2014, the MHS was reported as providing preventive and medical services at 416 in-patient hospitals, medical centers, and ambulatory care clinics around the world to members of the United States Armed Services (U.S. Department of Defense, 2014).

**Operation Enduring Freedom (OEF).** This Operation refers to the U.S., led combat operation that supports the Global War on Terror (GWOT) active in Afghanistan, the Philippines, and parts of Africa. The operation was intended to bring stability to Afghanistan (Army, 2017).

**Operation New Dawn (OND).** This Operation marks the official removal of the name of Operation Iraqi Freedom. U.S. service members in Iraq conducted stability operations, focusing
on advising, assisting and training Iraqi Security Forces (ISF). It represents a shift from U.S. military presence to one that is civilian, as the Department of Defense and State Department work together with governmental and non-governmental agencies to help build Iraq’s civil capacity (Army, 2017).

**Operation Iraqi Freedom (OIF).** A protracted military conflict in Iraq that began in 2003 with an attack by a coalition of forces led by the U.S. and that resulted in the overthrow of Saddam Hussein's regime. US combat troops were withdrawn in 2010 (Operation Iraqi Freedom, 2011).

**Post Traumatic Stress Disorder.** This disorder is a mental health condition that is triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event. Any person who was exposed to death, threatened death, threatened serious injury or threatened sexual violence (Mayo Clinic, 2017; American Psychiatric Association, 2013).

**United States Military.** The United States military, also known as the United States Armed Forces, is composed of five branches: Army, Navy, Air Force, Marine Corps, and Coast Guard. It is also comprised of individuals who served honorably in the Uniformed Public Health Service (PHS), Uniformed Oceanic and Atmospheric Administration (NOAA), and Military Reserves within the classification of veterans (Department of Defense, 2016).

**Sexual assault.** Sexual assault is any type of sexual contact or behavior that occurs without the explicit consent of the recipient. The definition of sexual assault includes sexual activities as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape (Department of Justice, 2017).
Sexual harassment. Harassment that includes unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature. Both victim and the harasser can be either a woman or a man, and the victim and harasser can be the same sex (U.S. Equal Opportunity Employment Commission, 2018).

Military Sexual Trauma (MST). Military Sexual Trauma is the term used by the Department of Veterans Affairs (VA) to refer to experiences of sexual assault or repeated, threatening sexual harassment that a veteran experienced during his or her military service (Department of Justice, 2017).

Transitions. Transitions are triggered by critical events and changes in individuals or environments. The transition experience begins as soon as an event or change is anticipated. Human beings face many changes throughout their lifespan that trigger internal processes. (Meleis, 2010).

TRICARE. TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services, is a health care program of the United States Department of Defense Military Health System (Tricare, 2017).

The Transitional Assistance Management Program (TAMP). This program provides 180 days of premium-free transitional health care benefits after regular TRICARE benefits end (Tricare, 2017).

Veteran. A veteran is an individual who served on active duty for a period of more than 180 days and was discharged or released with other than a dishonorable discharge or was discharged or released because of a service-connected disability; or as a member of a reserve component under an order to active duty pursuant to section 672 (a), (d), or 673 (a) of title 10 U.S.C. served on active duty during a period of war or in a campaign or expedition for which a campaign badge is
authorized and was discharged or released from such duty with other than a dishonorable discharge (Government Printing Office, 2011).

**Veterans’ Health Administration** (VHA). This is the largest integrated health care system in the United States, providing care at 1,245 health care facilities, including 170 VA Medical Centers and 1,065 outpatient sites of care of varying complexity (VHA outpatient clinics), serving more than 9 million enrolled veterans each year (VA, 2016e).

**Veteran’s Administration** (VA). The VA is a partnership that divides a shared mission between three organizations: (1) The Veterans Health Administration (VHA), which manages one of the largest healthcare systems in the world; (2) The Veteran Benefits Administration (VBA), supplies compensation; (3) National Cemetery Administration (NCA), which provides veterans, their spouses and dependent children the eligibility to be buried in VA’s national cemeteries (VA, 2016e).

**Vietnam War.** A war that occurred in Vietnam, Laos, and Cambodia from November 1955 to April 1975. It was the second of the Indochina Wars and was officially fought between North Vietnam and the government of South Vietnam. The North Vietnamese Army was supported by communist allies and the South Vietnamese Army was supported by anti-communist allies, one being the U.S. (History, 2009).

**Theoretical Frameworks**

This study was guided by two theoretical frameworks. These were Madeleine Leininger’s (1991) Culture Care: Diversity and Universality Theory and Melies’s (2010) Transitions Theory. Madeleine Leininger indicated that culture care is the broadest holistic means by which a nurse can know, explain, interpret, and predict nursing care phenomena to guide nursing care practices (Leininger & McFarland, 2006). Culture care diversity refers to the differences in meanings,
values, or acceptable modes of care within or between different groups of people. Culture care universality refers to common care or similar meanings that are evident among many cultures. For example, the U.S. military places a strong emphasis on discipline and hierarchy. This unique culture uses specific rules and symbols to create a set of shared beliefs and values that are tied to important meanings. Military law requires those in authority to demonstrate virtue, honor, and patriotism. Such core values as courage, loyalty, and selflessness ensure that female veterans will take orders from those in command. Due to the intense shifting in behaviors that military life requires, transition into the VA health care system is often challenging and can seem unfamiliar (VA, Mental Health Tool Kit, 2017). By analyzing this cultural distinctiveness through the transcultural nursing perspective, the researcher aimed to explore and understand the health care transitional needs of the female veteran.

The second theoretical framework used in this study is Meleis’s (2010) Transitional Theory. This theory focuses on understanding the nature of and responses to change, facilitating the experience; responding to its different phases; and promoting health and well-being prior to, during and at the end of the change event (Meleis, 2010). This theory provided a framework that generated research questions and guided an understanding of care prior to, during, and after the transition.

Method

A phenomenological study design was used to explore the experience of females transitioning from military health care to post—active —duty health care. A sample of female veterans who were discharged from active duty between 1990 and 2017 was used to capture their transitional experiences in health care. Participants were recruited through purposive and snowball sampling techniques. Data were collected using interviews between the researcher and
each participant. A sample of 11 voluntary participants were interviewed sequentially and data was analyzed following each interview. The final number of 11 was determined when there was no new data being obtained and saturation was reached (Polit & Beck, 2017). 

**NVivo 12** was used to store and manage the data. Approval to conduct the study was obtained from Molloy College Institutional Review Board (IRB).

**Significance of the Study and Relevance to Nursing**

Care and caring are the central constructs of Leininger’s (1991) Culture Care Theory. Leininger (1991), posited that nursing is directed toward assisting, supporting, or enabling another individual with cultural care. The female veterans of the U.S. have experienced a unique culture while serving in the U.S. military. Female veterans have followed a hierarchy using a shared distinct language to create a shared set of beliefs and values that are tied to important meanings (VA, Mental Health Tool Kit, 2017). By utilizing and analyzing this cultural distinctiveness through the transcultural nursing perspective, the nurse caring for female veterans can better understand their health care needs related to being part of the military culture. This research emphasized the need to provide meaningful care that supports the health care needs of female veterans. This research may lead to insight into the transition of female veterans following active-duty service in the U.S. military.

**Chapter Summary**

This chapter provides a history of female veterans who have served in the U.S. military. The research questions used to interview the participants are presented to provide a comprehensive picture of the breadth and depth of this qualitative study. Definitions and terms that are unique to military culture are presented to expound upon the distinctiveness of the
language used in the U.S. military. The history presented will inform those who are unfamiliar with female service to the U.S. military. This researcher hopes to afford the reader the opportunity to see into the experiences of female veterans and understand the importance of their sacrifice. In the words of Maya Angelou (2012), “How important it is for us to recognize and celebrate our heroes and she-roses!”
Chapter 2: Literature Review

Introduction

Chapter 2 presents a critical evaluation of the current knowledge available about how female veterans transition to post—active—duty health care. To present a thorough picture of the phenomenon, this literature review explores studies regarding the health care of female veterans. The headings in this chapter are organized by topics to present a critical overview of the empirical evidence that adds to the body of literature on female veterans in the U.S. The headings are provided to synthesize findings across studies and compare and contrast different research outcomes, perspectives, and methods.

Transition and Reintegration to Civilian Life

Women are playing a larger role in the U.S. military than in previous generations, with increasing numbers of females having been deployed to Iraq and Afghanistan. Between October 2001 and December 2009, 154,545 women were deployed at least one time to Iraq or Afghanistan (Armed Forces Health Surveillance Center, 2011). This is in comparison to about 7,500 U.S. military women who served in Southeast Asia during the Vietnam War, with the majority of these women being military nurses (Bellafaire, 2012). In 2016, Defense Secretary Ashton Carter approved final plans from military service branches to open up all combat jobs to women (Howell, 2016). Prior to 2016, positions had been closed to women. Females have served as military police, convoy transportation, pilots, nurses, doctors, medics and mechanics (Street, Vogt, & Dutra, 2009). Serving in these positions have put females at risk for exposure to physical and psychological stressors.

Demers (2011), explored the experiences of 48 Iraq and Afghanistan War veterans to understand the challenges of reintegrating into civilian life and the impact on mental health. The
respondents completed preliminary electronic surveys and participated in one of six focus groups. High levels of distress were found to exist among veterans who were caught between post-discharge, feeling alienated from family and friends and experiencing a crisis of identity. Recommendations from that study included development of social support and transition groups; military cultural competence training for clinicians, social workers, and college counselors; and further research to identify paths for successful reintegration into civilian society (Demers, 2011).

In a qualitative descriptive study by Mattocks et al. (2013) themes from 19 Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) female veterans revealed that post-deployment reintegration problems included disrupted family relationships and the use of coping strategies when returning home from deployment. Findings from this study revealed that several female veterans noted the importance of connecting with other veterans to share their experiences. They also expressed a need to get together in person with other females who have served, similar to Veterans of Foreign Wars (VFW) or Veterans Service Organizations (VSOs) of previous war times. That study identified a need for female veterans to be able to make connections in their local communities or through the State Department of Veteran’s Affairs. The author described distinctions between negative and positive coping strategies that may yield better long-term outcomes and may be best promoted by post-deployment interventions specific to female veterans. Interventions to help female veterans navigate transition following post-war must occur at multiple levels, including the family, the individual, and the community. Interventions to assist female veterans must also occur at multiple institutions such as by both the VA and community- based providers. Appropriate reintegration coping strategies may increase the likelihood of healthy recovery from war-related stress (Mattocks, et al., 2013).
Gutierrez et al. (2013) conducted a qualitative descriptive study on female veterans’ deployment related experiences and potential suicide risks. Nineteen OIF/OEF female veterans were recruited to VA healthcare system in the Western U.S. Findings from this study found that female veterans were identifying loss of self-worth and grief following deployment. Combat experience which suggest that female veterans may find it very difficult to relate to and be understood by women without those life experiences. This may place them at an increased risk for feeling like they do not belong and make their transition to civilian life difficult. The results of this study suggest that generalizing from research conducted with mostly male service members and veterans may not provide the complete story (Gutierrez et al., 2013). It is necessary to learn from the unique experiences of women who have served in Iraq and Afghanistan to design more effective intervention and prevention strategies.

A descriptive qualitative study was conducted by Conard and Scott-Tilley (2013) that investigated the experiences of 12 female war veterans who served in the Gulf War. The study consisted of enlisted female participants who served in the Army, the Air Force, and the Marines. Elicited themes revealed that female veterans had a constant fear of being in harm's way. Seven sub themes found in this study were: living in constant fear while deployed, combat having different meanings, bringing the war home, fear of being forever changed, disrespect from fellow military members, better or worse for physical health, and rewarding experiences of combat.

Transitioning and reintegrating into civilian life for female veterans can also cause difficulty within the family dynamic. Kelly, Berkel, and Nilsson (2014) conducted a content analysis of the experiences of 42 National Guard female veterans reintegrating back to family life. This grounded theory study consisted of National Guard females deployed to Iraq or Afghanistan that returned from deployment from a few months to 10 years prior to their
Female Veterans’ Transitioning to Post—Active-Duty Health Care

interview. Some of the themes exemplified the difficulty of the reintegration process and focused on life being more complex, losing one’s military role, and reestablishing partner connections.

Reintegration into civilian life is difficult for female veterans who have PTSD and can negatively impact their transition and quality of life as a civilian. Veterans and military personnel are at a higher risk for developing PTSD and experiencing associated symptoms that negatively impact their health-related quality of life (Renshaw, Rodrigues & Jones, 2009). In OEF and OIF veterans, PTSD is a major concern, with an overall prevalence of 23%. Women comprise approximately 14% of military personnel deployed in support of OEF/OIF, which may result in a sequelae of mental health issues (Katz, Bloor, Cojucar & Draper, 2007). Multiple or extended deployments, common among the OEF/OIF service era, are associated with PTSD because of repeated exposures to trauma (Conard & Sauls, 2014).

In a recent descriptive qualitative study by Haun et al. (2016) regarding PTSD, three focus groups consisting of a total of 12 female participants elicited experiences regarding care in the VHA, even though these participants were not directly asked about this experience. The women expressed concern with the lack of female-only services, such as support groups, which in their experience included individuals of both genders. They also expressed a sense of fear of interacting or being alone in places dominated by a male presence, such as within the VHA. They felt uncomfortable having to interact with male providers and other male patients in order to access and receive VHA services. Though they expressed a sense of not belonging or not being comfortable with accessing care in a male-dominant health care culture, programs were mentioned as being helpful for managing PTSD. Coaching, vocational transition, and substance abuse recovery programs were cited as helping them increase and maintain function (Haun et al., 2016). The findings of this study demonstrate that care, availability, and options within the VHA
did not always meet the specific needs of the female veteran population. The authors indicated that further exploration of perceptions and experiences of female veterans’ health care options following their service to this country is needed.

Burkhart and Hogan (2015) conducted a grounded theory study on the process of transitioning from military to civilian life and the military experiences that affect both mental and physical health service needs. Data from 20 female veterans who served post-Gulf War were analyzed. Themes of feeling unprepared for civilian life and living two lives were identified. Female veterans felt unprepared for civilian life and experienced culture shock when trying to navigate the civilian system of health care and social systems. They described living two lives as time to learn that civilian and military sectors are separate with different social mores and values. The female veterans expressed identity issues and a sense of disconnection. Their findings of this study demonstrate that military and civilian cultures are not only different, but have a separate identity than civilian lives versus active military lives. Female veterans can choose to receive care in the VA or civilian sectors. More female veterans are opting to adopt the civilian health care sector. Many VA’s are partnering with civilian providers to help reach female veterans through community-based agencies (Burkhart & Hogan, 2015). Health care professionals in the civilian sector may not understand the complexity of the unique experiences and needs of female veterans. The findings from this study highlighted the boundaries between military and civilian cultures.

Maiocco and Smith (2016) conducted a phenomenological study with eight female veterans on the experience of coming back from war. Issues surrounding mental health were discovered to be common for female veterans who have served in Iraq and Afghanistan wars. That study used stories to elicit themes from the female veterans. Some of the themes that
emerged revealed that female veterans were arriving home and experiencing permeating aggravation from conversations with family, co-workers, and friends. As a result, they evolved to a changed view of the self, others, and family. They were found to be continuously remembering war experiences that never ended. The results from this study found that reintegration back into the community was a physical, emotional, and spiritual experience.

Kehle-Forbes et al. (2017) conducted a grounded theory study with 37 Vietnam and post-Vietnam female veterans (1975-1998) on female veterans’ perception of VHA care. Many participants expressed discomfort with being one of only a few female patients in VHA facilities. Those with and without a history of military sexual assault (MSA) voiced general discomfort and mistrust associated with being a minority in the healthcare system. Those with a variety of trauma types perceived unequal access to the full range of mental health services that are available to men. The type of services most often found to be lacking were group therapy and support groups for women. Some participants reported that groups were limited to male veterans; others noted that while groups were open to women veterans, they felt uncomfortable participating in groups that remained predominately male. Female-only groups were not available at many veterans’ clinics. Findings from this study demonstrate that while gains have been made in the provision of gender-specific outpatient medical care, at the time of the interviews, many women veterans with a history of MSA and PTSD symptoms continued to feel uncomfortable and unwelcome in VHA facilities. These female veterans perceived that they were not receiving the same quality of care as male veterans. Interventions at the system, clinic, and individual provider level may improve the experiences of women veterans seeking VHA healthcare.
Gender-Specific Issues

U.S. military members have been strained by a cycle of wartime deployments for more than a decade. Female veterans have been a crucial force in support of OEF and OIF. These returning female veterans have more complex health care needs than ever before, and the structure through which returning veterans receive health care has been challenged as it seeks to meet the needs of this population (Friedman et al., 2011; Hoge, Auchterlonie, & Milliken, 2006; Seal, Bertenthal, Miner, Sen, & Marmar, 2007). There were more than 1.8 million female veterans reported in 2010. The largest number of these females reside in California, Georgia, Texas, and Virginia (VA, 2012a). By 2016, there were 2,051,484 female veterans reported (VA, 2016b). The VHA and the American health care system are both currently challenged to care for younger females as they transition to veteran status following the OEF and OIF conflicts. The U.S. Census Bureau (2015) indicated that as of 2015, 84% of female veterans are younger than 45 years of age and 45.9% of these women are ethnic or racial minorities (U.S. Census Bureau, 2015).

Female veterans have reported problems similar to other traditionally marginalized groups, such as lower perceived quality of care, problems with access and continuity of care, provider biases, poor provider–patient communication, and poorer health outcomes (Lehavot, Hoerster, Nelson, Jakupcak, & Simpson 2010; Milliken, Auchterlonie, & Hoge, 2007; Washington, Bean-Mayberry, Mitchell, Riopelle, & Yano 2011a; Wright et al., 2006). In a 2006 study of 28,000 female veterans, lower scores were reported compared to the general population in every domain of physical and mental health, even when controlling for racial and ethnic differences (Frayne, Parker, & Christiansen, 2006). Lehavot et al. (2012) reported that in a study of 4,222 female veterans, they had poorer general health and greater incidence of health risk
behaviors, mental health conditions, and chronic health conditions than civilian women. Active-duty women reported better access to health care, better physical health, less engagement in health risk behaviors, and greater likelihood of having had a recent pap smear test than civilian women. Women from the National Guard or Reserves were comparable to civilians across most health domains, although they had a greater likelihood of being overweight or obese and reporting a depressive and anxiety disorder (Lehavot et al., 2012). To date, this is the only study that has compared the health status of female veterans to female civilians.

In 2006, the VHA responded to the challenge of gender-specific care by integrating gender-specific clinics (Yano, Goldzweig, Canelo, & Washington, 2006). Additional guidance and education for health care providers who predominantly care for women, and increased women’s health research through an innovative women’s health practice-based research network were subsequently implemented (Yano et al., 2006; Yano et al., 2010). However, these changes may not have immediately impacted health outcomes of all female veterans or addressed the needs of women veterans who access health care in private clinics instead of a VHA facility at that time (Yano et al., 2010). The complexity of multilayered health disparities among military servicewomen necessitates examination of additional systemic and structural-level issues (Yano, et al., 2010; Yano, et al. 2014).

In 2015, the VA reported 11.8% of female veterans had an incidence of PTSD, 6.5% had major depressive disorder, 5% had migraines, 5.5% had back disorders, 3.1% had an ovarian removal, 2.6% had a uterine removal, 2.6% had asthma, 2.5% had intervertebral disk syndrome, 2.4% had degenerative spine, and 2.3% had tinnitus (VA, 2015a). Access to care for female veterans continues to be a priority of the VA. In 2015, VA Secretary Robert Mc Donald announced a transformation initiative of the VA called My VA. The Center for Women Veterans
headed a My VA initiative for the Fiscal Year 2017 that specifically impacts female veterans. This initiative reduced disparities in wait times, outcomes, and utilization between men and women veterans across the U.S. All VA medical centers have women veterans program managers who are designated individuals to advise, advocate for, and assist female veterans with their health care needs. In addition, all regional offices in the Veterans Benefits Administration (VBA) have female veteran coordinators to advocate on behalf of their fellow women veterans (VA, 2017a).

Access to Care

The original health care systems for veterans were designed to care primarily for men. Empirical research demonstrates gender disparities related to access and quality of care, which impacts health outcomes for female veterans (Murdoch, et al., 2011; U.S. General Accounting Office, 1999; Washington et al., 2007). The 1980 Census was the first in which that American women were asked if they had ever served in the Armed Forces, and an astonishing 1.2 million said “yes” (VA, 2014). Because very few of these newly identified veterans used VA services, the U.S. Congress and the VA began a concerted effort to recognize and inform them of their benefits and entitlements. Activities were initiated to increase public awareness about services for female veterans. In 1982, at the request of U.S. Senator Daniel Inouye, the U.S. General Accounting Office (GAO), conducted a study and issued a report entitled: “Actions Needed to Ensure that Female Veterans Have Equal Access to VA Benefits.” This study found that women at that time did not have equal access to VA benefits, did not receive physical examinations, did not receive gynecological care, and were not adequately informed of their benefits under the law (VA, 2014).
Female veterans have reported dissatisfaction and confusion related to clinical VHA facilities (Washington et al., 2007). Female veterans who elected not to use the VHA system for health care had significant misconceptions and confusion about the availability of health services designed specifically to meet the needs of women patients. Washington et al. (2007) reported that female veterans who did not use the VHA sometimes assumed the VHA system did not offer women’s health care. In addition, female veterans have reported lower inpatient quality in the VHA than men have reported, after adjustment for transitions, physical comfort, involvement of family and friends, courtesy coordination, and access to care (Wright et al., 2006). In 2011, Washington et al. conducted a cross-sectional population-based national telephone survey of 3,611 women veterans on access to care. Results of that survey indicated that 19% of them had delayed healthcare or an unmet need (Washington, et al., 2011b).

In 2010, Bean-Mayberry, Batuman, Goldzweig, Washington and Miake-Lye found that compared with male veterans, female veterans were younger, more educated, and more likely to be a member of an ethnic or racial minority. Lehavot et al. (2012) reported different health conditions and access to care issues within the female veteran population. Female veterans were reported to be significantly more obese, more likely to report frequent poor health, more likely to engage in risky behaviors, and significantly less likely to engage in regular physical activity than were nonveteran women (Lehavot et al., 2012). Among patients served by the VHA, 1 in 5 women and one in 100 men reported experiencing some form of sexual trauma, assault, or repeated sexual harassment while on active duty. These findings do not indicate whether the perpetrator was a military member (National Institute of Mental Health, 2017).

In a 2007 report, female veterans were noted to have a significantly higher standardized mortality rate than did male veterans (Zivin et al., 2007). In 2017, the VA reported that the
mortality rate for all veterans during the 2000-2014 time frame was 0.9% to 1.2%. This was less than males and females in the civilian sector of the U.S. (Department of Veteran Affairs, 2017).

