Barriers to Care for Women Veterans with Post-Traumatic Stress Disorder: Interface of Gender, Culture, Diagnosis and Compensation

A Thesis

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ABBREVIATIONS

C & P exam	compensation and pension exam
CBOC	Community-based outpatient clinic
DoD	Department of Defense
DSM	Diagnostic and Statistical Manual
MSA	military sexual assault
MST	military sexual trauma
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OND	Operation New Dawn
PTSD	post-traumatic distress disorder
PTS	post-traumatic stress
SC	service-connected
VA/VHA	Veterans Affairs/Veterans Health Administration-used interchangeably throughout this paper
VBA	Veterans Benefit Administration
VISN	Veterans Integrated Service Network
VRO	Veterans Resource Office

CHAPTER I: INTRODUCTION

> *Returning from the initiatory space of the battlefield to the normal world is every bit as mysterious a journey as entering the Temple of Mars. The world you left behind has changed and you have changed. You know parts of yourself that you, and those you've lived with all your life, never knew before. You've been evil, and you've been good, and you've been beyond evil and good. You've split your mind from your heart, and you've split your heart with grief and your mind with fear. Ultimately, you've been in touch with the infinite, and now you are trying to reconcile yourself to the mundane. The warrior of the future will need to know how to enter and exit both worlds, if not with ease, then at least without permanently disintegrating his or her personality (Marlantes, 2011, p.9).*

Purpose

1. To explore gender disparities related to the diagnosis of, and compensation for, post-traumatic stress disorder (PTSD) with and without military sexual trauma (MST) at Veterans Health Administration (VHA) on a national level. Although MST affects both men and women, the foci of this work will be on women, as women are the majority of victims of sexual assault. If women are not diagnosed and compensated at similar rates as men -where warranted- this discrepancy can lead to poverty, drug and alcohol abuse, homelessness, despair, and even

suicide.

2. This paper will specifically address processes that may create a difficult evidentiary burden that female veterans must meet in order to qualify for disability compensation benefits; notably more difficult burden of proof than their male counterparts (Schingle, 2009). The VA regulations governing service- connection for post-traumatic stress disorder (PTSD) in both combat exposure and military sexual trauma are explored.
3. Also, critical in this process, is the impact of cultural and gender competence and sensitivity on barriers to care for this particular subset of the veteran population. As women continue to serve in the military in increasing numbers, and as the roles expand to include those previously held by men, there is a great need for a better understanding of the stressors that women veterans face and how these stressors impact their lives and the lives of their families after deployment. This paper will address gaps between the progress made at VHA so far, with suggestions for improving barriers to health care and mental health treatment for women.
4. A thorough examination was conducted (ongoing) of the relevant and current literature regarding individual,

as well as systemic barriers to treatment for PTSD and mental health disorders in women veterans; PTSD diagnosis and compensation in women veterans; Literature review also includes general medical care as it relates to cultural competence and an environment that has been mostly focused on male veterans' issues.

5. More importantly, this project is also pertinent to my interests as a woman and veteran of Operation Iraqi Freedom (OIF). As a combat veteran struggling with my own PTSD issues, I am hoping that the process in writing my thesis will help me resolve these issues to move forward in a positive way. A personal goal is to enhance my scholarship and use my experiences as a woman veteran and student of Bioethics to work with other women veterans at VHA.

CHAPTER II: Literature Review

To analyze the current literature associated with PTSD related issues for female veterans, I conducted an extensive review searching articles from 2003 to the present. Literature was gleaned from databases such as PsycINFO, ScienceDirect, Google Scholar, Wiley, CINAHL and OVID. An independent search was conducted of various journals such as Journal of Traumatic Stress, Military Medicine, Allied Health Literature, Medline, Health Sciences (Sage), ProQuest, Published International Literature on Traumatic Stress (PILOTS). The PILOTS database was accessed from the National Center for PTSD, via the U.S. Department of Veterans Affairs. No limiters were used to restrict the search.

Search words included female veterans and deployment, female veterans with PTSD, PTSD in combat females who were sexually assaulted, PTSD rates and disability compensation rates. This review covered four main categories: Combat women Veterans with PTSD, disparities in diagnosis and disability compensation for combat women with PTSD, Military sexual assaults in combat and barriers to care for women at VA returning home from combat. Literature searches were done specifically on the Gulf War II (Iraq and Afghanistan) era because of the unique characteristics of multiple deployments and the increase of female service members in combat-exposed areas.