In response to the return of large numbers of veterans from Iraq and Afghanistan with physical and mental health problems, and to the growing readjustment needs of active-duty service members, veterans, and their family members, the U.S. Congress included Section 1661 of the National Defense Authorization Act for fiscal year 2008. That section required the Secretary of Defense, in consultation with the Secretary of Veterans’ Affairs, to enter into an agreement with the National Academies for a study of the physical-health, mental-health, and other readjustment needs of members and former members of the armed forces who were deployed in OIF or OEF, their families, and their communities as a result of such deployment. In 2008, the Institute of Medicine (IOM) was assigned by Congress to study the health needs of the veteran population. That study, consisted of two phases. Phase 1 was a preliminary assessment. Phase 2 provided a comprehensive assessment of the physical, psychological, social, and economic effects of deployment and identification of gaps in care for members and former members, their families, and their communities. The Phase 1 report was completed in March 2010 and delivered to the U.S. Department of Defense (DOD), the VA, and the relevant committees of the U.S. House of Representatives and the Senate. The Secretaries of DOD and VA responded to the Phase 1 report in September of 2010 (Institute of Medicine, 2010). The Secretary of Defense and the Secretary of Veterans Affairs initiated projects to address the issues raised by the IOM. The areas the DOD and VA focused on due to this report are as follows: A assessment of the particular impacts of multiple deployments; an assessment of the full scope of effects of traumatic brain injury (TBI) and the efficacy of current treatment approaches; an estimate of the long-term costs associated with undiagnosed injuries such as PTSD and mild
traumatic brain injury (mTBI); and recommendations for programs, treatments, or policy remedies targeted at preventing, minimizing, or addressing the impacts, gaps, and needs identified (IOM, 2010).

In 2017, the U.S. Congress passed the Deborah Sampson Act S.681 which aims to eliminate barriers and access to care for female veterans (Deborah Sampson Act, 2017). Deborah Sampson was a self-educated woman who disguised herself as a man and fought in the Revolutionary War in 1782 and it is due to her heroic efforts that this bill was named in her honor (National Women’s History Museum, 2018). This Act supports the designation of the Secretary of Veterans Affairs to add existing medical facilities with materials that support the provision of care female veterans receive at VA facilities. The legislation promotes the initiation of full- time or part-time women’s health care providers in each VA medical facility. Female provider duties include providing training to other health care providers of the VA on the needs of female veterans (Deborah Sampson Act, 2017).

**Culture-Centered Approach**

A unique feature of the health culture for the active-duty service woman and man is the interdependent relationship between their workplace and the health system. Both active duty servicewomen and men access health care through the Department of Defense Military Health System (MHS), which provides preventive and medical services at 416 inpatient hospitals, medical centers, and ambulatory care clinics around the world. Through this system, all active-duty personnel are required to complete annual periodic health assessments, including an annual physical and annual update of immunizations (U.S. Department of Defense, 2014). However, when women and men leave military service, in addition to facing the challenges of navigating a variety of health care choices, they exit this workplace-embedded health care system.
Military personnel form a distinct subset of American society, governed by a separate set of laws, norms, traditions, and values. Having been shaped by a pervasive military culture, individuals who leave the military after many years of service may encounter the same type of culture shock that immigrants experience when first arriving to the United States. They may feel disorientation, change of status, and a search for identity and meaning (Coll, Weiss, & Yarvis, 2011).

The female veterans of the U.S. have experienced a distinctive culture serving in the U.S. military. Female veterans have followed a hierarchy using detailed rules and language to create a shared set of beliefs and values that are tied to important meanings (VA, Mental Health Tool Kit, 2017). It is essential that both clinicians from inside the VA and civilian hospitals have an understanding of military culture. In a research study by social workers Coll, Weiss, and Yarvis (2011), female veterans’ reintegration into the civilian health care system was elucidated. Female veterans were found to be unable to readjust to civilian life and negotiate values, traditions, and behaviors of military culture with those of civilian culture. Female veterans who were not able to make the transition back to civilian society were experiencing cultural dissonance, mental health problems, and/or physical disability.

The theory of Culture Care Diversity provided a guiding framework to study female veterans. This theory has been used to discover similarities and differences among clients of diverse cultures (Leininger & McFarland, 2006). Those who care for female veterans may find this transcultural nursing approach helpful to understand the female military culture. Cultural distinctiveness through the transcultural nursing perspective may provide the nurse caring for female veterans an opportunity to understand their health care needs. This research may also elucidate strategies to provide meaningful care that supports the health care needs of female
veterans and gain insight into the transition of female veterans following active duty in the U.S. Military. Analyzing this cultural distinctiveness through the transcultural nursing perspective, has guided an understanding of their health care needs.

**Transitional Theory**

Meleis’s Theory of Transition articulates a need to continue studying transitions of various types to describe nursing phenomena (Chick & Meleis, 1986). Meleis’s Theory focuses on understanding the nature of and responses to change; facilitating the experience, responding to its different phases; and promoting health and well-being prior to, during, and at the end of the change event. This theory can provide a framework for application in practice, research, and theory building (Meleis, 2010).

Transitions are triggered by critical events and changes in individuals or environments. The transition experience begins as soon as an event or change is anticipated (Meleis, 2010). Though human beings always face many changes throughout the lifespan that trigger internal processes, nurses come face to face with people going through a transition when it relates to their health, well-being, and their ability to take care of themselves. In addition, nurses deal with the environments that support or hamper personal, communal, familial, or population transitions. According to Schumacher and Meleis (1994), transition conditions that influence the way a person moves through a transition and facilitate or hinder progress toward achieving a healthy transition. Transitional conditions include personal, community, or societal factors that may facilitate or constrain the processes and outcomes of health transitions. Personal conditions include meanings, cultural beliefs and attitudes, socioeconomic status, preparation, and knowledge (Meleis, 2010). Meanings attributed to events precipitating a transition and to the transition process itself may hinder healthy transitions. Cultural beliefs such as stigma related to
transitions may influence the transitional experience. Anticipatory preparation or lack of preparation may also inhibit people’s transitional experience (Meleis, 2010). To capture the definition, meaning, conditions, and outcomes of transitions, this researcher used Meleis’s (2010) Transitions Theory to provide coherence and direction from which to ask questions and analyze the participants in this study.

Female veterans have numerous options for health care following their separation. If a female veteran served for fewer than 20 years in the military, she might file for VHA benefits. If a female veteran is retiring from military service, she might maintain MHS benefits or choose to pursue health insurance through new employers or a spouse. In the case of a transition from MHS to VHA, women veterans still encounter a federal, military-oriented health care system, but one that supports a different mission and different health programs from those intended to equip military members to defend the U.S. (Jackonis, Deyton, & Hess, 2008). Whatever choice female veterans make, they are required to adapt to different norms when they leave the active-duty military structure of obligatory preventive screening, weight and fitness management, and the prevention of certain health risk behaviors (Conway et al., 2004). Unlike the MHS, which has programs and facilities to promote health and fitness for all military members and their families, the VHA have traditionally focused solely on treatment of disease and illness among aging veterans. Both MHS and VHA had to deal with institutional stressors from the increase in female-oriented services needed to address women’s health care needs (Batuman et al., 2011), which range from reproductive health care (Araneta et al., 2004) to physical and mental health services after sexual assaults (Bell & Reardon, 2011).

Female veterans are experiencing periods of transition that may or may not lead to an ability to cope with these changes. How, when, why, and in what ways female veterans
experience transition are essential concepts in this study. The human experiences, the responses, and the consequences of transitions on the well-being of people are areas of scholarship that have become even more central to the discipline of nursing. Equally important are the strategies that nurses may use to care for and support people to achieve healthy transition processes and outcomes.

The Transitional Theory (Meleis, 2010) offers a focus that can enrich our understanding of development, formation, and stressful responses to both predictable and unpredictable change in the female veteran. Nursing is concerned with growth and development, mental health promotion, and coping with the demands of the human experience of illness and recovery. Transition theory acknowledges these concerns but also focuses on a comprehensive view that includes relationships, change over time, and the person in particular situations and contexts. There is a need for nurses to study persons in their social relationships and experiences when transitioning into new self-understandings.

To evaluate Meleis’s Transitional Theory, Chinn and Kramer (2011) conducted a text analysis of four publications, three nursing expert focus groups in Switzerland, and a mapping review of the transition literature over five years. The findings of their study identified that people are more vulnerable to health risks during transitions and that nursing interventions can facilitate positive transitions, which impact the outcome of a transition. Meleis (2010) also stated that transitions refer to the process and outcome of complex person-environment interactions. To study the impact of the transitional process of female veterans, research must acknowledge that transitions can have a negative effect on the female veterans’ health.

The research of Chin and Kramer (2011) highlights the importance of Meleis’s Transitional Theory and that bio-psychosocial phenomena have a lot to do with prevention as
well as health promotion. It could be linked to the definition of health by the World Health Organization (WHO) as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. All kinds of changes might also have an impact on health during transition and/or be an outcome of transitions. Changes in health care financing can also impact the health of a population and how incentives are set. This can be seen with the changes following the passage of the U.S. Affordable Health Care Act (Bohner, 2017).

In 2015, Ahern et al. conducted a qualitative study on 24 female veterans from the Afghanistan and Iraq Wars on the challenges female veterans face entering civilian life. In-depth interviews with the participants revealed the need to better support veterans in transition given the long-term risks to those who do not transition successfully. Their research suggested that the support that veterans provide to one another is extremely helpful in navigating a successful transition. Further research needs to consider how to support the subgroup of veterans who may face challenges connecting with veteran peers. Given the pervasive feeling of alienation expressed by many returning veterans, it is also important to develop ways to foster reconnection between veterans and their families and to explore the means to engage the broader community in understanding and supporting returning veterans (Ahern et al., 2015).

In 2015, Burkhart and Hogan conducted a grounded theory study of 20 female veterans and their transitional experience following the Gulf War era. That study not only expounded on the health care needs of female veterans but also explored the transitional process. Coping with transitions emerged as the core category. It was the basic psycho-social process used by the participants as they coped with transitioning from a civilian role into living as a servicewoman, and transitioning out of the military and readapting to live as a veteran-civilian. The initial transition out of the military resulted in culture shock and feeling unprepared for civilian life,
while also adapting to life as a veteran in a civilian society. Those participants also reported the stress of living with a PTSD diagnosis. Helpful coping strategies with transition included maintaining connections with other servicemen/women and recognizing that one had personally evolved as a result of military service. They felt pride in having served in the military and identified themselves as a respected leader with a strong work value (Burkhart & Hogan, 2015). Despite the evidence regarding the difficulty of female veterans transitioning to the civilian world, there still remains a paucity of research in the area of transitioning to health care following active duty for female veterans.

**Transitioning Health Care Coverage**

In order for a female or male veteran to receive VA benefits and services, the veteran’s character of discharge or service must be under other than dishonorable conditions. (e.g., honorable, under honorable conditions, general). However, individuals receiving undesirable, bad conduct, and other types of dishonorable discharges may qualify for VA benefits depending on a determination made by the VA. By law, certain situations resulting in a discharge under less than honorable conditions constitute the legal inability to receive payment of benefits (Veterans Benefits Administration, 2017c).

There are several health care programs available to assist female veterans and retirees as they transition into post—active—duty health care. These programs are designed to meet specific needs depending on their duty status and transition circumstances. Some of these programs are long term, while others are temporary in nature and provide coverage for only up to three years (Military Wallet, 2017). These are explained as follows.

**Tricare**
The female and male veteran will first be offered the Transitional Assistance Management program under TRICARE. This program provides TRICARE medical coverage for 180 days following a veteran’s departure from active-duty status. If the veteran lives in a TRICARE Prime area he or she will be allowed to receive TRICARE Prime and will be able to choose a health care provider. If this is not offered to the veteran, he or she will need to enroll in TRICARE standard in which a health care provider is chosen for him or her. This can be confusing to any veteran when returning to unfamiliar territory following active-duty service so it is imperative that veterans are knowledgeable regarding the attainability and affordability of health care options when leaving active duty. The TRICARE website can be of assistance in this venture, but this depends on the knowledge base of the veteran about how to navigate websites (Military Wallet, 2017).

**Continued Health Care Benefit Program**

Following the 180 days of provided health care afforded to all veterans, a Continued Health Care Benefit Program (CHCBP) is available for those veterans and families who are not covered by a spouse or an employer. The CHCBP can provide an extra 18 to 36 months of coverage. However, the veteran will have to enroll within 60 days of losing entitlement to TRICARE or TAMP. Moreover, the veteran must be aware of the monthly premium for this coverage (Military Wallet, 2017).

**Tricare Reserve Select**

For veterans who decide to continue to serve in the National Guard or Reserve, there is another form of health care called TRICARE Reserve Select (TRS). If a veteran has exhausted all the options and doesn’t have health care through their civilian employer, he or she must acquire individual health insurance (Military Wallet, 2017).
**VHA Health Care System**

The VHA is the largest integrated health care system in the U.S. It is responsible for delivering comprehensive quality health care to 9 million enrolled veterans (US Department of Veterans Affairs, 2014). Women are a substantial minority of those patients. Female Veterans comprise 10% of the veteran population (DOD, 2016). According to Freedy et al. (2010), female veterans have significant health conditions different than male veterans, necessitating more informed treatment and health care alternatives. By the year 2040, female veterans are projected to be 18% of the VA population (Frayne, Phibbs, Saechao, et al., 2014). Given the present increase in female veterans in the VHA, it is essential that research focus on health care needs of female soldiers transitioning from military to civilian life and thus health care in the VA health care system. The face of VA healthcare is changing. Younger female veterans are using VA services more frequently for maternity care and having service connected disabilities for a myriad of health-related conditions. Older female veterans are using VA services for menopausal needs, geriatric care, and extended inpatient stays (VA, 2016c).

In 2015, the VA addressed the need to evaluate female veterans’ health issues with a quantitative study of 90,151 female veterans from a U.S. Veterans (USVETS) database. The study consisted of a Barriers to Care Survey that was sent to all participants: This Survey was developed in collaboration with a team from the Women’s Health Services office that built upon the 2009 National Survey of Women Veterans (NSWV). The Barriers to Care survey was conducted via Computer Assisted Telephone Interviewing (CATI) using professionally trained female interviewers. The 2015 study assessed preferences for gender-integrated comprehensive primary care versus comprehensive primary care provided in clinics for women only. In that research, comprehensive primary care was defined as one provider who provided all general
medical care and routine women's health care such as the Papanicolaou (Pap) test, contraception, and menopausal care. The study showed that 60% of female veterans who used the VA placed a great importance on having health care clinics for only women. 52% of the female veterans who reported previous unwanted sexual attention preferred women-only clinics which was slightly more than the 48% of those who did not report unwanted experiences. The authors concluded that the changing demographic of the VA population make it imperative that the culture of care accommodate female veterans and actively embrace their needs and respond accordingly. The study included questions about satisfaction on relationships with providers and clinic staff and about whether women felt respected. The authors noted some actionable areas where the VA system can invest effort and resources to improve access to care and delivery of services in ways that would influence women veterans’ decisions to seek care through the VA (VA, 2015b).

**Impact of Service on Female Veterans’ Health**

To provide a historical overview of the impact of female veterans’ health, this section presents evidence that adds to the body of literature concerning the impact of service on the female veterans’ health. The effects of military service on females has been associated with increased odds of developing a variety of conditions and illnesses. According to Stern et al. (2000), sexual assaults and sexual harassment have several long-term health implications and are common in all female veteran cohorts, including WWII veterans. In 1996, Davidson, Hughes, George, and Blazer reported that frequent psychosocial complications of sexual assault included an increased suicide risk. Since then, additional reports have described posttraumatic stress disorder, major depression, alcohol and drug abuse, long-term sexual dysfunction, disrupted social networks, and employment difficulties (Fontana et al., 1998; Wolfe, et al., 2017). Medical
conditions associated with sexual assault include heart attacks, obesity, and asthma (Murdoch, Polusny, Hodges, & Cowper, 2006; Stein & Barret-Connor, 2000).

Female veterans who have been exposed to combat have experienced after-effects, prevalent among deployed nurses, and increasingly common among deployed women serving in nonmedical capacities (Fontana, Schwartz & Rosenhack, 1997; Fontana & Rosenhack, 1998; Carney et al., 2003). Combat effects on physical and mental health are similar to those described in military sexual assault (Erickson, Wolfe, King, King & Sharkansky, 2001). Thus, combat and military sexual trauma experiences, as well as other deployment related stresses, could explain deployed female veterans’ greater risks for drug-related disorders (Kimerling, Gima, Smith, Street, & Frayne, 2007). PTSD, accidental deaths, higher levels of general psychiatric distress, and frequent somatic complaints may be explained by deployed female veterans’ risks and need for advancement in health care treatment (Murdoch et al., 2006).

In 2015, the VA reported that the top five diagnosed health conditions were PTSD, major depressive disorder, migraine headaches, lower back pain, and uterine complications (VA, 2015a). Though much research has evaluated the impact of military-related stressors in the predominantly male veteran population, less attention has historically been given to military trauma in women (Luxton, Skopp & Maguen, 2010). This has been problematic because much of the extant research has revealed a differing impact of military stressors based on gender. For example, female service members had been found to have a higher severity of depressive symptoms but not PTSD symptoms, compared with male service members at post-deployment (Luxton et al., 2010). Similarly, female veterans have been found to have higher risk for depression than male veterans (Street, Gardus, Giasson, Vogt, & Resnick, 2013). Given the expanding numbers and roles of women in the military, it is prudent to better understand the
impact of military stressors on female veterans’ mental health to facilitate appropriate assessment and care.

**Post-Traumatic Stress Disorder**

In 2015, 20% of female veterans who served in the conflicts in Iraq and Afghanistan were diagnosed with PTSD. There were 27% of female veterans who served in Vietnam who suffered from PTSD during their postwar lives (National Center for PTSD, 2015). In 2015, the VA reported that 11.8% of female veterans were diagnosed with PTSD, the highest incidence of health conditions in female veterans. In 2015, nearly 48,000 female veterans received compensation for PTSD and accounted for roughly 12% of all service-connected disabilities for women veterans (VA, 2015a). According to the Department of Veterans Affairs National Center for PTSD, PTSD is a mental health problem that some people develop after experiencing or witnessing a life-threatening event, like combat, a natural disaster, a car accident, or sexual assault (American Psychiatric Association, 2013; VA 2017b).

In 2010, Luxton et al. conducted a retrospective analysis on 6,943 active-duty soldiers following deployment at an Army facility. The study included 516 females and 6,427 men who served in OIF and Afghanistan. The association between Combat Exposure (CE) and PTSD were analyzed from a pre-and post-deployment screening database at a large Army installation. The results demonstrated that females who were exposed to combat had a higher incidence of depressive and PTSD symptoms. The researchers identified that this study provided evidence for gender-based differences in depression and PTSD risk. Screening for degree of CE in addition to symptoms associated with depression and PTSD can help with the care for service members who are returning from deployments to combat zones (Luxton et al., 2010).
In a subsequent study in 2013, Street et al. conducted a quantitative random sample study of 1,137 male and 1,207 female veterans. This study compared experiences of female and male OEF/OIF veterans on deployment stressors, including sexual harassment, general harassment, social support, combat, and other war-related trauma. Female and male veterans reported symptoms of probable PTSD in roughly equal numbers: just over 20% of both groups. Women appeared to be at higher risk for depression and men at higher risk for clinical alcohol use. These findings may indicate that these disorders are gender-linked conditions for the expression of post-deployment distress, possibly resulting from gender differences in biology, cognition, or societal norms governing expressions of sadness and substance use. The associations of both harassment and combat stress with probable PTSD were similar across genders. This adds to the evidence suggesting gender differences in PTSD observed in other populations are not found among OEF/OIF veterans. The authors concluded that perhaps the increasing similarity in women’s and men’s military experiences (e.g., training, preparation for deployment, deployment experiences) may override pre-existing differences in their vulnerability when exposed to extreme stressors. Despite evidence from the general population that the prevalence of PTSD is twice as high in females than in men, data from specific traumatized veterans suggest that the gender-specific risk of PTSD varies significantly by trauma (Street et al., 2013).

Major Depressive Disorder

In 2015, approximately 26,500 female veterans received compensation for major depressive disorder (VA, 2015a). According to the National Institute of Mental Health (2017), depression is a common but serious mood disorder. It causes severe symptoms that affect how a person may feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks. Some forms of
depression are slightly different, or they may develop under unique circumstances, such as, persistent depressive disorder, perinatal depression, psychotic depression, and seasonal affective disorder.

In 2017, Goldstein, Dinh, Donalson, Hebenstreit, and Maguen conducted a quantitative study utilizing a military trauma self-report tool of 403 female veterans. The findings of the study concluded that sexual assault had the strongest association with symptoms of PTSD and depression in a cross-sectional sample of female veterans who attended at least one appointment at a VHA medical center. Experience sexual assault or sexual harassment, feeling in danger of being killed, and seeing others injured or killed were associated with symptoms of PTSD above and beyond the effects of other traumatic military experiences. Only sexual assault and harassment were uniquely associated with symptoms of depression. The authors concluded that since all combat roles in the U. S. military have been opened to females, future studies will need to evaluate the impact of this increased combat exposure on psychological symptoms, both alone and as interacting with other types of trauma, such as Military Sexual Trauma (MST). Though clinicians may assume that traumatic events result in PTSD and focus their attention on that particular disorder, other responses may and do occur and should be addressed in assessment and intervention, particularly in women who have experienced MST (Goldstein et al., 2017).

In 2017, Lam et al. conducted a cross-sectional study of all VA primary care users with a new episode of depression from the U.S. federal fiscal year of 2010, covering nine geographically diverse regions. The study examined the quality of depression care based on receipt of minimally appropriate depression treatment within 1 year of a new episode of depression and on receipt of depression-related follow-up visits within 180 days. On average, female veterans had modest yet statistically significant increased odds of minimally appropriate
depression treatment compared with male veterans. The authors indicated that female and male veterans need care for depression. However, due to the increased number of female veterans projected in 2020, it is imperative that both male and female veterans achieve comparable care in these areas as women are projected to comprise 10% of the veteran population by the year 2020.

**Migraine Headaches**

In 2015, over 24,000 female veterans from the USVETS data base received compensation for migraines as a disabling condition (VA, 2015a). Migraines often begin in childhood, adolescence or early adulthood. Migraines may progress through four stages: prodrome stage which are subtle changes that warn of an upcoming migraine); aura (usually visual disturbances that may occur before or during migraines), headache (usually lasts from 4 to 72 hours); and post-drome (some may feel drained while others may feel elated after a migraine attack. Individuals may not experience all stages (Mayo Clinic, 2017).

In 2013, Seng et al. examined differences in 551 male and female veterans of OEF and OIF period of service in taking prescription headache medication, and associations between taking prescription headache medication and mental health status, psychiatric symptoms, and rates of traumatic events. Results indicated that 29.1% of females reported taking prescription medication for headaches compared to 19.7% of males. Findings indicate that of OEF/OIF veterans, the prevalence of clinically relevant headache is high, particularly among female veterans. Taking prescription headache medication is associated with poor mental health status, higher rates of psychiatric symptoms, and higher rates of traumatic events; however, these variables did not appear to meaningfully account for gender differences in prevalence of taking prescription headache medication. Future research should identify factors that might account for the observed differences (Seng et al., 2013).
In 2016, Jaramillo et al. conducted a retrospective longitudinal cohort study of female and male veterans of Iraq and Afghanistan wars. This study used data from the National Veterans Health Administration (VA) data repository for Iraq and Afghanistan veterans who received VA care from 2008 to 2011. Data from 38,426 veterans were analyzed. Results revealed that traumatic brain injury (TBI) is a strong predictor of headache in the first year of VA care among female and male veterans and that psychiatric comorbidities increased the likelihood of headache among individuals with TBI. However, among those with baseline headaches, only tinnitus, insomnia, and vertigo were baseline clinical predictors of headache persistence. These results suggested that attention to other symptoms and conditions early in the diagnosis and treatment of headaches may be important for understanding prognosis.

**Lower Back Pain**

In 2015, it was estimated that 22,200 female veterans received compensation for lower back pain (VA, 2015a). According to the Cleveland Clinic, Center for Continuing Education (2017), low back pain can best be described in terms of specific accompanying features. Low back pain is acute if it has a duration of about 1 month or less. Chronic low back pain is usually defined by symptoms of two months or more. Both acute and chronic low back pain can be further defined by the presence or absence of neurologic symptoms and signs.

In 2006, back pain was described as the most common cause of chronic non-cancer pain among veterans (Gironda, Clark, Massengale, & Walker, 2006). Among OEF, OIF, and OEF veterans receiving treatment at VA healthcare facilities in the United States between 2001 and 2009, 17.5% were diagnosed with lower back pain conditions. These pain conditions all occurred within 7 years of deployment (Haskell et al., 2012).
In 2016, Naylor et al. conducted an exploratory pilot study of 403 OEF and OIF veterans’ neurosteroid levels for lower back pain. Studies in this area have been limited. Results of this pilot exploratory study showed that serum dehydroepiandrosterone sulfate (DHEAS) levels were inversely correlated with self-reported lower back pain. Female veterans reporting moderate to severe low back pain had significantly lower serum DHEAS levels than those reporting no pain or little pain. Nonparametric analyses indicated that female veterans reporting moderate/extreme low back pain demonstrated significantly lower DHEAS levels than those reporting no/little low back pain. These preliminary findings support a role for DHEAS in pain physiology of low back pain and the rationale for neurosteroid therapeutics in pain analgesia. The authors indicated that further research with larger veteran cohorts will be required to replicate those findings and to determine whether DHEAS levels are also inversely associated with pain symptoms in male veterans (Naylor et al., 2016).

In 2016, Sakr, Black, Slade, Calfo, and Rosen conducted a cross-sectional analysis of 178 Iraq and Afghanistan veterans who received compensation for lower back pain. Findings from this small sample concluded that 62% of veterans had limited back function. Limitations to this study included the sample size and the use of the electronic health record to assess the data (Sakr et al., 2016). Based on the available data, veterans who have lost or impaired function in their backs receive higher service connection for their conditions than those without such impairment.

**Uterine Complications**

In 2015, the VA reported that 12,700 female veterans from the 2005 to 2015 USVETS data base had the complete removal of their uterus and ovaries. Roughly an additional 10,500 women veterans had the removal of their uterus that included their corpus (VA, 2015a). According to the U.S. Department of Health and Human Service, Office of Women’s Health...
(2017), a hysterectomy is a surgery to remove a woman’s uterus. Sometimes the fallopian tubes and ovaries are included in this procedure.

Women on active duty are often exposed to conditions that may increase risk of uterine complications. The contributing factors associated with uterine complications include urinary tract infections (UTI) and pelvic organ prolapse (POP). The risk of UTIs is high since military women are subject to poor hygiene, postponed urination, and fluid restriction while on deployment in combat zones (Resnick, Mallampalli, & Carter, 2012). POP has been identified as another health condition that contributes to uterine complications in female veterans. POP is defined as the descent of the bladder, uterus, and rectum as a result of the weakening of the muscles and connective tissue within the pelvic floor. Risk factors for POP include age, number of vaginal and multiple deliveries, high birth weight deliveries, chronic cough, obesity, genetic susceptibility, and manual labor (Resnick et al., 2012). According to Larsen and Yavorek (2006), POP may be caused by strenuous activity in military women. Basic training and paratrooper training can increase the risk of POP. Larsen and Yavorek (2006) identified that 50% of U.S. Military Academy females exhibited some loss of pelvic support after training. Additional studies are warranted to assess the correlation between military training and uterine complications.

In 2012, Levahot et al. conducted a Behavioral Risk Factor Surveillance Survey of 4,221 female veterans, 661 active duty females, 995 National Guard and reserve females, and 274,399 civilian females. Health outcomes were compared by military status using multivariable logistic regression among the female participants. This study indicated that female veterans were more likely than both civilian and active-duty women to report having a hysterectomy. The authors identified the need to continue exploring gynecological health among female veterans.
In 2016, Ryan et al. reported on a quantitative survey of 1,104 female veterans between 2005 and 2008. The telephone interviews took place from two Midwestern U.S. Veterans Affairs Medical Centers and associated community-based outreach clinics. The results indicated that female veterans had a significantly higher amount of hysterectomies compared with civilian data sets. Sixty-two percent of participants had experienced attempted or completed sexual assault in their lifetimes. A history of completed lifetime sexual assault with vaginal penetration (LSA-V) was a significant risk factor for hysterectomy. A history of PTSD was also associated with having a hysterectomy. The findings of this study indicated that premenopausal-aged veterans may be at higher overall risk for hysterectomy, and for hysterectomy at younger ages, than their civilian counterparts. Veterans who have experienced sexual assault with vaginal penetration in childhood or in military and those with a history of PTSD may be at particularly high risk for hysterectomy, potentially related to their higher risk of gynecological symptoms. The authors indicated that their findings have important implications for women’s health care providers and policy makers within both the VA and civilian health care systems related to primary and secondary prevention, costs, and the potential for increased chronic disease and mortality. The VA (2011) has recognized that the evidence base for gynecological issues of the female veteran is modest, mostly consisting of single studies of specific deployments and particular outcomes.

**Conclusion**

There are numerous health conditions that accompany the female veteran following active duty. This literature review focused on the top five reported in 2015, which were PTSD, major depressive disorder, migraine headaches, lower back pain, and uterine complications (VA, 2015a). However, it is important to note that there are other medical and health needs of female veterans that need to be studied. These other health care and medical needs include but are not
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limited to preconception, contraception, fertility, conception, breast health, endometriosis, HIV, premenopause, postmenopause, LGBTQ-gender issues, ETOH, drug abuse, PMS, osteoporosis, heart disease, lupus, anxiety, role changes in mothering, and family access to care.

The review of literature has examined differences in health conditions across the transition from active-duty to post—active—duty health care. The results revealed in this review indicate the need to provide health services directly focused on female veterans. The research reviewed focused on female veterans’ health issues and their decline in physical and mental health following active duty service, as well as the transition to civilian life and civilian culture. There are implications for health disparities to be viewed from a culture-centered perspective. Specific communication strategies and educational strategies may help to reduce health disparities occurring when the female veteran leaves the U.S. Armed Forces.

This literature review recognized health care issues pertaining to the female veteran culture while serving and transitioning from active-duty service in the U.S. military, but there still remains a paucity of research in transitioning to post—active—duty health care, combat female veteran effects, results of military sexual trauma, and other related deployment health conditions. Therefore, the purpose of this study was to interpret the meaning of the lived experiences of female veterans transitioning to post active duty health care. In addition, this researcher aimed to identify potential needs for educational opportunities that may create a safer and effective health care environment for female veterans. The data collected may also reflect needed areas for further health education.
Chapter 3: Method

This chapter explains the research methods and design, description of the participants, and recruitment. Data collection, management, and analysis will be detailed, along with ethical considerations. This chapter concludes with personal beliefs and potential limitations. An interpretive phenomenological study based on Martin Heidegger’s philosophy was used to understand the lived experience of U.S. female veterans. This method advocates for the interpretation of core concepts of experience and seeks meanings that are embedded in everyday occurrences (Lopez & Willis, 2004). Heidegger adopted ontology and the science of being by broadening hermeneutics. He posited the concept of being in the world rather than knowing the world (Creswell, 1994). Heideggerian hermeneutics focus on interpretation that combine aspects of both descriptive and interpretive phenomenology (Miles, Chapman, & Francis, 2015).

Martin Heidegger (1889-1976) was born in Messkirch in Baden-Wurttemberg, Germany. He studied theology and philosophy at the University of Freiburg and lectured there as an assistant to Edmund Husserl in the early 1920s. He then taught at the University of Marburg and wrote his magnus opus, Being and Time (1927), before returning to Freiburg to assume the chair of philosophy upon Husserl’s retirement. In his seminal work Being and Time (1962a), Heidegger described his attempts to simply interpret being-in-the-world. His approach is premised on a relational view of the person, and it is this characteristic that distinguishes Heidegger’s phenomenology from that of his teacher and mentor Husserl. Heidegger was devoted to ontology, the meaning of being, and took on an important shift that looked at existence itself and the quest for understanding (van Manen, 2014).

Heidegger indicated that phenomenology must be descriptive but postulated that its descriptions cannot pretend to rest on pure eidetic (denoting mental images) insight into
something present in pristine form in consciousness. Heidegger believed that phenomenology must be interpretive or hermeneutical. Hermeneutical phenomenology offers insight not just by exhibiting what is already self-evident in awareness but by drawing out, eliciting, evoking, and uncovering what lies hidden in and around whatever manifests itself openly to the world (Heidegger, 1962b). For Heidegger, phenomenology would be to describe, by uncovering or interpreting the existence of ourselves, our being, and the world around us (Heidegger, 1962a).

Phenomena have innumerable hidden aspects, all potentially worthy of hermeneutical excavation and elucidation. Phenomena have deep and important hidden aspect of things and not just some arbitrary characteristic they happen to share. It is essential to understand that we deal with things constantly, not just by thinking about them, but by using them, relying on them, taking them for granted, and even ignoring them in various ways. In all such human behaviors, things manifest themselves to us and we are familiar with them. But their being is so pervasive and fundamental that it ordinarily withdraws into the background of our understanding as it conceals itself (Heidegger, 1962b).

The goal of this research was to interpret the lived experience of female veterans transitioning to health care outside their military comfort zone. Female veterans carry within them a past that may reveal itself only through the use of the hermeneutical approach to this study. Therefore, this researcher endeavored to understand the experiences female veterans had during their transitional experience. Little is known about the lived experience of the female veteran transitioning to post—active—duty health care, so a phenomenological method of inquiry is appropriate to explore the phenomenon. In order to fully understand the experience of the female veteran, it is important to use a qualitative methodology and allow for their experiences to emerge in their own voices. The purpose of this interpretive phenomenological
research was to interpret and describe the meaning of the lived experience of the female veteran in order to uncover the meaning of what it is like to transition to post—active—duty health care.

**Rationale for the Method of Interpretive Phenomenology**

The interpretive phenomenological method is structured to elicit what lies hidden in the world around us. Martin Heidegger’s philosophical framework, methodological approach, and data analysis was used in this study. Heidegger professed that interpretive hermeneutical phenomenology is to both describe and interpret the meanings of the existence of oneself, their being, and the world around them (Heidegger, 1962a).

In qualitative studies, the ongoing process of questioning is an integral part of understanding the unfolding lives and perspectives of others (Agee, 2009). Phenomenology is an inductive qualitative research tradition rooted in the 20th century work of Martin Heidegger. Heidegger introduced the idea of ontology by studying the concept of being in the world rather than knowing the world. Hermeneutics moves beyond the description of core concepts of the experience and seeks meanings that are embedded in everyday occurrences (Lopez & Willis, 2004). The beginning and end point of phenomenological research is lived experience, because its aim is to explore being-in-the-world. Hermeneutic phenomenological researchers transform participants’ lived experiences into textual expressions of the essences or themes as a means to interpret the meaning of their own being-in-the-world (van Manen, 1990). An interpretive hermeneutic phenomenological approach was utilized to gain insight into female veterans’ world by directly examining particular experiences of transitioning to post—active—duty health care.

Martin Heidegger believed that bracketing is not warranted in a hermeneutical approach. He postulated that it is impossible to negate our experiences related to the phenomenon under study. He believed that personal awareness of the phenomena is intrinsic to phenomenological
research. Heidegger rejected the understanding of how we know as humans but accepted knowing as what it means to be (Dahlberg, Drew & Nystrom, 2008). Heidegger’s interpretive hermeneutics utilizes the hermeneutic circle method of analysis, in which there is continual review and analysis between the parts and the whole of the text. The basic tenet of the hermeneutic interpretive school of thought is that researchers cannot remove themselves from the meanings extracted from the text. The researcher becomes a part of the phenomenon. In this study, the researcher is a female veteran so, it would not be possible to fully bracket preconceived ideas or opinions (Polit & Beck, 2017).

Phenomenology aims at gaining a deeper understanding of the nature of meaning of everyday experiences and asks, “What is this or that kind of experience like?” (van Manen, 1990). It is a systematic attempt to uncover and describe the meaning structures of the experience from the perspective of the participant. This interpretive phenomenological method was used to answer the following research question: What is the lived experience of female veterans transitioning to post—active—duty health care in the United States?

**Research Procedures**

**Participant Sample**

The voices of female veterans who have lived the experience of being a female veteran residing in the U.S. uncovered the phenomenon of interest. A convenience, purposive sample of 15 female veterans who reside in the U.S. were invited to participate in this study. Eleven female veterans participated. The participants had to meet the requirements of being at least 18 years of age, having the ability to speak and understand English and be able to provide written consent. Female veterans who had been discharged between the years of 1990 and 2017 were recruited.
Each of the participants had to self-identify as being a female veteran of the U.S. Armed Forces who was discharged from the military from the years 1990-2017. Setting strict inclusion criteria enabled this study to include similar participants, but may also limit research analysis and findings (Creswell, 2009). An all-female sample was used in this study because there are limited published studies to date that specifically address the experiences of female veterans in the U.S.

In a phenomenological study, the sample size is determined by the quality of the interviews and when data saturation is achieved. Data saturation is reached when the researcher begins to hear the same information reported from multiple participants (Creswell, 2009). Phenomenological studies using purposive sampling have achieved data saturation with 10 to 15 participants (Creswell, 2009). Small sample sizes are common in qualitative research focused on meaning instead of larger sample sizes needed for generalizability in quantitative research (Hess-Biber & Leavy, 2006).

**Recruitment**

Purposive and snowball sampling was used as the sampling recruitment for this study. Purposive sampling is used most commonly in phenomenological inquiry with individuals selected to participate based on their phenomena of interest. Purposive, non-random sampling was used to ensure that appropriate participants share the experience of this phenomenon. Snowball sampling was used as a recruitment method to access female veterans through the participants’ social networks (Creswell, 2009). These sampling methods have been selected based upon the research phenomena of understanding the lived experience of female veterans.

This researcher used interpersonal relationships with both male and female veterans to contact potential respondents. The researcher posted IRB-approved flyers (Appendix A) in public locations that have a veteran population. The researcher contacted colleagues within the
military who were able to refer potential participants. An IRB-approved letter to potential participants (Appendix B) was used to explain the study to those interested. The researcher conducted one interview before conducting the next interview to ensure accuracy and truthful descriptive and interpretive summaries, reinforce the delineation of participant data and conduct ongoing data analysis.

The interviews were transcribed by the researcher and a professional transcription service (Appendix C). Following transcription, this researcher used numerical codes that correlate to each participant. All external storage media, paper memos of interviews, and any hard copies of transcriptions and personal journals were locked in a file cabinet. The researcher retained all memory sticks, transcripts, and journals.

**Data Collection**

Data collection procedures included the use of semi-structured, one-on-one telephone interviews due to the participants’ geographical location. Semi-structured interviews allow for the flexibility of scope and depth, while keeping the focus on the phenomenon of interest. To determine the lived experience of the participant, the phenomenon of interest must have already occurred. Therefore, interviews were conducted with female veterans who have served in the U.S. military and were discharged between the years of 1990 and 2017. Interviews were used as a means of collecting an account of events experienced by female veterans. The participant’s age, active-duty branch affiliation, number of years in service, and personal contact information were collected as part of the demographic questionnaire (Appendix D). The demographic questionnaire was completed after the approved consent (Appendix F) was signed, prior to the interview.
In-depth interviewing is a common method of collecting data for qualitative researchers (Creswell, 2013). Engaged listening and active asking are appropriate methods of interviewing when a researcher is focused on a particular phenomenon and requires understanding from individuals who will be interviewed. The in-depth interview is a form of dialogue with the researcher asking questions and engaging in probes during the interview. This type of semi-structured interview process assists in guiding the conversation and allows for the participant to talk about areas of importance to them. This format puts the participant at the center of the interview process and recognizes the interviewee as the context expert of his or her experience (Rubin & Rubin, 2012).

The data collection and interview process should be gathered in a natural setting in order to maintain authenticity regarding human behavior and allow for the most comfortable situation for the participant as possible. Open-ended, semi-structured, one-on-one interviews in a private space of the participants’ choosing facilitated participants’ openness and increased their engagement in the interview process (Rubin & Rubin, 2012). According to Creswell (2013), “qualitative research is fundamentally interpretive and research should take place in a natural setting” (pp. 181-182). Creswell considers in-depth interviews as a data collection method essential for studies that focus on the lived experience. In this study, there were one to two audio-recorded interviews with the researcher that lasted from 1 to 2 hours each. The participants chose a time for the interview(s). Follow-up contact allowed the researcher and participant an opportunity to validate or clarify their interview analysis. This occurred approximately 1 to 4 weeks after the interview(s) and took approximately 30 minutes. The participants chose to complete the follow-up contact by telephone or email.
Interview questions are frequently unstructured, using open-ended questions (Creswell, 2013): this study used such semi-structured questions and probes (Appendix E). This type of interview was used to elicit depth, range, and specificity of personal context of possible responses (Salzmann-Erikson, 2013). It permits interviewees to “voice their experiences unconstrained by any perspective of the researcher or past findings” (Creswell, 2009, p.203) and allows interviewers to capture the deep meaning of the experience in the participants’ own words. This interview method helps participants express their experiences by prompting their reflections and allowing for probing questions during the interview process.

Open-ended interview questions are developed to help guide the interview process as well as the opportunity to ask situational questions and use probes to elicit additional information when appropriate (Rubin & Rubin, 2012). The semi-structured interview questions are formulated to meet the needs of the research process (Salzmann-Erikson, 2013). Asking the participants the same or similar questions assures the emergence of similar data and is considered a strong indicator for the reliability of data collection (Rubin & Rubin, 2012; Salzman-Erikson, 2013).

The NVivo qualitative computer system was used for data management during collection and analysis. NVivo is a computer software program that supports qualitative research and was used to organize and store the interviews, notes, memos, and journal entries, and assist the researcher in creating a final analysis of the data (QSR International, 2018).

The initial interview questions were broad and open-ended, followed by probing questions. Interview questions and probes are as follows:

### Questions

What were your experiences transitioning to post—active—duty health care?

- What educational resources were you provided with to transition to a health
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• What supported or hampered your transition?
• What would have helped you make a better transition?

• What have your experiences been attaining health care outside the military?
  • Have any military experiences affected your health since your discharge?
  • Have any health conditions affected your life since discharge from the service?

• How would you describe the culture of the health system in the military? (What was it like? How did it affect you)?

• How would you describe the culture of the health system where you are currently receiving care?

• Is there anything else you would like to share about transitioning to post-active duty healthcare?

Probes

• Think back to the time when you were discharged. What were your experiences of re-integrating back to family, friends and the civilian community?

• Think of any physical, emotional, or even spiritual aspects of your journey from back then until now.

• Describe any challenges you have faced since discharge related to your healthcare or that of your family.

• What should nurses and healthcare providers be aware of when providing care to female veterans?

• What health-related advice would you have for a woman about to be discharged
related to her health?

**Analysis**

The purpose of this study was to interpret the lived experience of the female veteran transitioning to post—active—duty health care. Understanding these experiences of female veterans necessitates a Heideggarian interpretive phenomenological approach of inquiry. This method is based on Heidegger’s phenomenology whereby phenomena have innumerable hidden aspects, all potentially worthy of hermeneutical excavation and elucidation (Heidegger, 1962a).

Interpretation is seen as critical to this process of understanding. Claiming that to be human was to interpret, Heidegger (1962) stressed that every encounter involves an interpretation influenced by an individual's background or historicality. Heidegger utilized the hermeneutic circle method of analysis, where there is continual review and analysis between the parts and the whole of the text. This researcher followed the basic tenets of the hermeneutic school of thought and did not remove herself from the meanings extracted from the text (Polit & Beck, 2017). The process of interpretation of the data is circular, having no bottom, top, beginning or end, and no subject-object distinctions. Interpretation takes place in a circular fashion in order to avoid a possible loss of meaning (Walsh, 1996). The data generated through this research study were analyzed by applying the hermeneutic circle that constitutes reading, reflective writing, and interpretation in a rigorous fashion (Laverty, 2003). Heidegger (1927/1962) stressed that all understanding is connected to a given set of fore-structures, including one’s historicality and background that one must recognize to account for these interpretive influences. This interpretive process is achieved through a hermeneutic circle which moves from parts of the experience, to the whole of the experience, and back and forth again and
again to increase the depth of engagement to understand the text of the participant (Polkinghorne, 1983).

To employ the hermeneutic circle this researcher also followed Gadamer’s (2004a) process of interpreting the phenomenological dialogue of the participants. Gadamer identified that all interpretations are derived from pre-judgements or understanding and that the reader of the participant’s interview is also a part of this interpretation (Gadamer, 2004b). This researcher employed Gadamer’s principles when interpreting the transcription of the words of the participants and was continuously aware of the hermeneutic circle, re-awakening the text and making sense of what has been written. This researcher was not only aware of what the participant’s life experience gave meaning to but also asked how the words resonated with herself (Gadamer, 2004a).

The process of analyzing the data began when the spoken language of the participant was transformed into the lived experience of the text. The data were read, re-read, and coded in an attempt to establish themes. This analysis included listening, observing, judging, challenging, reflecting, and looking for bias from the participant and as well as from the researcher. The hermeneutic circle runs along the text like a rhythm, open to the researcher’s anticipations, pre-conceptions, prejudices, and judgments (Gadamer, 2004a). This researcher was aware of the guiding principles that formulate an understanding and anticipation of the completed text, challenging hasty conclusions in order to be open to more possibilities. Therefore, the language use within the narrative acted as a middle ground between a search for understanding the text and interpreting it (Gadamer, 2004a).

Interpretive Phenomenology Analysis (IPA) was employed to explore the sense that participants make of their personal and social world, while acknowledging that the researcher’s
interpretation of the text is an important part of the development of a coherent research study (Biggerstaff & Thompson, 2008; Brooke & Horn, 2010). IPA is an approach to qualitative analysis with an idiographic focus, intended to offer insights into how a given person in a given context makes sense of a given phenomenon (Cohen, Manion, & Morrison, 2007). IPA enabled this researcher to identify the shared and unique experiences of the female veterans (Fade, 2004; Smith, 1996). IPA also enabled this researcher to be reflexive and creative in the methodological approach (Smith, Flowers, & Larkin, 2009) and to follow the central idea of IPA using the hermeneutic circle to make sense of the participants making sense of their own world (Smith & Osborne, 2003). This researcher worked with members of the dissertation committee to assist in examining the data, comparing identified codes, and to discuss interpretation and inductively developed themes.

**Reliability and Validity**

In qualitative research, reliability and validity are established by developing trustworthiness of qualitative inquiry. According to Lincoln and Guba (1985), trustworthiness is established by four criteria, including credibility, dependability, confirmability, and transferability. These four criteria represent parallels to the positivists’ criteria of internal validity, reliability, objectivity and external validity. This framework provided the researcher with the initial platform to establish rigor in this study. These steps are fluid whereby data collection and analytical methods were used to maintain scholarly rigor and trustworthiness of the research findings (Polit & Beck, 2017).

To establish the first of the four criteria of Lincoln and Guba (1985), this researcher established credibility. This was done by striving to establish confidence in the truth of the findings of the particular participants and contexts in the research. Lincoln and Guba (1985),
pointed out that credibility involves two aspects: first, carrying out the study in a way that enhances the believability of the findings, and second, taking steps to demonstrate credibility in this study. To establish credibility, reflexivity was employed in this study. Reflexivity is a strategy used to enhance credibility in qualitative studies. Reflexivity is continuous use of self-reflection about presuppositions, biases, and ongoing emotions, which can be obtained through journaling (Polit & Beck, 2017).