The literature searches were articles and peer-reviewed journals selected by specific criteria which are discussed under separate headings throughout this paper. Each article was analyzed individually, and the findings extracted from the articles have then been put together to form several conclusions.

CHAPTER III: Background

Department of Veteran Affairs/Veterans Health Administration (VA/VHA) Mission and Structure

"To care for him who shall have borne the battle and for his widow, and his orphan." Those words—an affirmation of the government's obligation to veterans and their families made by President Lincoln at his second inaugural address in 1865—constitute the mission statement of what is today called the Department of Veterans Affairs (VA.gov, 2015).

The VA was elevated to a cabinet-level executive department by President Ronald Reagan in October 1988. The Veterans Administration was then renamed the Department of Veterans Affairs and continued to be known as VA. VA's Department of Medicine and Surgery, established in 1946, was re-designated as the Veterans Health Services and Research Administration at that time, and on May 7, 1991, the name was changed to the Veterans Health Administration (VHA), (VA.gov/about, 2015).

The present-day VA provides three primary services: health care, benefits, and related social services, and cemetery management. Each of these services is provided by one of VA's three-line organizations: The Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration. The scope of these operations is vast. VHA, for instance, manages the single largest integrated health care system in the United States (IOM, 2007).

In addressing the needs of yesterday's, today's and tomorrow's veterans,

VA offers a continuum of healthcare services, including health promotion and disease prevention, primary and specialized ambulatory medical, surgical and mental health care, hospital care, residential specialized mental health and substance abuse treatment programs, home care, institutional long-term care and hospice and palliative care programs. (DAV, 2014). VA operates 151 medical centers, 820 community-based outpatient clinics (CBOCs), and 70 mobile clinics that serve 6.5 million veterans each year, including 1.9 million outpatient visits each week and 695,000 hospital admissions in FY 2013 (Natl Ctr Vets Analysis & Stats, 2015). The Department of Veterans Affairs health care system is organized into a system of 21 Veterans Integrated Service Networks (VISNs). The majority of services provided by the VA are delivered in facilities owned and maintained by the VA and staffed by VA employees. The balance, referred to as purchased services, is paid for on a fee-for-service basis. Currently, all veterans with at least 24 months of continuous active duty military service and an “other-than-dishonorable” discharge are eligible to receive care from the VA through a priority-based enrollment system. Veterans are prioritized for enrollment according to eight tiers: those with Service-connected disabilities (priority levels 1 through 3); prisoners of war and recipients of the Purple Heart (priority 3); veterans with catastrophic disabilities unrelated to service (priority 4); low-income veterans (priority 5); veterans who meet specific criteria, such as having served in the first Gulf War (priority 6); and higher-income veterans who do not qualify for other priority groups (priorities 7 and 8). Enrollment is currently suspended for priority group 8 to ensure that the VA can meet the needs of its

higher-priority enrollees. Reserve Component members who are combat veterans are also eligible to access the VA health care system (Natl Ctr Vets Analysis & Stats, 2015). The VA has numerous initiatives and programs designed to address psychological and cognitive injuries, ranging from screening programs and resiliency training, to use of care managers and recovery coordinators, and implementation of new therapies (Tanielian, Jaycox, et al., 2009).

Although hundreds of thousands of women served in uniform in World War II, Korea, Vietnam and intervening times of peace, it was not until 1988 that the VA began offering medical and mental health services to female veterans -- due mainly to a policy favoring vets who served in combat. Today, nearly all veterans are eligible for some level of VA services, but women still underutilize their entitlements (DAV, 2014). In response to the recent increase in women Veterans, the VA has put in place some health care and research programs just for women. This includes the Women Veterans Health Program and the Center for Women Veterans and every VA Medical Center in this country now has a Women Veterans Program Manager (VA.gov/PTSD, 2015).

Definition of PTSD

Post Traumatic Stress Disorder (PTSD) is a psychiatric disorder that can develop after direct personal experience or witnessing of an event that poses a perceived threat of death or serious injury. Symptoms include re-experiencing traumatic events through flashbacks and nightmares, avoidance of things associated with trauma, and hyperarousal. PTSD can cause substantial distress

and functional impairment and can interfere with readjustment to one's previous life (Seal et al., 2009). PTSD is recognized as a psychobiological mental disorder that can affect survivors not only of combat experience, but also terrorist attacks, natural disasters, serious accidents, assault or abuse, or even sudden and major emotional losses. It is associated with changes in brain function and structure, and these changes provide clues to the origins, treatment, and prevention of PTSD. Some cases may be delayed, with only subtle symptoms showing up initially and more severe symptoms emerging months after the traumatic event. (PTSDUnited.org).