The second criterion this researcher adhered to is dependability, which refers to the stability of data over time and conditions. Dependability is the ability for the findings of a research study to be repeated if the study might be replicated with the same or similar participants in the same or similar context (Polit & Beck, 2017). By keeping detailed documentation of interviews, field notes, and memos as an audit trail for verification this researcher aimed to establish dependability.

The third criterion that was established is confirmability, which refers to objectivity to establish congruence between two or more independent people about the data’s accuracy. This criterion is concerned with establishing that the data represent the information participants provided and that the interpretations of those data are not invented by the inquirer (Polit & Beck, 2017). Findings in this study were reviewed and reflect the participants’ voice and the conditions of inquiry, not the researcher’s biases, motivations, or perspectives (Polit & Beck, 2017).

The fourth criterion this researcher established is transferability. This assures that the findings are applicable to other settings. This researcher provided sufficient descriptive data so that consumers can evaluate the applicability of the data in contexts (Polit & Beck, 2017).

To triangulate the data analysis this researcher used van Manen’s (1990) criteria for trustworthiness (van Manen, 1990). This researcher considered the texts that explicate the life
world stories of the research participants. Trustworthiness was attained by orientation, strength, richness and depth of the participants’ experiences and stories. To establish orientation, the researcher involved herself in the world of the research participants and their stories. Strength was gained by the convincing capacity of the text to represent the core intention of understanding the inherent meanings as expressed by the research participants through their stories. Richness was established by the aesthetic quality of the text that narrates the meanings as perceived by the participants (van Manen, 1990).

**Ethical Considerations**

**Protection of Human Participants**

It is the ethical obligation to protect the participants and to safeguard their identities as well as their shared experiences. This study posed no serious ethical issues and was conducted in accordance with Good Clinical Practice (GCP: De Roy, 2004), the Declaration of Helsinki (World Medical Association, 2013), and the Molloy College Institutional Review Board rules and regulations. A Molloy approved IRB informed consent was obtained from the participants in this study for both the interviews and for audiotaping the interviews.

The informed consent (see Appendix F) was used to explain the terms of study participation in simple terms before the participant took part in the study. A participant was informed that she may voluntarily discontinue participating in the study at anytime. All research was conducted in accordance with the IRB procedures at Molloy College (Appendix G).

The researcher ensured that informed consent from each participant was obtained and the appropriate signatures and dates on the informed consent document were established prior to the interview. Participants were provided a copy of the informed consent form. Each participant’s signed informed consent is kept in a secure and locked location.
**Possible Benefits**: Participants were informed that there are no benefits for participation. It is possible that some participants may appreciate having the opportunity to talk about their experiences. It is hoped that the knowledge gained from this research will be of benefit to others in the future.

**Reasonably foreseeable Risks/Discomforts**: Participants were advised that there are research-related risks or psychological discomforts anticipated. It is possible that some participants may feel tired from talking for 1-2 hours. They were informed that they may stop the discussion at any time, reschedule, or withdraw. If the researcher detected at any point that the interview was causing distress to the participant, a referral to counseling or supportive services was available to that participant if desired. The ethical principles of autonomy, beneficence, and justice were upheld (Leavy, 2011).

**Conditions for Participation - Voluntary Participation/Withdrawal**: Participants were told that their participation was voluntary and they could withdraw at any time. Any information participants may have contributed could be excluded at their discretion. Participants were ensured that refusal or discontinuation at anytime would not result in a penalty.

**Costs/Compensation**: There were no costs involved or compensation provided for participation. A $25 thank you gift card was provided to each participant at the completion of the interviews.

**Confidentiality**: The researcher safeguarded the participant’s data through to the completion of this dissertation. While coding data and working with various computer programs, the researcher purposefully saved files multiple times so data would not be compromised. Furthermore, a default feature of *NVivo* is saving an open file every 15 minutes. All aforementioned files were password protected. Access to de-identified data was limited to the chairperson and committee members of this dissertation study. Results were presented in aggregate form to avoid
identification of individual participants. Participants are identified only by a pseudonym (another name assigned). Their personal information and signed consent are kept confidential. Their name will not be reported in any publication. Only the data obtained as a result of participation in this study will be made public. Personal identifiers such as addresses, workplace, or health care providers will not be used in any publication. Email communication was kept confidential and deleted after read and transcribed by the researcher to a secure study file without any personal identifiers. Interview audio-tapes were labeled only with a code number that is kept locked in the researcher’s files. A participant may at any time review her audiotapes and ask that all or any portion of the recording be erased. The audiotapes were confidentially transcribed by a professional service and reviewed by the researcher. The tapes were destroyed upon study completion. The researcher took notes during the interviews. All notes were transcribed and destroyed upon study completion.

**Personal Belief**

Since the researcher is the primary tool in a qualitative study (Creswell, 2013), it was essential that she clearly express her personal values, assumptions, and biases at the outset of this study. This study is an amalgamation of the experiences of other female veterans, and this researcher understands that their experiences are the driving force in the doctoral study. This researcher followed the basic tenets of the hermeneutic school of thought and did not remove herself from the meanings extracted from the text (Polit & Beck, 2017). She is a female veteran of the United States Navy Nurse Corps, and I bring the benefits of those experiences to this study. So as to establish trust between the interviewer and interviewee, I have fully disclosed my position as a former Navy Nurse in the U.S. military.
This researcher used journaling throughout the research process in to identify personal interpretation of the interviews. This researcher regularly debriefed with the dissertation committee chair and members of the dissertation committee to discuss the ongoing research process and data analysis. Qualitative research methods rely on the researcher as the tool to generate and analyze the data. Therefore, memos and journaling over the course of this research study assure the ability to retrace the path of analysis. An audit trail leads from the researcher’s thinking, and subsequent analysis of research findings.

**Limitations**

The limitations of this study, as in usual qualitative studies, are that the findings can be generalized only to the study participants. Other limitations that may be of concern are sample size, alternative interpretations, and the participants’ willingness to disclose their experiences. Small sample size may make the findings inapplicable to the larger population of female veterans. However, the study may have value in that it might facilitate other female veterans to reflect on their own experiences.

It is expected that data, depending on the perspective and interpretations of the data, can be understood in different ways in relationship to the literature. A method of qualitative practice, which the researcher utilized, is to actively record and analyze the data. This researcher wrote memos reflecting on the phenomena of interest, keeping reflections separate and apart from the data coding and analysis.

Female veterans’ willingness to participate in this study was anticipated to be a challenge. A trust was needed to gain access to potential participants. The necessity of exploring their experiences, values, and beliefs within the veteran community was expressed as the intention of
this study. The researcher was able to explicitly convey that the interest of this study was how to better understand the transitional process of health care of female veterans.

Summary

The purpose of this interpretive phenomenological research was to interpret and describe the meaning of the lived experience of the female veteran in order to uncover the meaning of what it is like to transition to post—active—duty health care in the U. S. After obtaining IRB approval, data collection using telephone semi-structured interview questions was conducted. The researcher completed the data analysis using Heidegger’s (1927/1962) interpretive phenomenological methods, in order to focus on the synthesis of the experience of all the participants. The researcher analyzed the data and linked the theoretical frameworks employed. By exploring the female veterans’ lived experience the research intended to reveal social and cultural factors that may have played a role in their transitional experience to post—active—duty health care. This research has the potential to uncover the barriers that female veterans face attaining health care outside the military, thus contributing to the advancement of nursing science.
Chapter 4: Study Results and Analysis

Introduction to Findings

This study illustrates the lived experience of female veterans transitioning to post—active—duty health care in the U.S. The female veterans in this study were from the West Coast, East Coast, and Mid-Western regions of the U.S. as well as one person living in Germany. The data was analyzed utilizing the interpretive phenomenological methods of Heidegger (1962a), van Manen (2010), and Gadamer (2004a). This chapter reveals the experience of female veterans and the possible meaning in the formation of the participants’ view. Descriptions of the participants, data analysis, findings, and essential themes are discussed in this chapter.

Study Sample

The recruitment process began as soon as Institutional Review Board approval from Molloy College was obtained. Recruitment was achieved through the use of social media, personal connections with female veterans, and interpersonal relationships within the veteran community. Recruitment of research participants was done by each participant recommending another participant by using snowball sampling. Prior to the interview, each participant completed a demographics form (Appendix D). Data collected included age, academic status, ethnic affiliation, marital status, number of children, military service, military branch, current health care facility, current health conditions, and religious or cultural health practices. This information provided further description of the participants, enriching the findings of their lived experiences. Interviews were conducted until data saturation occurred.

The study sample consists of 11 female veterans who had all self-identified as U.S. female veterans. Two of the participants resided in Maryland, two in Texas, one in South Dakota, one in Germany, two in New Jersey, one in New York, one in Pennsylvania, and one in California.
Seven participants were in the Army, three were in the Air Force and one was in the Navy. The participants ranged in age from 23 years to 63 years. Eight of the participants were married to men, one participant was married to a woman and one participant was unmarried. Eight participants had children. Six of the participants were nurses, two were telecommunications officers, one was an equipment operator, one was a systems specialist, and one was an aircraft maintenance officer. A brief demographic of the participants is shown in Table 4.1.

Table 4.1: Demographic Data

<table>
<thead>
<tr>
<th>ID/ Pseudonym</th>
<th>Military Affiliation</th>
<th>Culture / Religion</th>
<th>Residence</th>
<th>Age</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Army</td>
<td>None</td>
<td>Maryland</td>
<td>47</td>
<td>Caucasian</td>
</tr>
<tr>
<td>TM</td>
<td>Army</td>
<td>Non-denomination</td>
<td>Texas</td>
<td>41</td>
<td>Native American/Caucasian</td>
</tr>
<tr>
<td>DL</td>
<td>Air Force</td>
<td>None</td>
<td>South Dakota</td>
<td>52</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Jules</td>
<td>Air Force</td>
<td>Unitarian</td>
<td>Pennsylvania</td>
<td>48</td>
<td>Caucasian</td>
</tr>
<tr>
<td>MF</td>
<td>Army</td>
<td>Catholic</td>
<td>Germany</td>
<td>23</td>
<td>Hispanic</td>
</tr>
<tr>
<td>Jen</td>
<td>Army</td>
<td>N/A</td>
<td>Texas</td>
<td>28</td>
<td>Non-identified</td>
</tr>
<tr>
<td>Skydiver</td>
<td>Army</td>
<td>Catholic</td>
<td>New Jersey</td>
<td>45</td>
<td>Black/Caribbean</td>
</tr>
<tr>
<td>Taser</td>
<td>Army</td>
<td>Non-denomination</td>
<td>New York</td>
<td>49</td>
<td>African American</td>
</tr>
<tr>
<td>KT</td>
<td>Army</td>
<td>Catholic</td>
<td>New Jersey</td>
<td>43</td>
<td>Open</td>
</tr>
<tr>
<td>SK</td>
<td>Air Force</td>
<td>Catholic</td>
<td>California</td>
<td>43</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Mary</td>
<td>Navy</td>
<td>Catholic</td>
<td>Maryland</td>
<td>63</td>
<td>Caucasian</td>
</tr>
</tbody>
</table>

The demographic data in Table 4.1 show the pseudo-name chosen by participants, the military branch of service, culture, religion, residence, age and ethnicity.

Data Collection

All interviews took place between April 2018 and August 2018. Prior to the individual interviews, I asked each participant if we could connect either via telephone or email to gather information in order to screen for inclusion criteria and asked the participant to select a time and
place for our meeting. Telephone, email, or text message confirmations of time were provided to each participant depending upon the participant’s location in the country or overseas.

All interviews were via telephone due to the participants’ geographical location. At our recorded meetings, I provided each participant with the approval letter from Molloy College IRB (Appendix B) that described the study. I secured written consent from all the informants (Appendix C) and made clear to each participant the purpose and nature of the study and their respective role. I further assured the participants that confidentiality would be maintained by sharing that each participant would be assigned a pseudonym to protect her identity and preserve their privacy.

Participants were informed that collected information would not be shared with other participants or individuals outside of this research project and their personal information would be protected (Creswell, 2013). Furthermore, I asked if participants wished to be contacted upon completion of this study; all wished to receive an email notification. All of the interviews took place over the telephone and email. Although I had a list of prepared question probes and began each interview in the same manner using the open-ended question “What was your experience like transitioning to post—active—duty health care?” I did not follow the probing questions in any set order. This was because the answers the interviewee provided continually informed our evolving conversation. The length of interviews ranged from 45 minutes to 1 hour and 30 minutes. The length of the interviews varied because some informants had a lot to say and others were very concise and to the point. If the interview lasted longer than an hour, I asked for permission from the participant to continue. Following each interview, a follow-up email was sent to participants to assess if the participants had any other information they would like to
share. Nine of the participants responded, and the participants were satisfied with all the information they gave at the interviews.

All the participants were very willing to share their experiences. I expressed my genuine interest in each participant so she could “feel” my sincere care and true concern. At the conclusion of each interview, I thanked each participant for her invaluable contributions to this study. All interviews were digitally recorded using two digital recorders—a primary and a backup recorder in case of technical difficulties. A fresh set of batteries were placed in each recorder and a sound check was conducted prior to the start of each interview to ensure optimal recording. After each interview, I transferred the digital file to my personal computer using a secure system available only to this researcher. All the interviews were transcribed verbatim after each interview and prior to conducting the next interview. Immediately following each interview, observation memos and personal field notes were recorded. I incorporated the observation data into the participant’s interview transcript as part of that participant’s data. All the information about the participant could be identified only through their pseudonym. I stored the digital information, hard copies of transcribed interviews, and my journal and field notes in a locked file cabinet. All information related to this study including transcripts, digital files, and journals are retained according to the Molloy College IRB regulations.

Field Notes

Field notes incorporated interpretive and reflective data about each interview and were recorded to the fullest extent possible in a notebook dedicated to the study. These notes were utilized along with the transcripts during data analysis. Field notes were used to document to further describe the participant. It also allowed an opportunity for this researcher to record and reflect on personal assumptions and biases related to this study (Creswell, 2013).
All the participants expressed, in different ways, appreciation for having the opportunity to participate and engage in nursing research. All the informants said they were grateful for having had the opportunity to reflect and discuss things that they had never talked about. Some comments that indicated this were: “Thanks for giving me the opportunity to share my experiences,” “I hope that by sharing my experiences, I help other females transitioning to the civilian world of health care, and I hope this study helps female veteran understand that advocating for oneself will help the transition experience.” All the participants shared the sentiment of being grateful to participate. The participants were all forthcoming, even when the conversations became intensely personal, and they were generous in sharing their experiences and honest feelings.

Data Analysis

This researcher employed Gadamer’s principles when interpreting the transcription of the participants, and was continuously aware of the hermeneutic circle, re-awakening the text and making sense of what had been written (Gadamer, 2004a). This researcher was not only aware of what the participant’s life experience gave meaning to, but also asked how the words resonated with herself. The analysis of the data began when the spoken language of the participant was transformed into the lived experience of the text. The data was read, re-read, and coded to establish themes. NVivo software was used to manage data and assist in the analysis. The tables in this chapter indicate the codes and themes that emerged to answer the research question: What is the experience of female veterans transitioning to post-active duty health care?

In phenomenological research, interpretation is seen as critical to this process of understanding. Claiming that to be human is to interpret, Heidegger (1927/1962) stressed that every encounter involves an interpretation influenced by an individual's background. Heidegger
utilized the hermeneutic circle method of analysis, where there is continual review and analysis between the parts and the whole of the text. During the interview process, the sharing of personal experience by way of stories, vignettes, and occurrences, in conjunction with the interaction with the interviewee, allows for the interviewer to gain insight and get close to the actual lived experience of the participant. Through analysis, the text and data resulting from the semi-structured interviews provide a way for the researcher to capture the essence of the participants’ experiences (Creswell, 2013). The themes are understood as structures of the experiences. Although the themes to be reported are framing the experience for all the participants, the themes did not appear in the same sequences or in a fixed order. Between April and August 2018, I re-evaluated all the interviews by listening to each of them several times and by reading the transcripts numerous times until I felt that the transcripts mirrored the recorded interviews. Data reliability and validity were thus enhanced. I also imported all the transcribed data into the NVivo software (QSR International, 2018). NVivo is a qualitative computer software program used for data management. Using NVivo, I was able to conduct my analysis and monitor the process of my data analysis through the features of indexing and searching. I finished analyzing all of the participants’ data regarding their individual experiences of being female veterans and began identifying similarities among the data by comparing and contrasting the participants’ experiences until an intentional proposition surfaced. In this stage of data analysis, I found using NVivo was helpful in comparing and keeping the data organized. The participants described their experiences as female veterans with statements and sentiments that corresponded to several categories or topics. Together with a qualitative methods expert and a member of the dissertation committee, the categories and their meanings were condensed to five essential themes. The themes reflected in Table 4.2 are considered the lived experiences of the female veteran.
Table 4.2: Primary Themes and Thematic Elements

<table>
<thead>
<tr>
<th>Theme</th>
<th>Thematic Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 1</td>
<td>Military Culture: She-rovers on Equal Ground</td>
</tr>
<tr>
<td>Theme 2</td>
<td>Health Conditions: Sacrifice and Commitment to the Mission</td>
</tr>
<tr>
<td>Theme 3</td>
<td>Health Insurance: Gender-Specific Health Care</td>
</tr>
<tr>
<td>Theme 4</td>
<td>Facing Roadblocks and Challenges</td>
</tr>
<tr>
<td>Theme 5</td>
<td>Creating a New Normal: Acknowledgement of Service</td>
</tr>
</tbody>
</table>

Table 4.2 Themes and Thematic Elements

**Theme 1: Military Culture: She-rovers on Equal Ground**

Most participants’ experiences of transitioning to post—active—duty health care were shaped, in part, by their experiences of the military culture they were leaving. Nine out of 11 participants contributed data to this theme, and 49 data units were included in it. Table 4.2 indicates the codes and sub-codes that were grouped into this theme during data analysis, as well as the number of participants who contributed to each and the number of data units included in each.

The codes for Theme 1 are listed in Table 4.3. created from NVivo 12 Software.

Table 4.3: Theme 1 Codes

<table>
<thead>
<tr>
<th>Code (standard font and left-aligned), or sub-code (italic font and indented)</th>
<th>N of participants contributing</th>
<th>N of data units included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differences from civilian culture</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Good relations w-locals</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Importance of service recognition</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Issues person centered versus cultural</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Issues receiving proper medical care</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>PHS-reserves different culture</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Positive work culture</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Service experiences</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td><em>Being apart from children</em></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Schedule and sleep issues 1 1
Trauma experience, including:
Re-experiencing trauma 1 2
Work overload leading to PTSD 2 4
Useful training 1 2
Sharing service experience with children 1 1
Support-over and above 3 3

Participants’ Experiences

Jules described her military culture experience as differing from her civilian work experience. She described a camaraderie amongst her military co-workers of one that was embedded with team work and assistance.

Jules: I guess that is one thing about the medical culture or the military culture that I will say is completely different. You couldn't just call in sick. You couldn't just not show up, call your boss and say, "Hey, I'm sick today." You had to get your ass out of bed at 6:30, 7:00 in the morning, walk over to the hospital, go to sick call, and have them say, "Yeah, you're sick," and most of the time, just having to get out of bed, most people are like, "Ah, screw it. I'll just go to work," you know? Well, that and just the culture of: you know that ... because I used to work on the flight lines, so you knew that if you weren't there, whoever was supposed to be there, they had to then do twice as much work, and you were such a close-knit unit, you didn't want to do that to somebody, but in the civilian world, I don't think anybody cares about screwing anybody over at this point, truly, like, "Nah, not my job." That's the overall difference: "Oh, that's not my job but I'll help you with it. Let me learn it and that's awesome," and now it's like, "That's not my job description." What? God, everybody has your back, yeah. And you spend all your free
time together. You go camping together. You go rolling down the rapids together. We were a family.

DL described her workload in the military and the positive cultural experience she received at Fort Meade. DL stated:

**DL:** Well, you know, I was a Colonel in the military and I was treated very well. The military hospital worked around my schedule when I was on active duty. Well, not just because I was a high rank but I was extremely busy. The military understood this and accommodated my schedule at every turn; they realized my position and always called me by my rank. I was very happy with the military health care system, as well I am now happy at Fort Meade. I even received a care package that had a nice baseball cap. My husband was jealous. As you see he is active duty and never received a care package. They are very good. When I first arrived at Fort Meade, I was assigned a case manager who personally took me around to every appointment as I was unfamiliar with the hospital. They treat me very well and in fact as if I am a queen. You see, they do not know rank in the VA. Well, maybe they know I was high up but it is different. They treat me well in the women’s clinic. They treat me well, like a woman.

Taser described transitioning from the military culture as traumatic and the cost of civilian life compared to the military.

**Taser:** It was a traumatic experience going from military culture of health to the civilian world, Okay, this is the military way that there's the Standard Operating Procedures (SOPs), there's this and that, and maybe a few of those tricks, ways, things that you did, in Public Health Service is was like, okay. I think I had a hard time transitioning over and
then it was from, okay, this is military and this is non-military. The cost is different, definitely different. I would prefer military health care culture.

KT described her military cultural experience in a positive light, with the focus on building a relationship and affinity for the Afghanistan culture. She felt strongly that the team work in Afghanistan was outstanding.

**KT**: Oh, I think the culture in the military is great. I think it really is great, I think we are doing a good job over there trying to help the Afghani people, and you know we all get along well, you know there was different branches, different services. I mean there were NATO soldiers: we'd all get along well, and even when we walked down there were some point bazaars that were on base that the Afghani people could come on and sell kind of like their stuff that were handmade. You could get rugs, you could get pottery, you know and it was just interesting, the people there they're so grateful, they're so nice. They shared a lot with us, you know. We all worked together, we're all a team, we actually had one incident where we had a mass overwhelming of heat exhaustion soldiers that came in on the airplane and there was probably like 50 or 60 patients all in one swoop. It was really wonderful, wonderful. The team work was Awesome!

Skydiver described the military culture in a positive light while on active duty but found difficult to transition to post—active—duty culture.

**Skydiver**: I found the culture positive. I personally was lucky enough to be in a deployed environment where I could get the care that I needed right away. Post deployment, it was a little trickier getting the care that I needed because I didn't know the system. Once I got to know the system and understand it and ask a lot of questions then it was easier for me to navigate. The care that I got was absolutely great and I made sure
that I did not tell them that I was a nurse. I did not tell them that I was a nurse. So went I went to the VA in Brooklyn after I came back from my follow-up physical and whatever it is that I needed, I was sure to not tell them that I was I mean they can see on my ID that I'm medical and my rank. So they passed it on to each other. Okay, she's a Lieutenant Colonel. At that time, I was a Major, at that time, just coming back I was a Major. I threw on Lieutenant Colonel just like a minute ago, like a month ago. PTSD was something that I was preparing for, because I didn't know what to expect when I went into Theater. I had never been deployed before and it was deploying to a war zone. Even though I was on base it was still a very dangerous area. The only thing that bothers me are loud noises. That's the only thing that bothers me. At first I had enuresis, I was voiding, I was passing urine at night. I just chalked it up to fear. Eventually it passed. As time went by, it passed. It lasted maybe about eight or nine months. I would have an accident sometimes every night, sometimes every other night. Then it went down to once a week and then eventually it just left. So my past accident was probably, I would say seven or eight months ago. But loud noises still bother me. Saturday, I just went to the post office and someone opened that black gate to put in her package which is right next to me, and she slammed it down and I said, "Are you okay? Because you don't need to slam it that hard." You know? I just asked her if she was okay just to make myself feel better. To make sure she's okay. Like to reassure myself, oh it's nothing, she's just putting her package, in. You know? Loud noises, mostly from the hospital is a hardened facility. So once you go into certain hallways if there is an incoming announced, then you run into the hallway. You put on what are called battle rattle. So the battle rattle is a 50-pound vest that covers you up to mid-thigh. Your helmet and your eye protection within the facility, you put that on.
Then when you get the all-clear sometimes it takes up to about a half an hour, sometimes 45 minutes. You get the all-clear, you can't even go and see your patients. So if they're sick, you just have to let them be sick.