According to VA National Center for PTSD (2015), DSM-IV Diagnostic criteria for PTSD included a history of exposure to a traumatic event and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerned the duration of symptoms; and, a sixth criterion stipulated that PTSD symptoms must cause significant distress or functional impairment.

The latest revision, the DSM-5 (2013), has made some notable evidence-based revisions to PTSD diagnostic criteria, with both important conceptual and clinical implications (APA, 2013, VA Natl. Ctr., PTSD, 2015). First, because it has become apparent that PTSD is not just a fear-based anxiety disorder (as explicated in both DSM-III and DSM-IV), PTSD in DSM-5 has expanded to include anhedonia/dysphoric presentations, which are most prominent. Such presentations are marked by negative cognitions and mood states as well as disruptive (e.g., angry, impulsive, reckless and self-destructive) behavioral

symptoms. Furthermore, as a result of research-based changes to the diagnosis, PTSD is no longer categorized as an Anxiety Disorder. PTSD is now classified in a new category, Trauma and Stressor-Related Disorders, in which the onset of every disorder was preceded by exposure to a traumatic or otherwise adverse environmental event (VA, Natl Ctr, PTSD, 2015).

Depression and Other Comorbid Conditions

PTSD is often comorbid with other psychiatric conditions (i.e., anxiety and depression) and substance use disorders (IOM, 2009). Accordingly, depression is the second most common mental health diagnosis in U.S. combat troops deployed to Iraq and Afghanistan. The Department of Defense (DOD) and its Millennium Cohort Study is an ongoing longitudinal cohort study headquartered at the Naval Health Research Center in San Diego, California and was designed to evaluate any long-term health effects of military service, including deployments. It is the largest population-based prospective health project in US military history, currently collecting data on over 200,000 enrolled participants (DOD, MCS.org). The prevalence of depression in the Millennium Cohort Study (30,000 men; 10,000 women) in deployed service members who were exposed to combat in Iraq and Afghanistan was 5.7% in men and 15.7% in women (Wells et al. 2010). Symptoms of depression include persistent feelings of sadness, changes in appetite and/or sleeping patterns, loss of interest in activities, fatigue, inability to concentrate, and hopelessness or suicidal thoughts. Depression is a major contributor to health dissatisfaction and mental and physical health (APA,2013).

If an individual meets diagnostic criteria for PTSD, it is likely that he or she will meet DSM-5 criteria for one or more additional diagnoses (APA, 2013). Most often, these comorbid diagnoses include major affective disorders, dysthymia, alcohol or substance abuse disorders, anxiety disorders, or personality disorders. There is a legitimate question whether the high rate of diagnostic comorbidity seen with PTSD is an artifact of our current decision-making rules for the PTSD diagnosis since there are not exclusionary criteria in DSM-5. In any case, high rates of comorbidity complicate treatment decisions concerning patients with PTSD since the clinician must decide whether to treat the comorbid disorders concurrently or sequentially (VA, Natl Ctr PTSD, 2015).

A Word About Pre-Military History of PTSD and Its Effects

As VA healthcare providers struggle to address the increasing and challenging demand for treating female combat veterans, many of them have experienced trauma before entering the military, known as pre-military trauma (PMT). While addressing and treating the traumatic event in a female combat veteran, mental health professionals often fail to address previous events. Maguen et al. suggested that future studies should deliberate the damaging influences of numerous exposures to traumatic events over the lifetime of the subject and ways in which these events contribute to an increased hazard for post-deployment hopelessness and additional psychiatric disorders.

In 2006, Himmelfarb et al. examined relationships among MST, non-military sexual trauma, and PTSD. A sample of 196 female veterans was assessed for trauma occurring before, during, and after military service, and for current PTSD. The prevalence of MST was higher than that of pre-military and

post-military sexual trauma. Pre-military trauma did not significantly increase the odds of experiencing MST but did increase the odds of experiencing post-military sexual trauma. Logistic regression analyses revealed MST was more strongly associated with PTSD than was pre-military or post-military trauma. Women with MST had the greatest increased odds of developing PTSD. They proposed that understanding risk factors for and taking steps to prevent MST may reduce cases of PTSD in female veterans (Himmelfarb et al., 2006).