TM described the distinction between military and civilian worlds with regards to the care she received in the military hospital and civilian hospital.

**TM**: There is a big difference in the culture of the military and civilian worlds…

Like my husband, like I said, because when he's on orders I'm on Prime, so I can still see my military doctors. But what ended up happening and it was the same kind of thing they really felt like I was out of there- It was so complicated, my primary care physician there, she finally just said, "Look," which she was a nurse practitioner at the time too. She just said, "Look, we're not doing you any justice because every time we send you to a specialist, we have to send you to civilian hospital."

AM described the transitional experience in culture when she moved to the civilian world and articulated being taken advantage of in both civilian and military hospitals.

**AM**: The only place I where I had issues, that's when I moved. Obviously, you're more a customer when you're in the civilian world. Obviously, you're more a customer when you're in the civilian world. I got treated more like that. At the same time, I know I've been taken advantage, or not me but my family. The doctors have done what I know shouldn't have been done. At the same time, that's not everywhere. I think that's a local issue. I think that's culturally where you're at, that you will have TRICARE providers who don't care and that just see you as yet another patient. "Why do I have to do this?" Since they're not motivated, they are not concerned. Yeah, even within the military, you have that pill.
Maria described the culture of the leadership having an influence over transitional cultural experiences. She articulated the need to understand orders and the repercussions of the military culture if you do not adhere to direct orders.

**Maria:** Oh no, yeah like Army as a whole has the transition program, has the resources, but it ultimately is up to the culture of the leadership whether they want to help access the program. Because the army can give you a profile, a paper saying, hey, this soldier, she's pregnant, yada, yada, yada, can only do so much, but then again, if your leadership doesn't want to honor that medical statement or that piece of paper that says that this is what you can and can't do. Granted, it is your health that you need to worry about, but then you got to realize what the repercussions are that could happen if you don't listen to that leadership.

Mary described a positive, supportive culture in the military. She recognized that our society here in the U.S. is not familiar with female veterans losing limbs during active duty but feels that society is changing and the acquisition of knowledge and acceptance of female veterans has grown in the past years.

**Mary:** Both military and post military, I found a positive supportive culture. So when I left the military and I had surgery back in the states at a military facility, I had support from my military friends and even the hospital itself. In follow up and I think, again, being in this area, there's a lot of family members, and, let's face it, especially back then the family members, well predominantly wives are there, so that was a big. I think that some females that I see in Walter Reed have a tremendously difficult time because they have real loss such as loss of a limb. You see, our culture and society are not used to
seeing females in this condition. I think that the civilian culture is changing and becoming more acceptable of this, well, I truly hope it is.

In summary, the participants of this study found the teamwork and comradery in the military supportive and understanding. Depending upon the leadership culture, there were deficiencies in recognizing female medical issues. The culture of the military differentiated from civilian culture by civilians working in the VA. Civilian VA workers could benefit from instructional classes on the health care issues afflicting all female she-roes. Recognizing that female veterans have the same medical problems and physical ailments could be beneficial when helping females navigate the health care system outside the military. Overall, the participants of this study recognized a cultural shift from military to civilian life. The participants value their service and desire for society to recognize and understand the value and hardships they face during and after their military service.

**Theme 2: Health Conditions: Sacrifice and Commitment to the Mission**

Ten out of 11 participants reported that their experiences of transitioning to post-active duty health care were shaped, in part, by their experiences of health conditions and surgery.

Twenty-five data units were included in this theme. Table 4.4 indicates the codes and sub-codes that were grouped into this theme during data analysis, as well as the number of participants who contributed to each and the number of data units included in each.

**Table 4.4: Theme 2 Codes**

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<td>Epilepsy</td>
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</table>
Participants’ Experiences

The participants expressed their thoughts and experiences about their sacrifices in the military and the ability to advocate for themselves for health care during and following active-duty service. Their sacrifices were based on their commitment to the military mission. Their personal sacrifices to complete the military mission is exemplified by a variety of medical conditions. Each of these health conditions was acquired while the participants served on active duty to the detriment of their health but for the crucial commitment to the military mission.
Maria described her health condition before the military and a work-related concussion. Maria has not received care for her concussion following her military service and continues to suffer from migraine headaches.

**Maria:** Before the military, I had one concussion, one sports-related concussion, and sports-related ankle sprain. During the military, I had the boys, which were via C-section for both of them, so that's one surgery. I fractured my wrist, and I had nerve damage. In the military I had a work-related rollover incident which caused a concussion. Right now, I really don’t know how I feel. I'd get migraines here and there, but I'm not a 100% sure if they're from the concussion from the rollover, cause the way the rollover happened was it ended up landing on the passenger side when it stopped. I was on the passenger side and that's where the main impact happened. I wouldn't really know if the migraines are from the concussion; I didn't really get it checked out as much as I should have. I also had two C-sections when I was in the military.

Sandy described having no medical issues prior to her military service. She articulates struggling with many medical issues that she experienced from serving on active duty.

**Sandy:** I didn't have any issues before I went in. Then during, I didn't really have any issues. After, I had a bladder problem after I got out of the service because I held my urine too long when I was active duty. I had like 10 surgeries because of that problem. Yeah. I had Pyelonephritis so I had a kidney infection. It caused a lot of issues and a lot of problems. Now that I'm outside, I can talk freely. There's not a lot of people in my job, on my unit, because 911 happened, so a lot of people deployed. I stayed behind. Sometimes it's even worse that I stayed behind, because there's not a lot of staffing. I was
at Langley in Virginia. Because there wasn't any staffing there, I was in the ER 9 months pregnant. The only nurse in the ER that night and I'm triaging. I'm taking care of patients and doing everything by myself. It was pretty impossible to do. As a result, I never went to the bathroom. As a result, I stretched out my bladder and got a kidney infection. My urethra was damaged. I wound up having 10 surgeries. They had to dilate my urethra, because it had so much scar tissue. I had my bladder drop. All this stuff. I literally 10 surgeries. Then I got random things like hemorrhoids from being on the floor all the time. What else did I get? I got PTSD from being a nurse and the shit I saw. What else did I get? Depression because of that. What else? I guess that's it. I had a foot surgery because my feet were injured from being in boots all the time. My toes were all screwed up, so I had surgery on those. Then I wound up having varicose veins from being a nurse. I had to wear combat boots in the emergency department and my feet were squeezed together.

Jen described the health care condition she acquired during her time at the Air Force Academy and her dream to become a pilot prior to her seizure which has been attributed to her depression during and following active-duty service.

Jen: So I went to the Air Force Academy and about two months before graduation, I had a seizure. So I actually went through the Medical Board process to get stationed. Yeah, so they knew about it before I entered active duty, so that wasn't news to them. Yes. It's been a little bit of a ride and that's the primary reason of my departure early from the military. It just wasn't a very good environment for me to be in. That was part of the three-hour conversation that I had with the doctors. The conclusions of why to my depression was related to my epilepsy. I feel like we can't really talk about psychology without talking about neurology and how linked those two are. I mean, I had a pilot slot
up until my seizure, so that really impacted my life. Granted, I'm doing great. My life is wonderful and I couldn't ask for a better life, but when you get so close to one dream and then suddenly in a blink of an eye it changes, it takes its toll.

Debbie described the culture in the military health care system as a positive experience due to her thyroid condition. Following active duty, Debbie was frustrated with the teleconference system but has since found peace with an endocrinologist in person at the VA in Fort Meade.

**Debbie:** Well, I have a thyroid condition and I was really skeptical about leaving the military health care system as I had a specific endocrinologist. I was extremely satisfied with my military doctor and my condition was stabilized. However, when I left active-duty I entered the VA system in 2013. I want to say that overall I was very pleased with the VA with all other issues, but they did not have an Endocrinologist at the time so I spent about 3 years trying to find one. The VA in South Dakota provided me with a video teleconference, but that was disappointing as the doctor basically said I was fine and it was in my mind. So that time period was frustrating, but now I have a new endocrinologist at Fort Meade who is wonderful. I love Fort Meade as I wish every VA hospital was like this hospital. I have been going there for about two months now. I also have two bad knees and they are bone on bone. The military doctors were great treating my knees. I am receiving a lubricant therapy through Fort Meade.

Kerry described a frightening experience in Afghanistan from an Indirect Fire attack (IDF). Kerry’s commitment to the mission is a powerful example of the sacrifices made by female military service members.
**Kerry:** Well, I had a second hernia repair after I came back from Afghanistan, but I would say this: since being deployed, it's the people that you're with and when you're in that situation. There's like a bonding that goes on, you know. So what happened to me was I became so into exercise. And today I went running; you know what I mean, it makes me feel good, you know? So and I think it helps with my anxiety too, I think it really helps. You know, cause that's the thing; when I was over there, I was extremely nervous. I just needed a little bit of control over myself and I think exercise helped me do it. I had a lot of anxiety when I first arrived overseas. Oh my god, I will never forget this. I wasn't really nervous until the day we had to leave. When we all gathered at the unit and I remember there was somebody giving a prayer, a blessing, and I lost it, I literally lost it; I was crying uncontrollably. I had to excuse myself and go take care of myself, you know. I volunteered for this too; that's another thing I want to say for the record. I volunteered to go and I think almost all of us volunteered, there was a couple that were voluntold. So yeah, so that day and then we traveled to Qatar, we finally made it over to Afghanistan. The first day we arrived we were on jet lag. We were on no sleep and we were trained, we were tutored, you know, transitioning, orientation, the whole works, and we're exhausted. And that night at 10:30, I'll never forget it, I heard the sirens going off, they had an IDF attack, you know the thing. I put on my gear and I was shaking, I was nervous I was trying in my head not to cry, you know I just felt like I wanted to, I was so nervous. And somebody grabbed my hand and said "It's going to be okay; it's going to be okay." And we were in the hallway; we were ducked down. Yeah, and I think for the whole time that we were there we had IDF attacks, because the summertime is pretty busy for the Taliban, right, maybe I want to say 54 times, 55, maybe even more than that.
You know, but it was funny, near the end when we were going to go, the sirens become routine, they do. It's just so weird because it happens that near the end you're like, "okay, another IDF attack, get your gear on. But that first night with the first siren, one of the people actually came in the hospital; we were in the hospital too, one of them actually died, a soldier outside died, they rushed him in the hospital and he was pronounced dead because he was standing up, and I guess with shrapnel and everything. Once it hits, you're supposed to duck to the ground and he was up, and the shrapnel I guess cut him through his neck and he didn't make it. So it just shell-shocked me. I do think about this now that I am home and safe. This attack was in the news, actually, when we came back. I think it was I want to say November, maybe mid-November, three people died inside the base because a suicide bomber got in. I don't know how the hell he got in through six checkpoints and he went to the fun run and he blew himself up in front of three or five people died. And there were like 17, 18 injuries. So they put me on melatonin, then they put me on Trazodone, I had headaches from that, I didn't feel good, I felt a little bit better after I went 2 days. I felt a little bit more normal. I mean at least I got a little bit more sleep.

TM described a traumatic experience being deployed twice during the Continuous Promise Mission. She experienced an unknown ailment and the military was concerned that she was fabricating. She also experienced Military Sexual Trauma (MST) while serving on active duty.

**TM:** I have a diagnosis of mast cell activation syndrome. And then as part of that, I have severe anxiety from that condition. I can't control my emotions when I have an episode. While I was deployed, I got really sick. And before I had
been deployed, I had different types of sickness. I started having rashes and hives and stuff like that. Right before I deployed on the Continuing Promise Mission, the military said that for whatever reason they had lost all my shots records and they had never loaded them up in the system. So before I deployed they did all my immunizations again and then after. So I was working before deployment at a civilian hospital and they said I had some kind of unknown allergic reactions. And then right when I got home from Continuing Promise. I got home in November and then by January, I was already doing pre-appointment training to get deployed again. And so then that point in time, with the Continuing Promise, it was just a medical routine. So off I went to deploy again because the military doctors said there was no actual diagnosis to keep me away. I got really sick and I threw up at work. There were some questions about, ‘Maybe she's malingering? We don't know what's going on because she's keeps throwing up and diarrhea and all that kind of stuff and I was in Kuwait at this time.’ I was part of the cache in Kuwait. And I ended up really, really sick. They sent me home and then they sent me back to work and I kept throwing up and I was going to pass out and everything else. No one was in charge. I went over to the ER and they're like, 'We'll just give you some fluids and you can half-work while you're doing your thing because you have dehydration— everybody is doing their thing.” And then the next morning, I was so sick and I'm getting worst. I don't know what to do. Somebody in the lab was like, ‘You know, they didn't do a per-protocol work up on you any of the times that you've been admitted.’ They're like, ‘We have to run tests. ‘Thank God they helped me. I said to them thank you so much as you're different I actually kind of got in trouble because they were like, ‘Well we have to run this test on the machine anyway.’ Just regular test. They're
like, ‘But if you want we'll just- We'll use that. Your blood.’ And then it came back and I had pancreatitis so bad that I went to one of the doctors and they're like, ‘Which one of my patients is this?’ And I was like, "It's me." And they were like, ‘There's no way you're walking around like this and we need to fly this person out.’ I was in so much pain. Yeah. So they redid the lab. They admitted me and redid the labs and they came back and they apologized and they were like, "Well you actually let your blood get run without having a doctor's order, so you’re kind of like in trouble except for we're in trouble more because we didn't follow protocol and we almost killed you." That kind of thing "Oh." It was crazy. The lab people said that my blood levels were really high. They actually had to dilute it out five times just to even get the machine to be able to read how bad my levels were. It was that bad. It was so totally bad. Then there I was in the hospital, but my unit was actually coming home. So I thought I was going to be able to discharge me from the hospital. Then they readmitted me and they thought I was still going to be able to go home soon, but then they were like, ‘We just are uncomfortable. We're going to go ahead and put you in a hospital.’ I was medevacked to Qatar from Kuwait. I got even sicker in Qatar. I then was transported to Germany. They placed a pic on there because they put a line in theaters. They had to redo all that stuff. But then they decided that they thought my gallbladder because of all the infections. The pancreatitis kind of subsided, but the pain had not gone away. I was still so sick and they said that they thought it was my gallbladder as well. So essentially, they let it go so long that it kind of spilled over into my gallbladder. I didn't have any stones or anything, but the function wasn't working. Then they decided to send me home. They decided not to take it up there, "Well your unit is already home. So we're just going to Medevac you home." And so they did but it was
not fun, but we came home and on the flight home though I progressively was getting so bad they were intending to get me to Fort Winter Wood because it would be close to my family. But when we landed in San Antonio, I wasn't doing well. My vital signs were bad and everything else and I was in so much pain I couldn't handle it. They took me to the emergency landing off the plane and took me to the ER in San Antonio. Well, I was moving to Texas anyway afterwards, so it actually was meant to work out this way. I ended up there and they took my gallbladder out and then they put me in a wounded work unit thinking, "Oh, you're just going to be a quick little recovery. You'll go back and you'll back to your unit and it'll be fine." Only I just kept getting sicker and sicker and sicker and sicker. I was hurting all the time and I started having tremors and everything else. I got to where I was struggling to be able to walk and it was kind of a random thing. They had me seeing an allergist because I was having a lot more aggressions and I was having a lot of admissions for having angioedema and stuff and they were sure what in the world was going on? I saw an allergy specialist and he did all the random tests. I did the normal stuff and my lab results look pretty decent except for my liver functions were off. He randomly was like- He's like, "I think I might know what you have." He's like, "My roommate in college or in med school specializes in this. So I want him to look at you." So he consulted with him and worked at NIH and that's when it was decided that the mast cell. I don't have mastocytosis, but I have the mast cell. Oh no, no. Through all of that, they started me back on immunosuppression and I did better. And then they discharge and implement a lot of litigations when they discharged me and I was actually in a wheelchair. I want to say sometimes they actually diagnosed me in February of 2013 and in a month or two of that I was in a wheelchair. I was in a wheelchair until after I was
discharged from the army and then I started using a walker and I've gotten better to now I
don't use them, but I tend to. If I don't feel good, I just stay home and rest. I also had a
sexual assault while I was in the military too. So it was a lot of things. So I think and I
felt very frustrated because I felt like when I called in, when I changed my medicines and
I called in and said, "We need to come in," and I'm like, "I'm too sick to come in. I really
felt like I was too weak and I really was too sick for the tests." Then whenever I did show
up the immediate thing they wanted to do because I was emotional, because I was sick
and I felt like nobody was looking into me and I felt like I was being run around
everywhere. Then they started doing the, "Oh well we got to put you in the psych ward."
They did put me in the psychiatric ward. My case manager and the police came to my
door and I just I started feeling disappointed, so I completely backed away from the VA. I
only been there one other time and it was because I had fallen and I thought I broke my
rib.

Skydiver described having PTSD and the physical ailments that accompany this
diagnosis. She chose to keep her PTSD a secret from the military as she didn’t want anything to
disqualify her from receiving her benefits.

**Skydiver:** I have a history of mild PTSD. So I have enuresis and headaches that I
receive medication for it at this time. So I was voiding; I was passing urine at night. I just
chalked it up to fear and eventually this passed. It lasted maybe about eight or nine
months. I'm going to have to be honest with you that I can go to the clinic at anytime and
see behavioral health or psych whatever they call it. People will tell you certain things on
your medical record can disqualify you… but I’m not sure, so I keep quiet. But I am sad
and depressed. I was sad before I went to Bagram, Afghanistan. I worked in Craig Joint
Female Veterans’ Transitioning to Post—Active-Duty Health Care

Theater Hospital. I was so sad before I left. My 11-year-old son, "Mom, mommy, you're going on a mission?" And they play these video games and whatnot, so they know about, you know, going on missions and whatnot. And so I said, "Yeah." And he's like, "But on the video games, you get more lives, but in real life you only have one life." My religion is what's keeping me going. And my support system is what keeps me going.

Mary described a positive experience in a military hospital where she received a double mastectomy following her active-duty service. She expressed her gratitude towards the physician who cared for her at the military hospital.

Mary: I had a double mastectomy. Yeah, the cancer was present in both sides. It was 100% in one and 75% in the right side but it was all in stage 2, so I'm the lucky one. So both breasts had to be removed and I was very lucky at the time, there was a doctor there who, I can't remember what the acronym stands for, the tram where they take some stomach muscles and use that to rebuild the breasts. It's unusual for the military to provide that service but she did it there and it was the right time and the right place. And I just happen to be there. I think probably a year after or a year before I probably would not have had that option. I haven't looked back, I think it was a great thing and like I said, I consider myself extremely lucky because a year or two in either direction I would not have had that door opened for me.

Taser described a surgery she had outside of the military system. She articulated her weight gain following military service as a result of not having to take the physical readiness exam every 6 months.

Taser: I had a lumpectomy in the Reserves locally at Long Beach Hospital in New York. It was really more of a preventative. No family history; they just found an
abnormality on mammogram, and then we did the sonogram, and he said just to be preventative through a ... I guess, prophylactically. But my weight problem was after the military. I don't know, maybe it is because I didn't have to take the PRT, and I was so happy not to have to do that anymore. I had liposuction after the military. A lot of my friends were having tummy-tucks, and so to me, it was a lot safer. It had less risks attached to it than having a tummy-tuck done.

The participants in this theme articulated powerful and life-altering experiences from their time on active duty. They experienced medical conditions that are attributable to hardships following active-duty service. Some of the participants continue to suffer from the after-effects of military service. Overseas duty contributed to a myriad of health conditions in some of the participants and the effects are still persisting today. This theme demonstrates the commitment and sacrifice female veterans have made to the U.S. Some participants are receiving the necessary health care outside of the military, while others are frustrated with the health care system.

**Theme 3: Health Insurance: Gender-Specific Health Care**

All participants reported that their experiences of transitioning to post—active—duty health care were conditioned in part by their experiences of insurance and medical care. Forty-eight data units were included in this theme. Table 3 shows the codes and sub-codes that were grouped into this theme during data analysis, as well as the number of participants who contributed to each and the number of data units included in each.

**Table 4.5: Theme 3 Codes**

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Some of the participants in this study were able to use Tricare Insurance following active duty. Tricare is a program designed to provide health care services to people associated with the U.S. military. The participants expressed their thoughts and experiences about their gender-specific health care and the attainment of health care following active-duty service. They articulated having a difficult time transitioning with limited support.

**Participants’ Experiences**

AM described difficulty transitioning to health care outside the military and noted that she received limited support during her discharge from active-duty service. She stressed the difficult process of navigating the Tricare Health Care System.

**AM:** I had a hard time with transitioning. They just kind of drop you off, at least at that point. Even my unit did nothing for me. There was very little support. I think I

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</table>
understand insurance a little better as I am a health care provider. I have been a provider for a while now. I'm not currently. But the fact is that people don't understand how insurance works. You go from Tricare. So many of the soldiers and their spouses, too, they are 18, 19, 21. They have joined the military themselves, to go from the health insurance of their parents or someone else's insurance, whatever they had, to having Tricare. They're not used to anything, and they're bitching and complaining about having to use Tricare and having to use the military health system, and whine, whine, cry, cry. Yes, you don't understand that if you have health insurance you pay your premiums are meant as a, basically just as an entry fee that you're allowed, that you have maybe some coverage, but what really is covered is still a crapshoot.

Then in addition to paying your premiums, you still have to pay extra to use the services. I think that explanation, what insurance actually does, how health care is, that health care, unfortunately, is a business and it shouldn't be. And health care being the business that it is, that there's fees that you have to pay for. I can give you the perfect example right now is my husband didn't listen to me. My son is an ROTC cadet. And he's also called simultaneous service member program or something like that. So he also drills with the unit but as a cadet, but he's still under his dad as far as health insurance and Tricare. He's a dependent because of the cadets. Well, somebody screwed up his record last year sometime. We didn't know until the Tricare regions merged and all of a sudden he got bills. He had a procedure done last year. And the Tricare regions merged, and they popped him off of Tricare Prime in the Tricare statement. All of a sudden, he keeps on getting these bills. I'm arguing with my husband. I tell him, "Listen, it’s not supposed to happen because Tricare will not cover unless we have him backdated to whenever they
merged the region, because they won't." Their job is to pay off the least amount of money possible. I had the same problem with the other health insurance. Actually, I understood rather quickly that once you're with a network of some sort that they're supposed to only charge you X amount of dollars and everything else. They need to take it off your bill. I remember that we had a health insurance through my husband's employer at the time, and that was his first job out of the military actually. So this is the first time we're dealing with civilian health insurance, and no bill. Every pediatrician’s visit, there was a leftover amount, and they charged us. The health system charged us the leftover amount. Every time, I had to call them back and say, "You know for a fact that you cannot do that. Why do you keep on doing this?" It was a constant battle, and the only time I had more luck is when I started work as a nurse. We were lucky to keep our pediatrician because he was in the hospital system has their own insurance. It was very cheap, but you had to use one of the staff providers that were scattered throughout the suburbia. By chance, our pediatrician did have staff privileges at the Children's Hospital, so I could continue seeing her. They screwed up my insurance papers. I get the HR. They screwed up dates. On my son's birthday. They were nice enough, and I mean it was a mess. I made sure that it wasn't me. No, they couldn't read his German or his international birth certificate properly at HR. That was a problem. So they were nice enough to call me. The pediatrician called me and said, "Hey, listen," because I had been with them for a couple years at that point. They're like, "Listen, something is not right. You need to talk to HR to get that fixed." It's little stuff. If you don't understand what is part of your privileges or whatnot. Again, Tricare, not too long ago, twice, were trying to give me a primary care appointment more than 30 days out. It was a resident switch, and I told them. I looked
right at the person like, we both know you're wrong doing this. We both know you're not supposed to do that, and it's the same, the constant conversation every time you go somewhere. "We need your social security number for benefits." "No, you don't." And that's with two and three different insurances and multiple doctors where I just tell them and I just stick my heels in. I said, "You absolutely do not need my social security number. You just need the benefits number to make it work." Yes. So I figured out how this works, and I make it work for us but only because I'm putting my foot down if something happens. But you're right. What do you do to our TRICARE beneficiaries that don't speak English? They don't know. But they need to have the spouses in there, too, and they need to do it in more than one language.

TM described her experiences transitioning to post—active—duty and having difficulty navigating the health care system to obtain her pain medication following active duty. She described the hardships she faced obtaining custody of her children after she served on active duty due to her health and the attainment of health care of her children following her divorce.

**TM:** So it's hard for me though in the whole system and even retiring out of the military because they didn't have a code for me. They have codes for, "Okay you lost your leg." Or, "Hey you have sight condition. You have PTSD." I mean they did have some type of a code, but it was kind of an interesting way. For my VA ratings and stuff most of my rating is actually more on—Instead of rating me just for the mast cell disorder, they rated me more for what it causes. It's all the signs and symptoms of it like the migraines, the tremors, the anxiety, and all this surgery. All that kind of stuff. I actually lost custody of the kids when I got out, as I was in the Wounded Warrior unit and my husband had gotten medical coverage. We were getting a divorce. So their dad used my medical care
to keep the kids, but in 2014—Like the end of 2014 I think- after I got home and I was
discharged from the army. That following year, I was able to travel to court in Missouri
because before that I haven't been cleared to travel and then I was able to eventually gain
custody of the kids because I proved that I could take care of myself and them. Yeah.
And my kids have lived with me for the last few years. Yeah. And I have been a nurse
before I even deployed, so it was rough. Yeah it was exciting. I was like, "I have my kids
back." But yeah it was tough. So when I first came home I was really kind of by myself
and then when I first went to the VA, I was on a lot of medications when they sent me
home. And then what happened, I wasn't on enough. By the time I got my first VA
appointment, this is where I feel like I fell down. I was out of my fentanyl because you
can only have a certain amount. It's tight, so they can't give you all your other
medications. They can send you home with 30 days. But they can't send you home with
100 micrograms or something really high. I was on a good-sized dose of fentanyl. I went
home on this huge dose and I didn't have enough for the date for my VA appointment.
Not only that, I was sick anyway and then I started withdrawing and I was so sick it was
so hard to get to my appointment. So I ended up running out of medicine before my
appointment. I ended up going to the ER, which is a no-no because then you're drug
seeking and I was in the ER on the floor withdrawing terrible from fentanyl. And it was
forever. And then finally when the doctor came in to see me, he said he felt so bad for the
fact that I had been there withdrawing for so long before somebody saw because I had
been there for six or seven hours. It was a ridiculous amount. But then he set me up with
somebody because like I said I was on the VA system. I'm still on Prime though because
I had come home. So then when I went to the VA system and that was kind of a mess
because I was in the middle of my divorce. The divorce wasn't finalized. My ex was still in the military. They were trying to say that even though I was on Prime and I came out since there was this big question is I needed to provide paperwork of all his information and income and I was- It was a huge mess at the first. And then I was like, "Oh, I'm not. I'm not going to do this again. I have the shake tremors really bad and I'm vomiting and I'm having withdrawals and you're asking me even to tell you the same story I told you the person in the office next to you 30 minutes ago. Can somebody else help me navigate this? It would've helped.

DL described a positive experience transitioning to health care at Fort Meade, VA, and articulated the positive recognition for being a female veteran.

**DL**: I wanted to tell you that my husband was traveling to D.C. the other day and ran into Senator Rounds. The senator was very nice and thanked my husband for his service but wanted to ask about me. He asked if I was being treated at Fort Meade and if the care was good. My husband was very happy and pleased to tell him that I was in good hands and they were taking good care of me at Fort Meade, VA. That meant a lot to me that the senator recognized me as a woman in the military and that he was concerned about the care at Fort Meade.

Jules discussed her easy transition experience as she was able to obtain employment and private insurance following active duty. She articulated concern for friends who have had difficulty in the VA hospital setting.

**Jules**: Yeah, my transition in medical insurance was actually really easy because when I got out, I went straight to work in Michigan for Ford Motor Company, so I had great benefits, insurance. I think I had to do probably 90 days, but I don't believe I got sick in
that time, so I don't remember there being any issue with transitioning. Like I said, now, though, I would not want to get out now because you don't realize when you're in having everything covered and everything on base and never having to pay for anything, how awesome that is until you get out and you struggle, like nowadays, people that have to go through the VA and I couldn't do it. It would be awful because I have a friend who is prior Navy, and he's got some serious medical issues. He has a disability, discharged from the military, and he waits six months at a time for an appointment.

Maria articulated that her transitional class from active-duty service was provided via a powerpoint presentation. She discussed the difficulty in being seen at the VA as a dependent family member of an active-duty service member.

Maria: The thing I remember about the powerpoint presentation I received was that that veterans are covered for like six months, so that was six months on Prime. And then after that, I guess there's no more health care, no more health insurance. Yeah, you know what, it does depend… I have heard and have seen that it's more difficult to be seen as a dependent than it would be as active duty.

Jen discussed the comfort in the military and her unfamiliarity with the TRICARE system following active duty. She articulated a knowledge deficit related to where to obtain women’s health care.

Jen: The military takes care of a lot of day-to-day type worries, like insurance and just those types of things and budgeting and bill payments. I mean, they give you housing allowance, which is like a good portion of your pay that you don't have to worry about and things like that. Because your active-duty military and especially if your spouse is active duty, health insurance, it's just automatic. You just have one choice: you get Prime
that day. You don't have choices. So what does one level mean versus the other? I hear my mom and dad talk about the Cadillac version of healthcare and their companies and stuff like that. And I'm just, what exactly does that mean? These like high deductibles, and well, what does that mean for you? The realities of that. So I have to go out and find that information myself and I'm just grateful that I have parents that are willing to share that information or are able to share that information and kind of have those experiences’ because my mom's company just recently started offering healthcare options, so they've gone through that recent transition themselves of shopping around. But I'd definitely say, before you transition out, you need to go and weigh options, like actually look at healthcare plans and premiums and what deductibles are and how that factors in because a $1,500 deductible is very, very different than like a $500 deductible. On that note, even the VA healthcare system, going through the transition program, even today, I'm still a little confused as to what it means to have female healthcare offered through the VA.

Because they say, "Oh, women's clinic or women's healthcare, but what does that mean?" Because I know that I have to have service-related conditions in order to be covered and not everything's covered and it's still not full coverage. Right not clear. So what does that mean in terms of my reproductive health? Is that covered by the VA, or am I on my own for that? It wasn't clear coming out of that. I think we could do better in terms of the female end of that education, in terms of transition, because that's another piece. Like, where do I need to go for my annual well women exam or stuff like that? Can I go to the VA for that, or do I need to get separate insurance to cover that?
Skydiver discussed the brevity of the review she received regarding TRICARE and the VA following her active-duty service. She articulated the need to be diligent when navigating the Tricare medical system for veterans.

**Skydive**: Yes. It was very brief. They told us that we should apply for Tricare which at that time was the insurance that they were using for the VA hospital. So I didn't apply for Tricare because my children are under the birthday rule. So because my husband's birthday comes first, their medical needs are covered by his insurance. It takes navigation and time if you are in general healthy to understand the health system. If you come back with issues and personally have problems navigating or getting around, transportation, things like that, and it's a rural area, I could see where they would have problems. Do you understand what I mean? I'm lucky enough that I live in north Staten Island, close to the VA. I can get around; I can move around. You know what I mean? I have good support.

Taser indicated that she is pleased with the use of the VA in Brooklyn, New York. She is happy that her children are covered under her medical insurance plan post-active duty.

**Taser**: My son and I receive VA benefits and my son will get them until he is 24 years old. Yeah, he will receive so as long as he was in school. Yeah, 24, 18, and then as long as they're in college; then it'll extend until 24. I access all my appointments through the VA in Brooklyn and if I need a specialist, the VA will set it up. I am happy with the health care at the VA in Brooklyn.

KT said that she is eligible to use TRICARE but chooses to use her primary insurance as she is covered under her husband’s health care plan.
**KT:** I'm under my husband's insurance. When I was deployed, I could have used tricare, but I really never did. I mean, I'm very healthy, number one, and I never really had any problems, so if I go for healthcare, if I just go for a primary checkup, I just go in the area. Maybe it takes me ten minutes, 15 minutes.

Sandy indicated that the VA was not abreast of her health care situation so she chose to treat herself as a nurse practitioner. She discussed dissatisfaction with the VA not recognizing her military status because she was not a combat veteran.

**Sandy:** I have VA, whatever, but I don't use it. Well, since I'm a nurse practitioner, I treat myself, which is bad. The VA wasn't really an option form me. As a woman, first of all, they didn't get me. They don't understand healthy woman. They weren't really helpful because I wasn't a combat vet. My husband was in the military, so he was stationed overseas. He was one of the first; he was on the Enterprise. He's a fighter pilot. He's one of the first people out to sea. They're on their way home and then turned around, and he was one of the first people to respond to that incident, that thing. So I was world-wide deployable, and I was trained. We did the whole air transportable hospital, and you had to do all that. I had a slot as far as they could deploy me. When everybody deployed, I said, “No. Please don't let me deploy. He's been gone for eight months. I'm young.” I was like 23 years old or something, 25, no 23. I said, “Please don't deploy me. I can barely function.” I was sad. I was depressed, because he was gone. That's the other thing; I was depressed. You don't really connect when you're 26 years old. You don’t get that you can receive VA benefits after the military. At the time, the VA disability really wasn't that known. So we talked about it, but I didn't know what the hell they were. I didn't care, you know. They didn't really help; they sit you down before you get out.
They do a PTSD screen. They do PTSD screens at every stage. I think I had about four of them. Two things. It was really frustrating, because I didn't know about any of this stuff. I got out in 2002. I didn't even find out about stuff until 2007. Then I got service connected for 40% for my kidney stuff. I didn't know about, in 2007, we still didn't really know about PTSD, like it is now. So I really should've been service connected 100%. I really should have claimed hemorrhoids and varicose veins. I had a foot surgery in the military.

Mary articulated the reliability of the Tricare insurance program.

**Mary:** The most important thing, right now, especially in this culture and climate is knowledge about what healthcare options are available to you, even if it's just a transitional program. Tricare might not be available to you in the long run, but they always have some sort of transition program for you. Tricare is reliable. There's also, and I don't know, not to give you more places to look. But there's a program they are pushing down here that is going to have a higher co-pay I can tell because they don't compare co-pays in the flyers, but John Hopkins, I'm like yeah you are not mentioning copay so clearly it’s going to be higher, but John Hopkins is doing some sort of a program as an alternate for Tricare. I mean it's sanctioned by the military so it's legit but that's something you also might want to look at too. That is like, it just started in the last two or three years, some of that's very new but we do continue to get their flyers and is definitely something to look at because I think you have more options for local healthcare and things like that.

The participants in this theme discussed their current health care insurance plan and what health care they chose following active duty. Some of the participants articulated difficulty navigating the Tricare insurance plan and the availability to healthy female veterans. Participants
discussed the brevity of the transitional class afforded to them while leaving active duty and the benefits that they could receive. Some of the participants found difficulty with familiarizing themselves with the gynecological specific gender issues that they required but some also had positive experiences with the VA. Overall, there is a disconnect within the military system as far as where and what type of insurance female veterans are afforded following active duty. It is essential that all branches of the military recognize the need for educational resources to help female veterans navigate their health care benefits following active duty.

**Theme 4: Facing Roadblocks and Challenges**

Nine out of 11 participants reported that their experiences of transitioning to post—active—duty health care were conditioned in part by their experiences of educational resources and transitional care. Twenty-five data units were included in this theme. Table 4 shows the codes and sub-codes that were grouped into this theme during data analysis, as well as the number of participants who contributed to each and the number of data units included in each.

Table 4.6: Theme 4 Codes

<table>
<thead>
<tr>
<th>Code (standard font and left-aligned), or <em>sub-code</em></th>
<th><em>N</em> of participants contributing</th>
<th><em>N</em> of data units included</th>
</tr>
</thead>
<tbody>
<tr>
<td>911 program benefits discovered late</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Didn't initially pay attention to</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Education center-info on GI bill</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Helpful mandatory evaluations</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Struggled-no transition support</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>TAP class helpful</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*Focus not on health care*  

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<th>2</th>
<th>2</th>
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</thead>
</table>
Participant’s Experiences

AM discussed the lack of information received about health care during her transition class out of the Army.

**AM:** In regards to a transition class, I went through the Army Career and Alumni Program which is basically about transitioning to civilian employment, but that's it and I do not remember that we discussed a lot about the transition in healthcare. However, I strongly remember that we were told that women needed to go to job interviews in a skirt, not slacks or pants, though clearly not very supportive of women's issues. It was 1996, so I have to give the lady a break.

DL discussed her positive experience with the transition program in regards to VA health care.

**DL:** I was able to take a transition class when I was discharging and was very happy with the three-day course that was provided. At first, I didn’t want to do the class, as it seemed that all were involved from E-1 to O-6, but in retrospect, the class was great. I think I was able to help some of the younger ranks, as they included what to wear on an interview and resume workshops. There was also a class on the VA health system and the benefits we were to be provided. The girl who gave the VA class was fantastic. I was happy in the end that I took the TAP Transitional Assistance Program class.

Maria discussed the lack of information about health care at her transition class. Maria expressed that she wasn’t given the opportunity to attend a three day in-class instruction.

**Maria:** So I was able to go to the education center and get information on my GI bill. I guess, other than that really, that's about it. Because I was actually rushed through the separation process, so all of the SFL-TAP and you know transitioning out from military
to civilian — I wasn't given the opportunity to actually sit in class. Everything had to be
done online. So the reason why I was actually discharged from the military was due to
being overweight according to the army standards, so I ended up doing the BMI
simulator and come to find out that I was actually right at my body fat percentage, but
according to the military standards I was over. So they decided to chapter me out for it.
Yeah. Oh no and I mean, so when I was going through the process of separating, I guess
they wanted to rush the paperwork and also according to regulation, they're not obligated
to allow me to sit in class. It can either be done online or in class. Yeah, so the classes
could be online like Power Point, but basically it's just PowerPoint classes.
Beverly articulated her experience in which she didn’t receive information on health care
following her active duty service.

**Beverly:** Okay. So my original transfer from active duty, there was really nothing
available for me, or to me. And as a matter of fact, shortly after having my son, so it was
really—Yeah, it was really a challenge the first couple of months trying to get everything
together. What happened when I got out of Public Health Service Corps, I guess being
more knowledgeable, knowing the system more, having been in the Reserves longer, so I
had more knowledge. Sadly, there was no transition class offered to me in 2011 when I
got out of the Public Health Service Corps.

Jen expressed that she received a limited amount of transitional information about health care
when she left active duty.

**Jen:** There was not really any class about transition other than the VA type healthcare
And really, that was just, "Here's how you get VA benefits." There really wasn’t
anything, other than just awareness of the Obamacare, like you have to get benefits, you
have to get medical care. There wasn't a lot of education in terms of what was out there or what was important or what to look for. So I'm still kind of lost when it comes to the civilian sector, so I'm very fortunate that I'm still covered in the military world.

Skydiver expressed that her transitional class was brief and there was an overall lack of information disseminated regarding her TRICARE benefits.

**Skydiver:** The transition class was very brief. They told us that we should apply for Tricare which at that time was the insurance that they were using for the VA hospital. So I didn't apply for Tricare because my children are covered by my husband's insurance.

Yes. So while I was deployed I am covered under the VA while I am on active duty, and up to a year after I come out.

Mary discussed the transitional process as being easier for her due to her geographical location and the abundance of medical care facilities offered to post—active—duty veterans.

**Mary:** I did receive a transition class, but a lot of people blow through this process. It's interesting because we're in a unique situation here because there was so much retired military; there's also large military healthcare facilities. So my experience is probably going to be a little different than say someone who retired out to Oklahoma.

Transitioning was easy as two very large facilities here, Belle Park Community Hospital and the Walter Reed Naval Medical Center, or something like that. So my healthcare actually has been very good I think access has been good; wait times are longer.

KT described her experience as being challenging having to repeat a psychiatric evaluation numerous times post-discharge from active-duty service.

**KT:** Transitioning was challenging as well; the military cover themselves just to make sure that we were okay quote unquote; we had to do psych test when we
Female Veterans’ Transitioning to Post—Active-Duty Health Care

SK expressed frustration with not receiving a transition class immediately following her active duty service.

**SK:** I didn’t receive any transition education at first. I didn't know about the 9/11 program, but you have 15 years between the time you get out to use your post-9/11 benefits. I was like 23 years old. No, I was 27. I guess it was kind of I didn't pay attention and I was pregnant. I just didn't care.

The participants in this theme expressed frustration and lack of knowledge about their health care benefits following active duty. Overall, this theme uncovered a lack of consistency within the branches of the military affording a seamless transition to civilian life and obtaining health care following active duty. Two of the nine participants who were high ranking officers and who were distinguished as retiring fully from active-duty in the military were well informed and acknowledged a positive transition to post—active—duty health care. Future recommendations would be to provide a fluid and seamless common transition class in person. One of the participants acknowledged a follow up to ascertain the level of PTSD. This follow-up occurred over two years. It would behoove military leaders to initiate follow-up conversations.
for all active duty females transitioning out of the military and to ascertain if they are in need of health care or if there are further barriers or knowledge deficits regarding health care attainability. Transitioning out of the military is a life-altering experience, and during this time, female veterans are vulnerable and concerned about where they will receive health care. It is imperative that military, VA, and U.S. leaders at the state level are abreast of what is afforded to U.S. military female veterans and provide follow-up classes once the female veteran has established residency in a particular state.

**Theme 5: Creating a New Normal: Acknowledgement of service.**

Eight out of 11 participants reported that their experiences of transitioning to post—active—duty health care included reflections on and lessons learned from the experience. Twenty-two data units were included in this theme. Table 4.7 shows the codes and sub-codes that were grouped into this theme during data analysis, as well as the number of participants who contributed to each and the number of data units included in each.

Table 4.7: Theme 5 Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>N of participants contributing</th>
<th>N of data units included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be a self-advocate</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Concern for vets with less knowledge</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Look into coverage before discharge</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Make full use of coverage while in service</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Need for evidence-based care</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Needed changes female veteran care</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Take college courses while in service</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TAP courses better in person</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Participants’ Experiences

AM articulated the need for female veterans to be abreast of the evidence based practice and be an advocate for their particular health condition. She articulated the need for all female veterans to follow up with gynecological care once a year.

AM: I would tell those transitioning to watch that your provider truly works evidence-based. Yes, because I'd say you need to get an annual. Don't say the military does not provide you with the same amount of care because you don't get the same frequency of tests, for example. Right? Because the military is pretty strict on the evidence-based care. Also, to have providers that still do pap smear every year and they do. I don't know how, but I argued about ultrasounds that "My civilian providers always did ultrasounds." I'm like, "No, really. They charge you for something you don't need and they make up something." So be aware of what the evidence is. Yeah, I think that's the biggest thing, they do not assume that a civilian provider is there working in your best interest all the time. It's the for-profits, and they want to make a profit. They want to run a business. I'm not saying they're bad people, but there's people that are milking the system in the civilian world. I would tell female veterans not take no for an answer and not have everything pushed on female problems. If they have a concern or an issue that it's not just because of hormone-related or because she is anxious or because of something else, it has nothing to do with the military or we're basically being cut off and not being taken seriously. To be very frank, you have to be an advocate for yourself, and not take no for an answer. If it doesn't sound right and if it doesn’t feel right.

Jules articulated the importance of benefitting from the various health care programs that a female veteran can receive while on active duty. She also suggested for all female veterans to
find the time to advocate for themselves and to receive the GI bill while offered to all military personnel on active duty.

**Jules:** I think one of the other big parts is, as a woman, if you have a pregnancy while you are in, you stay in because the health care is covered. So, I guess my biggest advice to someone who's in and may be considering getting out, you might want to go ahead and start that process and have the kid while you're in and then transition out after. Because, having a child, even with insurance, unless it's state insurance is expensive. So, that would be one of the biggest things and I would just make sure, I guess, all of your routine scans are done, your mammogram, your pap smear. Anything that you need done, get it done before you get out, because if you do run into a problem and you have to go the VA you have to wait a long time. I can't even imagine how long the wait is to get a breast exam or a pap smear done. Oh, one of the other biggest things I will tell people: while you're in, go to college. Take night classes and go because I never took advantage of any of that so I paid for all my college on my own. So, $140,000 later, yeah, it sucks, yep. And I see so many similarities because while I was in, I kept saying, "Oh, I'll have time. I'll go back to school. I'll go back to school," and quite honestly, we worked so many hours, it was very difficult, but then time passed and I didn’t. My husband did the same thing, and long story short, I like that advice because you have to find the time.

Maria discussed the importance of female veterans receiving the transitional assistance program to be given in person and not on-line.

**Maria:** I would suggest that the TAP course are given in person. I guess, other than that really, that's about it. Because I was actually rushed through the separation process, so all
of the SFL-TAP and you know transitioning out from military to civilian, I wasn't given
the opportunity to actually sit in class. Everything had to be done online.

Jen articulated the need for the transition class to specifically focus time on health
care benefits afforded to all female veterans.

**Jen:** I think it would've been helpful for my class to focus on health care. For the
transition class to really hone in on the transition to health care. Especially because it was
the prime time for Obamacare, so the marketplace opening up and stuff. Hey, let's
actually go check out what resources are out there currently. This is what you're going to
be dealing with, these are what you need to compare, and this is what you're looking for.

Mary discussed the need for all female veterans to be assertive when understanding what
health care options are available following active duty.

**Mary:** So you need to be a little more, I don't want to say aggressive, but conscious of
your options when you get out of the military. You need to remember it is time for you
know, OBGYN exam. And you know, if you make that annual physical and go, hey, what
do I need, this, this, this, this, and then okay, send in a referral and wait for it.

Beverly expressed the need for female veterans to be aware of every single benefit they
may receive following active duty.

**Beverly:** My advice would be to have them get connected with the VA, get connected
with the local VA even before they were getting out. I used to do physical corps reservist
a couple of years ago, and I would encourage them to get enrolled in their local VA. This
is because although they may not get every single benefit or every single service that
there is, at least they could tap in and then they could be guided to of the places to go into
for assistance, especially now.
TM articulated the need for VA staff to recognize all veterans whether or not they served in combat or non-combat situations.

**TM:** I would tell female veterans to be sure to explain to the person in the VA that they are a veteran if they served in combat or not? I think sometimes, is that people at the VA see men are they are easily recognized at veterans and women are not. And so that instantaneously everyone is thanking men and not women for their service. tied to them and then everybody is like, "Oh yay. Thank you." Which is fine. I don't need that recognition, thank you or whatever, but sometimes I feel like I'm not the same when they're like, "Oh well you weren't MT guy on the front lines, so maybe once I talk to this guy then I'll deal with your girl issues."