Also, according to the APA's (2013a) DSM-5, risk factors for PTSD pre-trauma include temperamental factors, such as childhood emotional problems; environmental factors, such as lower socioeconomic status, lower education, exposure to past trauma, childhood adversity, cultural characteristics, minority status, and family psychiatric history; and genetic and physiological factors such as female gender and younger age.

History of Women in the Armed Forces

American Revolution

During the American Revolution, women served on the battlefield alongside men, mainly as nurses, water bearers, cooks, and laundresses (Nat. Ctr. Vets An. & Stats, 2011). Despite Army regulations that only men could enlist, women who wanted to join in the fighting circumvented the rules by masquerading as young men or boys (Iskra, 2010). Several hundred women are estimated to have donned such disguises during the Civil War. While female spies had become common during the Civil War, by far the most significant contributions made by women were in the fields of healthcare and medicine.

Despite the remarkable efforts of these women, military leadership was still not ready to accept them as an integral part of the military medical service (Nat. Ctr. Vets An. & Stats, 2011). After the war ended in 1865, the Army returned to using enlisted men for patient care, and the female nurses were sent home (Iskra, 1999).

Spanish American War

As the Army faced an epidemic of typhoid at the outset of the Spanish-American War in 1898, Congress once again authorized the appointment of women as nurses, (Nat. Ctr. Vets An. & Stats, 2011). An estimated 150,000 contract nurses served between 1898 and 1902 in the United States, overseas, and on the hospital ship “Relief.” The nurses who served during the Spanish-American War paved the way for the creation of a permanent corps of nurses in the Army and Navy. In 1901 the Army Nurse Corps (ANC) was established, without full pay and rank. The ANC was followed in 1908 by the Navy Nurse Corps (Iskra, 1999).

World War I

It was not until World War I that the military implemented a physical examination requirement for Servicemembers, thus making it impossible for women to continue disguising themselves as men in order to serve. Altogether, more than 23,000 women nurses in the Army and Navy served on active duty during World War I (Nat. Ctr. Vets An. & Stats, 2011). The demands of this war made it necessary to expand the roles of women beyond nursing in order to free men to fight in combat. Women took over positions as telephone operators and

clerks in Washington D.C., and still, they were only allowed to serve in the enlisted ranks (Iskra, 1999).

World War II

By World War II, the roles of military women were once again greatly expanded to meet the needs of wartime. During 1940 and 1941, nurses were the only military women to mobilize. In May 1942, the Army was given the authority to establish the Women's Army Auxiliary Corps (WAAC). The Navy, Coast Guard, and Marines followed suit. In 1943, WAAC became the Women's Army Corps, (Natl Ctr. Vets Analysis & Stats, 2011).

It was not until the passage of the Armed Services Integration Act of 1948 that women in addition to nurses became a permanent part of the U.S. military (Public Law 625, 1948; Nat. Ctr. Vets An. & Stats, 2011).

Korean War

In 1950, fewer than five years after World War II had ended, the United States found itself once again confronted by war for which it was unprepared, (KoreanWar.org). As before, a downsized military establishment rushed to call up, draft and recruit troops, but recruitment numbers fell short of military requirements. Moreover, just as in previous wars, the services turned again to American women. Army nurses were the first American women to be dispatched with the Armed Forces to the combat zone. With more than 300 nurses in the combat zone, they provided expert surgical and bedside care in every hospital to which wounded were evacuated (KoreanWar.org).

Viet Nam War

The vast majority of the military women who served in Vietnam were nurses. Members of the Army Nurse Corps arrived in Vietnam as early as 1956, when they were tasked with training the South Vietnamese in nursing skills. As the American military presence in South Vietnam increased, beginning in the early 1960s, so did that of the Army Nurse Corps. From March 1962 to March 1973, when the last Army nurses left Vietnam, some 5,000 would serve in the conflict (Women in the Vietnam War, History.com).

OIF/OEF/OND

In this war, more than any other, women serving in Afghanistan and Iraq were directly exposed to combat and other violence. While women were still officially excluded from assignment to many combat roles and units, there was a critical need for their skills, and therefore they were "attached" to these units to serve as combat medics, military police, explosive ordnance clearance personnel, convoy truck drivers and other dangerous occupations (DAV, 2014).

It is the extent of their involvement in combat operations and integration into the services that have changed dramatically over time. Today’s women Veterans are the best-educated and the most diverse in VA history. They are generally younger than male Veterans and will have many opportunities to receive VA care. (Women Vets Health Services, 2016).