Andrea discussed the need for female veterans to have a good support system when transitioning from active duty and to understand the health care system and their benefits prior to leaving active duty.

**Andrea:** I would tell female veterans that before they deploy they need to be informed and know what is available to them. Navigating each of these different services can be difficult for a person. What I suggest, especially for young people, what I suggest is, one, make sure you have a good support system; family, friends. Two, understand the medical that they're going to need before they leave. Make sure someone that they know understands the care that they're going to need before they leave. That's what they're going to need the most before they leave. Understanding the system and make sure there's somebody that they love, that they know that loves them back, that they can trust, understands that system too.
The participants in this theme articulated the strong need for all female veterans to be knowledgeable about what health care benefits are available to them following active duty. There was a strong conviction from all participants for female veterans to be an advocate for themselves when facing roadblocks after transitioning home. Understanding all programs offered by the VA would be beneficial to female veterans. Offering a comprehensive class on health care services to female military service members may empower and facilitate a seamless transition to civilian life. Targeting specific residential areas where the female veterans will re-locate following active duty could enhance the attainment of health care resources.

It can be gleaned from this study that some states in the U.S. offer comprehensive programs to veterans, while others are still trying to enhance and develop effective services for female veterans. Navigating the health care system in the U.S. can be complicated if one is not informed about what paths they need to follow. Clear and detailed instructions offered to female veterans regarding their health care would promote the well-being and health of all female veterans.

Summary

The female veterans who shared their experiences were candid and open in their interviews. They shared challenging obstacles they faced when trying to navigate both the VA and the American health care system. Many of the female veterans interviewed articulated frustrations they encountered, having to repeat their medical history numerous times at the VA health care centers. The transfer of thorough electronic medical records from active duty to the VHA could help relieve the frustration some female veterans experience when transitioning from active duty.
The female veterans in this study reported a strong need to be recognized as veterans and receive the same respect offered to their male counterparts. They expressed disappointment when civilian health care workers confused them as being the spouse of a veteran. Being overlooked as veterans does not just occur in medical facilities but also in female veterans’ communities. It is always important that veterans be recognized as veterans regardless of their gender. Female veterans in this study interviewed articulated a sincere yearning to be recognized as veterans regardless of where and when they served. Further education for community members, VA and civilian health care employees can facilitate a safe and positive atmosphere for all female veterans and their families.

This study exposed some differences between male and female veterans. The availability of consistent gynecological care in the military was articulated by many females in this study. However, following active duty, receiving gynecological health care posed some challenges. It was found that some females were not aware of where and when to follow up on their gynecological health care needs. Compounding this issue is the fear female veterans have when discussing experiences of sexual assault and depression. A proactive initiation of ensuring all female veterans have a choice to be seen by a female health care provider could help alleviate this stress and frustration. The mental and physical health care issues that female veterans experience needs to be addressed. Providing them with female providers could enhance the improvement of the mental health of all female veterans. Furthermore, emboldening female veterans with knowledge regarding their health care benefits can facilitate a seamless transition to post—active—duty health care.

Female veterans in this study articulated a need not only to receive an orientation class to post—active—duty health care but also a class to orient them to both combat and overseas duty
stations. Female veterans expressed exhaustion and stress when arriving at their overseas destination. A preparatory class prior to deployment would help aid in the transitional process to their new surroundings. Recognizing and preparing all veterans prior to deployment are essential elements that could aid in the stability and difficulty of the transitional experience before leaving active duty.

The participants shared the aspects of their lived experience through their interviews. The context of the female veterans’ experience is clearly dynamic, individualized, and complex. Understanding the complexity of the female veterans’ experience provides a new basis of knowledge and awareness of this vulnerable culture. The emergence of the thematic elements discussed in this section deepens the understanding of the multi-faceted, lived experience of female veterans transitioning to post—active—duty health care.
Chapter 5: Discussion

The purpose of this interpretive phenomenological study was to explore the lived experience of the female veterans transitioning to post—active—duty health care. An extensive review of the nursing, psychology, sociology, cultural, and military literature was completed. Of the existing literature to date, there is a paucity of research in nursing designed for empirical studies related to female veterans transitioning to post—active—duty health care. What is not known is female veterans’ experiences transitioning to health care following active duty. There has been a lack of general information about this population. This study has contributed to the evidence and research related to female veterans that has been done and more specifically to the lived experiences these women have encountered transitioning to post—active—duty health care.

Female veterans have been growing in record numbers and are projected to comprise 10% of the veteran population in 2020 (Washington, Simon, & Sun, 2006). Given that most empirical evidence is focused on male service members, women’s expanding roles in the military presents both an opportunity and challenge to effectively capture how female veterans transition to health care outside the military (Street, Vogt, & Dutra, 2009). Examination of the lived experience of the female veterans, particularly as it relates to their unique culture, is pertinent given the growing awareness of meeting the needs of female veterans.

Five themes synthesized from the data were: (1) Military Culture: She-roes on Equal Ground; (2) Health Conditions: Sacrifice and Commitment to the Mission; (3) Health Insurance: Gender Specific Health care; (4) Facing Roadblocks and Challenges; (5) Creating a New Normal: Acknowledgement of Service. The data collected was rich and detailed, shedding light on the experience of the female veterans. Participants expressed their veteran status,
cultural views, and how their experiences would be beneficial to the enhancement of transitional programs for female veterans focusing on health care transition. Their interpretations contributed to the body of literature that recognizes the unique growing concerns of female veterans.

The ability of the participants to share their unique female culture with others was strong. The experiences of the participants highlighting their culture was one of personal growth and awareness when facing the differences and challenges of civilian culture after service to the U.S. military. The participants expressed how military culture differed from civilian culture especially in the workplace. They reported that their commitment and respect for fellow co-workers was different than experiences they encountered in the military. This was due to the respect for the chain of command and teamwork approach to the mission. Although veterans will differ in the extent to which they continue to identify with military culture after separation from military service, these female veterans did not consider their service to be a minor event in their life. The values and aspects of identity they acquired while serving may continue to be an integral theme for them as they move forward. Each female veteran had a unique story about her military service, and it is important that those caring for these women in the civilian health care sector recognize, appreciate, and understand each individual experience and the larger context in which that experience takes place. Increased knowledge and understanding of military culture can lead to an increased ability to support a stronger therapeutic alliance, recognition of mental health symptoms, and treatment planning. Educating health care providers about the female veteran can lead to a deeper understanding of the structure and branches of the military as well as the mission, ideals, and core values of military culture (VA, 2018).

In 2016, Defense Secretary Ashton Carter approved final plans from military service branches to open up all combat jobs to women (Howell, 2016). Prior to 2016, positions had been
closed to women. Since 2018, military leaders have made a modest but noteworthy success in integrating women into military combat roles. Female service will be vital to the U.S. national security as the military looks to expand and confront potential threats. Military leaders would be wise to learn from each other and their groundbreaking female service members as they continue down this path (Center for a New American Security, 2018). Given the expanding roles and number of females in the military, it is essential that health care providers in both the VA and American health care facilities become increasingly aware of the culture and care these women will require following service to the U.S. military.

**Links to Nursing Theory**

The shared experience of the participants that emerged from the data are the barriers and challenges that female veterans face in transferring from the culture of the VA to the American health care system. The underpinnings of Madeline Leininger’s (1991) theory of culture care diversity and universality recognizes the uniqueness of experiences in each culture. Leininger referred to cultural care diversity as the recognition of the meanings and values that cultures adhere to in a unique demographic of people (Leininger & McFarland, 2006). Culture care universality is prominent and recognized in the population of this study. All the participants referred to similar meanings that are indigenous to military culture. The participants recognized that the strong emphasis placed on discipline and hierarchy illustrates a different structure and set of shared beliefs and values that can only be found in the female military culture. Due to the intense shift of behaviors that military life requires, the participants in this study articulated the difficulty of transitioning to a different culture at the VA Health Care System and the American medical health care system and found the transition to be challenging (VA, Mental Health Tool Kit, 2017).
The challenge of the transition of female veterans navigating health care following active duty is directly linked to the literature review and Meleis’s (2010) Transitional Theory. Meleis’s theory focuses on understanding the nature of and responses to change, facilitating the experience, responding to its different phases, and promoting health and well-being prior to, during, and at the end of the change event. The participants in this study expressed difficulty articulating their veteran status to health care providers and were frustrated that they had to verbally repeat their medical history every time they returned for a visit to the VA. They expressed frustration and knowledge deficits after discharge from the military and articulated the need for the military to focus more attention on the health care benefits that would be afforded to them following active duty. Realizing that transition is difficult for female veterans, it would be prudent for military leaders, civilian health care providers, and VA case managers to integrate this theory into practice, providing a framework that guides effective care prior to, during, and after the transition.

**Integrating Findings with Literature Reviewed**

The analyzed data and themes identified in this study were compared with published literature on those topics. The literature review also focused on the top five health care disorders reported in 2015, which were PTSD, major depressive disorder, migraine headaches, lower back pain, and uterine complications (VA, 2015a). Female veterans in this study articulated the incidence of the top five diagnosed health care disorders linking an association with these disorders to the high prevalence of these medical conditions in the female veteran community. This section presents the recent research and recommendations of the five top female health conditions and discuss how the study participants experienced them.

In 2017, Kehle-Forbes et al. reported that many women believe that the VHA is falling
short of meeting women veteran’s needs including sexual assault and severe anxiety in using the VA. Moreau et al. (2017) conducted a semi-structured qualitative study with 40 key leadership and clinical stakeholders at VA medical centers and associated outpatient clinics about introducing telehealth services. That study revealed the perception that telehealth may increase access to mental health care for female veterans and other female veterans’ health needs. Same-gender care and access to providers with specialized training, especially for rural female veterans could also improve with the use of this computerized system. Respondents saw female veterans as being particularly poised to benefit from tele-mental health. Interviewees expressed enthusiasm for tele-mental health's potential and were eager to expand services, including women-only mental health groups. These findings can help to inform gender-tailored expansion of tele-mental health within and outside of the VA. The study Moreau et al. (2017) conducted demonstrates that while gains have been made in the provision of gender-specific outpatient medical care, many women veterans with a history of MSA and PTSD symptomology continued to feel uncomfortable and unwelcome in VHA facilities. These female veterans also perceived that they were not receiving the same quality of care as male veterans (Moreau et al., 2017). Female veterans seeking VHA health care would benefit by introducing the telehealth system at the VA, interventions at the system, clinic, and individual provider-level.

The participants in this study experienced depression and PTSD. Their experiences have also been similarly identified in the literature. In 2018, Newins et al. reported on a quantitative study of 187 female veterans regarding barriers to female health care in the VA health care system. The results of that study highlights, the need for outreach and education regarding eligibility and types of resources for physical and mental health problems experienced by female veterans who served in Iraq and Afghanistan, as well as services that the VA provides for female
Female veterans. The stigma of mental health should be addressed during and following active-duty service of female veterans. Newins et al., (2018) study was similar to a study conducted by Street et al. (2013), where female veterans were at a higher risk for depression. Furthermore, 20% of female veterans were diagnosed with PTSD. Twenty-seven percent out of every 100 female veterans who served in Vietnam suffered from PTSD in their lifetime (National Center for PTSD, 2015). Addressing mental health and PTSD should be on the forefront of military leaders’ agenda.

To address PTSD, health care providers should identify mental health professionals with expertise, routinely screen, discuss results and resources, and ensure follow-up. Screening should be conducted using a screening tool (U.S. Department of Veteran’s Affairs, National Center for PTSD, 2017). There are effective treatments for PTSD, and patients need reassurance that the symptoms are manageable with modalities such as cognitive behavioral therapy (CBT) and focus support groups. These forms of therapy are also successful for treating depression, which is frequently comorbid with PTSD (Iverson et al., 2011; Murihead et al., 2017). These studies highlight the importance of early identification of mental health conditions and appropriate referral to improve health outcomes. The participants in this study similarly experienced PTSD and depression, thus demonstrating that the PTSD screening tools developed by the VA can be effective interventions when treating both mental health disorders and PTSD.

Female veterans may also have a higher risk for experiencing urogenital disorders such as urinary tract infections, pelvic organ prolapses, urinary incontinence, and bladder pain syndrome because of military conditions. Although there may be general causes for these medical conditions, circumstances during deployment such as postponed urination, decreased access to care and restrooms, fluid restriction, strenuous military activity, and basic and paratrooper
training may all contribute to weakened pelvic floor muscle and other long-term urogenital problems (Resnick et al., 2012).

Assessing female veterans for pelvic floor disorders can be managed by taking a thorough history and physical. Therapeutic strategies for bladder retraining and behavioral modification including pelvic floor muscle exercises, fluid management, and scheduled voiding can be employed in the primary care setting. The use of biofeedback may also offer additional options. Referral to a gynecologist or urologist may be necessary for evaluation and further assessment for nonsurgical and surgical interventions (Muirhead et al. 2017). The participants in this study reported urinary issues and multiple surgeries to treat their pelvis and urinary disorders.

In 2018, Bradley, Nygaard, Hillis, Torner, and Sadler conducted a study on bladder syndromes in female veterans. This longitudinal study was conducted to better understand the relationship between bladder dysfunction occurring with anxiety, depression, and sexual assault of female veterans. The findings of that study indicated that overactive bladder symptoms are associated with mental health conditions, depression, and anxiety in female veterans. Currently, one in five female veterans report overactive bladders symptoms. Post-deployment problems for female veterans influence the natural history of an overactive bladder. The female veterans interviewed in this study support the concept of military and civilian health care providers acquiring knowledge to screen female veterans for mental health conditions and sexual assault in women with newly diagnosed persistent incontinence.

Military sexual trauma (MST), which has been defined as repeated sexual harassment or sexual assault during military service, is disproportionately more common in female veterans than male veterans. One of four women receiving VA healthcare service screens positive for
MST (VA, 2015b). The detrimental effects of MST include depression, eating disorders, alcohol and substance abuse, anxiety disorders, increased suicidal risk, long-term sexual dysfunction, chronic health conditions, as well as a disarray in social network and employment (Murdoch, Polusny, Hodges, & Cowper, 2006; Street et al., 2009). Female veterans who experience MST encounter greater difficulty adjusting post deployment, directly affecting their occupational and financial success (Shivakumar, Anderson, & Suris, 2015; Street et al., 2009). Understanding the effects of MST enables clinicians to screen women veterans for sexual trauma and provide resources for treatment and recovery (Muirhead et al. 2017). The females interviewed in this study reported experiencing MST but were not willing to share or describe their condition with their health care providers.

Sexual assault and harassment continue to be significant concerns within the U.S. military. The Department of Defense and military services have recently developed several initiatives aimed at preventing sexual violence within their ranks. A number of these programming efforts are modeled after prevention initiatives in other communities such as on college campuses (Gidycz et al., 2018). To address sexual assault health care, providers must be cognizant that both females and males can experience MST during their service (VA, 2018). To further address this issue, all veterans seen at VHA facilities are questioned about experiences of sexual trauma. Currently, the VA has free services for veterans to receive help if they were a victim of sexual assault. It is important for all veterans to know that military veterans do not need to have a VA disability rating to receive services related to any sexual trauma or assault. This information could be pivotal to those who are affected and should be relayed to veterans who are preparing to transition out of the military. It is essential to note that female and male veterans may receive these benefits even years after they are discharged from active duty (VA, 2018). The
participants in this study expressed experiencing MST but did not report this condition to the VA.

Migraine headaches and lower back pain were reported to be present in the top five diagnosed conditions of female veterans. In a survey of 67,696 adults from the National Health Interview Survey, veterans were found to have a higher prevalence of neck and back pain compared to the general population of the U.S. Furthermore, the number of veterans with severe pain was reported to be 40% greater than their civilian counterparts. Severe back pain and migraine headaches in younger veterans were reported at a higher rate than the general population of the U.S. (Nahin, 2017). Female veterans who have been deployed to OEF/OIF report more post-concussive symptoms following blast-related exposure and Traumatic Brain Injury (TBI) (Brickell et al., 2017). It is essential that health practitioners screen all female veterans who have migraine headaches for possible TBI. One of the participants in this study reported experiencing head trauma but did not receive any support or follow-up care following active duty.

Musculoskeletal lower extremity disorders are common and costly problems in veterans. One of the participants interviewed in this study articulated the pain and surgery she needed due to the continuous wear of battle dress—ready uniform while working in the emergency department. A study by Song et al. (2018) identified that musculoskeletal injuries are common among 67% of females during their basic training and 75% of injuries in Iraq and Afghanistan were from lower extremity conditions. It is imperative that the military consider alternative uniform requirements in the hospital setting.

**Limitations**

As with any study, there are limitations related to this study. This researcher followed
Martin Heidegger’s (1962) hermeneutical approach whereby bracketing is not fully possible. Heidegger believed that personal awareness of the phenomena is intrinsic to phenomenological research. Since this researcher is a U.S. Navy female veteran. She attempted to bracket her biases and opinions throughout, but according to Heidegger she could not fully remove herself from the study. Any preconceived opinions that were not fully bracketed could be a potential limitation of this study. The researcher also experienced similar themes extracted from the qualitative interpretive data (Polit & Beck, 2017).

Another potential limitation is the demographic location of the female veterans interviewed that were scattered throughout the U.S. and one in Germany. Due to logistical constraints, it was not possible for the interviewer to conduct face-to-face interviews with those who volunteered to participate, which may have resulted in a different type of data. However, interviewing the participants over the telephone in the comfort of their home enabled this researcher to gather rich qualitative data. The participants interviewed were not concerned with their attire and looks and were able to talk to me at an early time when their children were not awake or when they felt they had a convenient period of time to discuss their experience without impeding on the time change in geographical locations. The absence of visual cues via telephone is thought to result in a loss of contextual and nonverbal data and to compromise rapport, probing, and interpretation of responses. Yet, a phone conversation may allow respondents to feel relaxed and able to disclose sensitive information. Evidence is lacking that they produce lower quality data. This apparent bias against telephone interviews contrasts with a growing interest in electronic qualitative interviews (Novick, 2008).

Further limitations of this study, as in usual qualitative studies, are that the findings can only be generalized to the study participants. Other limitations that may be of concern are sample
size and the possibility of alternative interpretations. Small sample size may make the findings inapplicable to the larger population of female veterans.

**Implications of Findings**

Exploring the lived experience of the female veteran transitioning to post—active—duty health care offers insight into the encounters and circumstances faced by this unique culture. The data collected reflects the needed areas for further health education and the advice from the participants for all female veterans to be advocates for themselves when attaining health care following active duty. The findings in this study have important implications for women’s health care providers and policy makers within both the VA and civilian health care systems related to screening, barriers to care, and knowledge deficits of female veterans on how to attain post—active—duty health care. This study supports the need to explore the experiences of female veterans. The issues that have been explored may have the potential to influence and inform practice and research. In order to understand and develop strategies that incorporate differences, it is important to understand the experience of cultural uniqueness of the female veteran.

**Implications for Nursing Practice**

Given the findings of this research, there are several general recommendations that nurses caring for female veterans should consider implementing. In order to further develop cultural awareness and sensitivity toward female veterans, recognition of cultural awareness is necessary. Responding to cultural nuances of this female veteran population is integral to adequately caring for female veterans.

Cultivating cultural awareness in nurses has the potential to create a culturally sensitive atmosphere in the health care facilities that care for female veterans. Furthermore, when issues regarding culture or sensitive gender-related accommodations arise within a medical clinical
setting, providing alternatives to privacy may promote a safe area for female veterans to voice their medical issues and concerns. The VA has devised an internet “tool kit” for community health care providers that can aid in the allocation of resources and understanding the culture of female veterans. Community providers play an essential role in ensuring America’s Veterans receive the support they have earned. The purpose of this “toolkit” is to link community providers with information and resources that are relevant to Veteran’s health and well-being. This toolkit supports the behavioral health and wellness of veterans receiving services outside the VA health care system. Information resources such as the toolkit include information on screening for military service, handouts and trainings to increase knowledge about military culture and mini-clinics focused on relevant aspects of behavioral health and wellness (VA, 2018). The women in this study reported a need to be recognized by their community health care providers following active duty. They articulated the need for female veterans to be cognizant of the benefits afforded to them by their communities and to build strong bonds with community resources prior to leaving the military.

Many of the women who served in Iraq and Afghanistan in this study experienced unprecedented levels of combat exposure and returned with specific health care needs, such as traumatic brain injury, migraines, dizziness, anxiety, depression, and PTSD. There is a rise of female veterans reporting these symptoms as well as significant mental health conditions. More than 50% of females who served post September 11th terrorist attacks have utilized mental health services at VA facilities. Aside from post-traumatic stress, the staggering rate of suicide among female veterans is a major concern. Women in the military commit suicide at nearly six times the rate of other women, according to VA research covering 11 years of data. Rates of female veteran suicide rival those of male veterans, despite the fact that men are generally far more
likely than women to take their own life. Suicide has been the second leading cause of death among U.S. service members since 2010 (National Council of State Legislature, 2018).

State legislatures across the country are providing recognition of female veterans and developing programs to address the specific needs of female veterans. At least 23 states and Puerto Rico have enacted legislation to establish a female veterans program, designate a commemorative day or month, or provide for special license plates. A number of other states are considering bills in the current legislative session (National Council of State Legislature, 2018). At least 12 states in the U.S. have established a female veteran program or named a division female veterans coordinator to oversee state benefits and services for women who have served in the U.S. Armed Forces. These states include California, Connecticut, Hawaii, Illinois, Indiana, Kentucky, Maine, Nevada, New Jersey, New York, Oregon, and Texas. One such example is the Indiana General Assembly which enacted legislation in 2014 and passed the Senate Bill 354, creating the Hoosier Women Veterans Program within the Department of Veterans Affairs. The program has multiple purposes, including performing outreach to improve awareness of state and federal benefits, assessing the needs of female veterans, and reviewing programs and other initiatives designed to meet these needs. It also makes recommendations to encourage women to join a registry used to connect female veterans to various resources and benefits to which they are entitled. Indiana also has a full-time female veterans’ coordinator and has held a conference for female veterans every year since 2007 (National Council of State Legislature, 2018). Given the difficulty in delivering comprehensive health care for female veterans and the shortage of gynecologists to provide gender-specific care, this policy will help aid female veterans attain care and privacy (VA, 2016d). New York State has enacted an executive law that designates June 12 as a special recognition day for female veterans (N.Y. Executive Law 168, 2016). Other
states that honor a special female veteran’s day include Alaska, California, Georgia, New Jersey, New York, North Dakota, Pennsylvania, and Puerto Rico (National Council of State Legislature, 2018).

The participants in this study articulated the need for a specific female veterans case manager to understand their health care needs. In 2016, New York State created the position of a female veterans’ coordinator who manages programs for female veterans and recommends improvements where needed. The coordinator acts as a liaison between various state and federal veterans’ organizations and promotes various female veterans’ events recognizing sacrifices and commitment to the U.S. Armed Forces (N.Y. Executive Law, 361, 2016).

The participants in this study articulated the need for acknowledgment of the sacrifices and commitment they made for their county. In 2016, to recognize female veterans, Arizona, Florida, Georgia, Illinois, Missouri, New Mexico, Ohio, and South Dakota all offer special license plates recognizing female veterans. Revenue from plate sales help to fund veterans’ programs (National Council of State Legislature, 2018).

Female veterans have made significant contributions to the military service and represent a growing population of veterans seeking healthcare services. They have unique challenges that require a full spectrum of services to meet their needs. A thorough military history comprising of deployment status, separation history, occupation in the military, trauma occurrence, and exposure history are critical elements in designing effective patient-centered plans of care that advance the health of female veterans. As female veterans reintegrate into civilian life and create a new normalcy, discussions relevant to reproductive health and the effects of mental illness and substance abuse on pregnancy provide an opportunity for better preconceptions of health care, avoidance of unintended pregnancies, appropriate referrals, and access to specialized resources
such as those for military sexual trauma, PTSD, and TBI (Muirhead et al, 2017).

**Recommendations and Implications for Female Veterans**

The female veterans in this study expressed the recommendation of advocating for themselves and learning how to navigate the health care system following active duty. They recognized the importance of trust, community, love, and strong bonds to help them transition to civilian life. This researcher recommends that female veterans utilize organizations developed by the VA and reach out to local community organizations to aid them with the transition and locate a strong support system. One such organization is The Disabled American Veterans (DAV) chartered by the United States Congress for disabled military veterans of the United States Armed Forces that helps them and their families through various means. Female veterans in this study have faced roadblocks and challenges during their post-military transition to health care, as it was revealed that many policies and programs were catered toward the male veteran population. Today, as the number of female military members rise, their roles in the national defense continue to evolve. The need for equalized care becomes increasingly critical.

The Department of Women Veterans Committee Toolkit, developed with the help of DAV’s Women Veterans Interim Committee, was introduced at the 2015 National Convention in Denver. The toolkit for female veterans includes programs, services, legislative policy, tips for community outreach, and research and publications pertaining to female veterans. This toolkit is an essential element recognizing the unique health care needs of female veterans and offering guidance to new program development (Disabled American Veterans, 2018).

**Implications for Nursing Practice**

Female veterans are the fastest growing segment of the veteran population. The mission of the VA is to deliver equitable, high-quality, comprehensive health care services and to provide
a safe environment for the women who have served in the U.S. Armed Forces. The Women Veterans’ Health Care initiative has made strides in improving sensitivity to specific gender-care needs, safety, and comprehensive care (VA, 2018). To address the myriad of health conditions of all female veterans, the Center for Veterans Health created an acronym tool “S-O-L-D-I-E-R-S” used to aid nurse practitioners and other health care providers in providing a comprehensive care for veterans (Graham, Ulrich, & Ginty, 2017). This tool addresses not only health care in the VA but also serves as a helpful tool to civilian providers. Empirical data supports that 1 in 10 patients cared for outside the VA is a U.S. veteran (U.S. Department of Veterans Affairs, 2014).

Providing a systematic approach to assessment while obtaining a patient’s history is integral to assessing female veterans. Using this tool can improve the well-being and physical and psychological outcomes of female veterans. It is necessary that individuals caring for female veterans’ focus on their individual experience and story. The history will enable the provider to ascertain the female veterans’ training, length of service, diseases, drugs, environmental stress, injuries, disabilities, stress, anxiety, regrets, and remorse (Graham, Ulrich, & Ginty, 2017). Clinicians play a critical role in identifying health risk and helping female veterans start the sometimes arduous journey toward wellness. Discovering and acknowledging women's military history is critical in ensuring quality care and appropriate decision making.

**Implications for Nursing Education**

To address the health care needs of female veterans’ nursing curricula should highly consider integrating important content, health problems, and applicable educational resources to prepare professional nurses to care for female and male veterans and their families. Specific nursing courses at the associate and baccalaureate degree levels could include content in the neurological and psychiatric nursing curricula, including etiology, clinical manifestations, and
the care of female veterans who have mental health conditions such as PTSD, MST, and depression. In addition, curricula should include resources and care for service members who have substance abuse, anxiety and suicidal ideation (Allen, Armstrong, Conard, Saladiner, & Hamilton, 2013).

Professional development directed toward nursing faculty may enhance the didactic curriculum regarding war times and the health conditions that are specific to a particular population. For example, the geriatric population who served during Vietnam may differ than female veterans who served during OEF, OIF, and OEF. Geriatric patients may benefit from story-telling as part of an ongoing therapeutic communication whereas recent veteran patients may benefit from care of PTSD. To establish rapport with patients, it is essential that the individual patient’s history is understood. With the return of many female veterans who have experienced combat duties, it is important that nursing students are knowledgeable regarding the myriad of health conditions that affect recent veterans. For example, maternity curricula might include the effects of unhygienic issues and health concerns that affect female veterans (Trego, 2012).

Anticipation of both the veterans' potential short-term and long-term health challenges, as well as the medical costs, will require expert care management. Recognition of gender disparities in physical health conditions, environmental exposure, and socio-economic factors contribute to female veterans’ vulnerabilities. Many health conditions, if recognized in a timely manner, can be ameliorated and shift the health trajectory of female veterans. Nursing faculty play a critical role in educating nursing students regarding the health of female veterans. By acknowledging the need for inclusion of such female veteran-related health education for students, quality effective care can be afforded to all veterans and impact their transition back home.
**Recommendations for Future Research**

Nursing research is warranted in studying the transition of female veterans following active duty. As such, there should be quantitative and qualitative studies specifically focusing on the retention of knowledge regarding health care following the military’s transitional classes. It was gleaned from the participants in this study that they experienced difficulties when completing the transitional class regarding comprehension of health care that would be available to them as veterans. These difficulties included navigating the complicated veteran health care system and understanding what benefits are afforded to them as female veterans. Spouses and children of the female veteran could benefit from receiving a transition class dedicated to health care. Furthermore, the health care transition class should target the region in which the female veteran and her family will reside. This will aid in the cultural transitional process from military health to either the VA or the American health care system, as well as reading materials for military female veterans whose married spouses speak another language.

To prevent orthopedic injuries, further consideration should be placed on the attire that service members wear in the hospital and clinical settings on active duty. Consideration should be given to the long hours military nurses spend caring for patients in their military uniform, including foot attire. Currently, there is no research to support the recommendation for military hospital staff to wear comfortable, orthopedic, ergonomic attire to prevent stress fractures in their lower extremities. Nursing research in this area could be the catalyst for change and safety of all military hospital staff and prevention of orthopedic problems, including back problems following active duty.

There is a paucity of research on female veterans who identify as lesbian, bi-sexual or transgender. With the repeal of “Don't Ask, Don't Tell” (DADT) in 2011 and the Supreme Court
decision regarding Section 3 of the Defense of Marriage Act (DOMA) in 2013, military
providers are now able to openly address unique health needs of lesbian, gay, and bisexual
(LGB) service members and their same-sex spouse beneficiaries. The DADT and the DOMA Act
created health care barriers, either real or perceived, between providers and patients and often
limited medical research involving LGB patients in the Military Health System (MHS)
(Campbell, Wesley, Mojgan, Bavaro & Carpenter, 2017).

The Veteran's Health Administration has acknowledged the paucity of information
concerning the needs and health inequalities of the LGB service member and veteran and has
created the Office of Health Equity to address these disparities (Sharpe, 2014). More recently,
Blosnich, Gordan, and Fine (2015) researched known disparities in health markers within the
lesbian, gay, bisexual, transgendered, and questioning sexual orientation (LGBTQ) college
student population with military experience. LGBTQ veterans were more than four times as
likely to have attempted suicide in the last 12 months as compared with nonmilitary-experienced
LGBTQ counterparts. Considering these findings, it is crucial that health care providers consider
the vulnerability of the military MSM population and be prepared to engage their patients in
frank, respectful conversations about their lives (Campbell et al., 2017).

**Personal Reflections Serendipity**

When I began this journey, I found that time had moved forward and the identity being a
female veteran was in the back of my conscience. It was through mentorship and caring from my
educators at Molloy College that I was reminded of the valuable role I played in the U.S. Navy
and the difficulties I had when transitioning back to civilian life and health care. It was through
this journey and with the help of my participants that I have regained a perspective of honor and
commitment that all service members give to the U.S.
While pondering my own difficulties transitioning to post—active—duty health care, I was concerned that many female veterans would not have the available time to devote hours of conversation delving into their sometimes arduous past experiences. I found that I was mistaken and was privileged to learn about the participants’ eager enthusiasm to participate in a study regarding health care for female veterans. Like myself, these participants had many transitional struggles navigating the VA and American health care system and were eager to share their experiences. Although all experiences were unique there were many similarities to my own. I am sincerely grateful for their candor and their hope for a progression in the transitional experience for future female veterans.

The common misconception is that females do not experience the same medical conditions as their male counterparts who serve on active duty in the U.S. military. Through this experience, I found many circumstances where female veterans’ experiences were similar to each other, male veterans, and myself. The female veterans articulated the difference with civilian health care and military health care. All of the participants were able to easily access health care while serving on active duty, but most were unfamiliar and uninformed of the benefits they could receive as a female veteran. Common threads of wisdom for our future female veterans were uncovered. The goal of research to interpret each individual lived experience produced tangible knowledge that may hopefully lead to a proliferation of services toward the female veteran population.

Prior to conducting this study, I had not fully appreciated how much military culture impacted the everyday lives and the transitional experience of female veterans. I know that I often feel misunderstood with the military and veteran verbiage and terminology I use on a daily basis. I found that all the participants used a similar vernacular and they often expressed the
work ethic and the structure of a military unit differing completely from their current civilian employment. These female veterans truly appreciated being a part of a military family. They all had a strong desire to inform both civilian and VA health care employees of the need to try and understand the military culture of female veterans so that they are better prepared for their health conditions that they are experiencing and had undergone.

I was honored to conduct this study and sometimes found it difficult to hear stories that resonated with my own experiences. At times, I found that it conjured up both fond and difficult memories that I haven’t reflected upon in many years. However, hearing the stories and suggestions, I was more eager to learn about how we can improve the transitional experience for current and future female veterans on their journey to post—active—duty health care. The female veterans in this study provided deep insight on improvements in the health care transitional process and potential research opportunities where nurse scientists could be a catalyst for change. In the words of Maya Angelou (2012), I acknowledge and appreciate all she-ros and heroes who have served in the U.S. military, as she articulated best by saying, “How important it is for us to recognize and celebrate our heroes and she-ros!”

**Conclusions**

Because few providers are aware of the impact military service has on the health of women, they may fail to ask the all-important question, “Have you served in the military?” Recognizing women's military service can reveal important information that can answer perplexing clinical questions, aid in designing comprehensive plans of care, and enable women to receive the assistance needed to address complex physical and psychosocial issues to improve the quality of their lives.
The purpose of this study was to interpret the lived experiences and transitional challenges faced by female veterans exiting their military life and transitioning to post—active—duty health care. The results of this qualitative research study sought to unveil the lived experiences as described by the words of female veterans. Research has primarily focused on male veterans’ readjustment challenges within the context of homelessness, and PTSD (Resnick et al., 2012). As of 2013, the Combat Exclusion Policy, which included the exclusion of women serving in combat positions has ended. The exclusion of this policy ensures the next generation of females will serve on equal ground with their male peers. Thus, we must take immediate actions to ensure females that are transitioning out of the military stand on equal ground as well.

The recognition of quality, efficient, safe health care of female veterans is essential. The communities must recognize and respect female veterans for their duty, loyalty, and honor to our country. This is accomplished through providing a better understanding and educating stakeholders of the sacrifices females in the military make when leaving and returning to their families and communities. Some served more years than others; however, the transitional challenges to post—active—duty health care all affected their well-being following service to the United States Armed Forces.

Through open-ended audio recorded interviews, this study interpreted the experiences, feelings, thoughts, and beliefs of female veterans when they transitioned to health care following active duty. Exploring these transitional factors led to the conclusion that the females in this study had varied reintegration experiences to both the VA and the American medical system. Although the VA offers a variety of services for transitioning veterans, this study should promote additional specific health programs before and after transitioning out of the military. As women continue to enlist and serve in conflicts, the effects of combat on females must be introduced to
the U.S. military policy and program developments, including addressing psychological effects. I will always remember these 11 ambassadors as I reflect on how each discussed transitional experiences. I now listen to female veterans’ voices when they protest for equality in health care and ask to be treated with respect. I am grateful that each of the participants trusted me to share their thoughts, feelings, and experiences. As a result, I will continue to contribute to the existing body of literature, to be their voice, and to advocate for continuous awareness and understanding of all veterans, specifically our female veterans.
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Appendix A: Recruitment Flyer

Female Veteran Research Study

Be a part of an important female veteran research study.

The purpose of this study is to interpret the meaning of the experiences of female veterans transitioning to post—active—duty health care.

Did you serve between 1990-2017?

Do you want to express your experiences as a female veteran?

If you answered Yes to these questions, you may be eligible to participate in a research study.

Your participation would involve 1-2 audio-taped interviews, lasting 1-2 hours with the researcher.

A follow-up contact is requested for you to validate or clarify your interview analysis. You may choose to do that by telephone, email or in person. It should take no more than 30 minutes.

The purpose of this study is to understand the experiences of female veterans who have transitioned to post—active—duty health care.

Participants will receive a $25 gift card as a thank you for participating in this study.

If interested, please contact:

Sarah A. Bradwisch MSN, RN
Jonas Veterans Scholar
PhD Doctoral Candidate
Barbara H. Hagan School of Nursing at Molloy College
1000 Hempstead Ave, Rockville Centre, New York, 11570

SBrowne@lions.molloy.edu
Appendix B: Letter to Potential Participants

STATEMENT OF RESEARCH
(To send out after an inquiry has been made)

Dear (participant) Date _____________

Thank you for your interest in this study. I am a nurse researcher in the Barbara H. Hagan School of Nursing at Molloy College conducting research for my doctoral dissertation.

The purpose of this research is to understand how individuals who are female veterans transition to post-active duty health care.

Individuals are asked to participate by providing 1-2 in-person interviews for 1-2 hours, at their convenience that last from 1-2 hours each. These will be audio-taped and transcribed with your permission. A follow-up contact is requested for you to validate or clarify your interview analysis. You may choose to do that by telephone, email or in person. It should take no more than 30 minutes.

Your personal information is kept confidential. The information from all the study participants is reviewed as a collection of experiences. A final write-up of the results of this study will be made available to all participants, as desired.

Please feel free to contact me for any questions about the study and ways of participating. I can be reached directly at: Email: SBrowne@lions.molloy.edu Phone: 646-238-2640

Sincerely,

Sarah A. Bradwisch, MSN, RN
Jonas Veterans Scholar
PhD Doctoral Candidate
Barbara H. Hagan School of Nursing at Molloy College
1000 Hempstead Ave, Rockville Centre, New York, 11570

SBrowne@lions.molloy.edu
Appendix C: Transcription Agreement.

Confidentiality Agreement for use with Transcription Services

Research Study Title: Female Veteran’s Transitioning to Post Active Duty Health Care.

1. I, ______________________________ transcriptionist, agree to maintain full confidentiality of all research data received from the researcher related to this research study.

2. I will hold in strictest confidence the identity of any individual that may be revealed during the transcription of interviews or in any associated documents.

3. I will not make copies of any audio-recordings, or other research data, unless specifically requested to do so by the researcher.

4. I will not provide the research data to any third parties without the researcher’s consent.

5. I will store all study-related data in a safe, secure location as long as they are in my possession. All audio recordings will be stored in an encrypted format.

6. All data provided or created for purposes of this agreement, including any back-up records, will be returned to the researcher or permanently deleted. When I have received confirmation that the transcription work I performed has been satisfactorily completed, any of the research data that remains with me will be returned to the researcher or destroyed, pursuant to the instructions of the researcher.

Transcriber’s name (printed) __________________________________________________

Transcriber’s signature ___________________________________ Date ______________
Appendix D: Demographic Questions

This questionnaire is designed to help the researcher gather information. Your replies are optional. All information is confidential and will be compiled without any individual identifiers.

Your initials: __________

Pseudonym (name to be used in the study that is not your real name) ______________________

Age: __________.

What year did you discharge from active duty in the U.S. Military? _______________

What years did you serve on active duty? _______________ Reserve duty _______________

Military Rank _______________________.

Please identify your military affiliation ____Army ____Navy ____Airforce ______

Marine______, Coast Guard______, United States Public Health Service Corps____

(USPHSC), Uniformed Oceanic and Atmospheric Administration (NOAA) ______.

Do you consider yourself to be a veteran? ___yes    __no   Explain ___________________

Do you receive any health care benefits as a veteran? ___yes ____no

How far do you drive to get health care? (Miles/Hours) ______________________________

____________________?

Do you feel financially secure? _____________________________.

Can you afford to get health care? ____________________________.

Describe where you receive your health care and how it is covered (paid for)

______________________________________________________________________________

Do you have children? _______ If yes, please list the gender and age of each child (do not give their names).
Where do you reside? (Rural, Suburban, Urban area) ________________.

Marital Status (single, separated, divorced, widow, in a committed relationship) _____________.

Whom do you live with? ____________________________________________________________________.

Highest Level of Education (high school, college, graduate school) ________________________.

Special training ___________________________.

Work experience in the service or as a civilian ________________________.

Cultural/Ethnic Group ________________________.

Religious Health Practices ____________________________.

Please list any current or past health conditions (before, during or after your military service).

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Please list any past surgeries (before, during or after your military service).

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Please share anything else you wish to add ___________________________________________
Appendix E: Research Questions and Probes

The research question for this study is, “What is the lived experience of female veterans’ transitioning to post-active duty health care?” This study will focus on female veterans who have been discharged from active duty from 1990-2017. Several probes or sub questions may help the researcher gain an understanding of this phenomenon as follows.

- What were your experiences transitioning to post—active—duty health care?
  - What educational resources were you provided to transition to a health care system following active duty?
  - What supported or hampered your transition?
  - What would have helped you make a better transition?
- What have your experiences been attaining health care outside the military?
  - Have any military experiences have affected your health since your discharge?
  - Have any health conditions affected your life since discharge from the service?
- How would you describe the culture of the health system in the military? (What was it like? How did it affect you)?
- How would you describe the culture of the health system where you are currently receiving care?
- Is anything else you would like to share about transitioning to post-active duty healthcare?

Probes:

- Think back to the time when you were discharged. What were your experiences of re-integrating back to family, friends, and the civilian community?
• Think of any physical, emotional, or even spiritual aspects of your journey from back then until now.

• Describe any challenges you have faced since discharge related to your healthcare or that of your family.

• What should nurses and healthcare providers be aware of when providing care to female veterans?

• What health-related advice would you have for a woman about to be discharged related to her health?
Appendix F: Informed Consent

Title of the study: Female Veterans Transitioning to Post Active Duty Health Care.

Researcher: Sarah A. Bradwisch, MSN, RN, Jonas Veterans Scholar
PhD Doctoral Candidate Barbara H. Hagan School of Nursing
Molloy College
1000 Hempstead Ave,
Rockville Centre, New York, 11570

I am a doctoral student at Molloy College in the School of Nursing, and my interest in this study is generated by my experiences as a US Navy veteran. You are being asked to join this research study to answer specific questions. This consent form will explain:

The purpose of the study and what you will be asked to do.

You should ask questions before you decide to participate. You can also ask questions at any time during the study.

Purpose of the study: To investigate the experience of female veterans transitioning to post active duty health care.

Expected duration of the study: 3-6 months to gather data from participants. During that time, approximately 10-15 participants will be included in this study.

Description of the procedures/methodology: This is an interpretive phenomenological qualitative study. You will be asked to participate in one to two interviews about your transition to post-active duty health care which will take approximately 1-2 hours each. This interview(s) will be recorded and your personal information will be kept confidential. A follow-up contact is requested for you to validate or clarify your interview analysis. You may choose to do that by telephone, email, or in person. It should take no more than 30 minutes. The information gained from your interview(s) is reviewed as a collection of experiences. A final write-up of the results
of this study will be made available to you if desired. You will be asked to fill out a brief demographic form prior to the interview, which will take no more than 15 minutes.

**Possible benefits to the subject or to others:** There are no direct benefits from participating in this research study. However, this research may lead to insight into the transition of female veterans following active duty service in the U.S. military.

**Reasonably foreseeable risks or discomforts:** There are no known or foreseeable risks to participating in this study. If at any time you feel uncomfortable discussing experiences, you may choose to end the interview or even withdraw from the study if you wish without any penalty. If the researcher detects at any point that the interview is causing you distress, this author will refer counseling or supportive services available to you if you desire.

**Cost/compensation:** There are no costs to participate in this study. At the completion of your interviews you will be given a $25 gift card as a thank you for your participation.

**How, and the extent to which, confidentiality will be maintained:** You will be identified only by a pseudonym (another name you choose to use for the study). Your personal information will be kept confidential. Your name will not be reported in any publication; only the data obtained as a result of your participation in this study will be public. Your name or other personal and associated identifiers will not be used in any publication.

**Use of Audiotapes in the Study:** Interviews conducted in person may be audio taped, with your permission, to aid the researcher in obtaining an accurate account of your intended communication. Tapes will be labeled only with a code number, which will be kept locked in the researcher’s files. You may, at any time, review your audiotapes and ask that all or any portion of the recording be erased. The audiotapes will be reviewed by the researcher and transcribed for review. The tapes will be destroyed upon of the completion of the study.
Contacts for questions about the research: Sarah A. Bradwisch 646-238-2640.
Or my academic advisor and Dissertation Committee Chairperson Dr. Susan Vitale svitale@molloy.edu
Barbara H Hagan School of Nursing, Molloy College
1000 Hempstead Ave
Rockville Centre, NY 11754
516-323-3000

Voluntary Participation/Withdrawal: Your decision as to whether or not to take part in this study is completely voluntary (of your free will). If you decide to take part in the study, you may withdraw at any time. Any information you have contributed may also be excluded. Your refusal to participate or discontinuation of participation at any time is without penalty.

An explanation of the procedures to be employed in this study, in which I have voluntarily agreed to participate, has been offered to me. All my inquiries concerning the study have been answered to my satisfaction. I understand that the information collected will be held in confidence, and that my name will not in any way be identified. I understand that additional information about the study results will be provided, at its conclusion, upon my request. I know that I am free to withdraw from this study without penalty at any time.

The above information has been provided to me (check one) ____ In writing ____ Orally

______________________________________   _______________________
Signature of subject          Date

_______________________________________  ___________________
Signature of researcher         Date

Complete the following if you wish to receive a copy of the results of this study:

NAME: _____________________________________________________ (Typed or printed)

ADDRESS: __________________________________________________ (Street)

___________________________________________________ (City) (State) (Zip)
e-mail ___________________________________ Phone ______________________________
Appendix G: IRB Approval

Date: April 16, 2018
To: Sarah Bradwisch
From: Kathleen Maurer Smith, Ph.D.
Co-Chair, Molloy College Institutional Review Board
Patricia Eckardt, Ph.D., RN
Co-Chair, Molloy College Institutional Review Board

SUBJECT: MOLLOY IRB REVIEW AND DETERMINATION OF EXPEDITED STATUS

Study Title: Female Veterans Transitioning to Post-Active Duty Health Care: A Phenomenological Study
Approved: April 16, 2018
Approval No: 19021801-0416

Dear Sarah:

The Institutional Review Board (IRB) of Molloy College has reviewed the above-mentioned research proposal and determined that this proposal is approved by the committee. It is considered an EXPEDITED review per the requirements of Department of Health and Human Services (DHHS) regulations for the protection of human subjects as defined in 45CFR 46.110(7) and has met the conditions for conducting the research. Please note that as Principal Investigator (PI), it is your responsibility to be CITI Certified and submit the evidence in order to conduct your research.

You may proceed with your research. Please submit a report to the committee at the conclusion of your project.

Changes to the Research: It is the responsibility of the Principal Investigator to inform the Molloy College IRB of any changes to this research. A change in the research may change the project from EXPEDITED status that would require communication with the IRB.

Sincerely,

Kathleen Maurer Smith, Ph.D.

Patricia Eckardt, Ph.D., RN