In 2009, women comprised 8 percent of the total Veteran population in the United States (VHA Sourcebook, 2014) and in 2015, women made up 9.4 percent of the Veteran population (VetPop, 2014). As of September 2009, there

were 1,418,542 U.S. men and women in the active duty military. Women comprised 8% of Veteran Health Administration (VHA) patients in 2011 and 20% as of 2014 (Natl Center Vets Analysis & Stats, 2014). By 2035, they are projected to make up 15 percent of all living Veterans (Vets Analysis & Stats, 2014) and women are growing faster than the number of men, (VHA Sourcebook, 2014; Meehan, 2006). In 2014, there were 200,692 women in the Active component of the U.S. Armed Forces and 156,180 women in the Reserve and National Guard, representing 16.5% of the total military force (DOD Demographics, 2014). The number of women Veterans is expected to increase while the overall number of Veterans is expected to decrease.

Post-9/11 Iraq and Afghanistan war female veterans are less likely to find a job than their male counterparts, with an unemployment rate for post-9/11 female veterans at 8.5% in 2014 which was not statistically different from the prior year of 9.6%. At the same time, the unemployment rate for men declined from 8.8% in 2013 to 6.9% in 2014 (U.S. Dept. of Labor, 2014). High unemployment leaves female veterans at risk for homelessness and with female veterans now being the fastest-growing segment of the country's homeless population, including women in the civilian community (Karr, 2013, Hamilton, et al., 2011).

History of PTSD in the Armed Forces

During the early 1800s, military doctors began diagnosing soldiers with "exhaustion" following the stress of battle. This condition was characterized by mental shutdown due to individual or group trauma. Also, during this time, in

England, there was a syndrome known as "railway spine" or "railway hysteria" that bore a resemblance to what is called PTSD today. This syndrome was a reaction to catastrophic railway accidents. During World War I, overwhelming mental fatigue was diagnosed as "soldier's heart" and "the effort syndrome." During World War II, the term "shell shock" emerged, followed by the term "combat fatigue." These terms were used to describe veterans experiencing anxiety and stress as a result of being engaged in combat (VA, Natl. Ctr. PTSD, 2015).

As psychologists and other mental health professionals began to revise their ideas of trauma's etiology, they also started to identify risk factors and protective factors for developing symptoms of combat fatigue. Military psychiatrists observed that "the strongest protection against psychological breakdown was the morale and leadership of the small fighting unit" (Herman, 1992, p. 25).

In 1980, "the psychological trauma of war [was] finally recognized ...by the American Psychological Association (APA) [as] 'Post-Vietnam Syndrome,'" (Herman, 1992, p. 28), an appellation that would be fine-tuned for the same year's publishing of the DSM-III as "posttraumatic stress disorder." Herman in 1992, clarified the impetus for this dramatic sea change in mental health nomenclature, explaining that "the moral legitimacy of the [Vietnam] anti-war movement and the national experience of defeat in a discredited war had made it possible to recognize psychological trauma as a lasting and inevitable legacy of

war" (Herman, 1992, p. 27).

Posttraumatic stress disorder (PTSD) as a diagnosis initially developed out of research on the effects of combat exposure on Vietnam veterans (Koenen et al., 2007). Therefore, ironically, the long overdue validation of PTSD's existence came from the strong political pressure of the antiwar contingent to better care for disabled and indigent Vietnam veterans, rather than from advances in medical science around the impact of combat trauma on the psyche as well as the human body (VA Natl Ctr. PTSD). According to Matthew Friedman, Senior Advisor and former Executive director, National Center for PTSD, PTSD became a diagnosis with influence from a number of social movements, such as Veteran, feminist, and Holocaust survivor advocacy groups (VA, National PTSD). Research about Veterans returning from combat was a critical piece to the creation of the diagnosis. It is indeed possible that PTSD would not have been included in DSM-III without strong support from Veteran and feminist advocacy groups. Unlike depression, schizophrenia, and other anxiety disorders, PTSD emerged from converging social movements rather than academic, clinical, or scientific initiatives (Friedman et al., 2014). As a result, PTSD received an ambivalent, if not hostile, reception in many prominent psychiatric quarters when it was first introduced in 1980. The response to this negative reception was an outpouring of research to test the legitimacy of PTSD rigorously as a diagnosis. So, the history of what is now known as PTSD often references combat history. This realization would not come until much later. The official designation of PTSD did not come about until the publication of the Third edition of the Diagnostic and

Statistical Manual of Mental Disorders (DSM) in 1980. (VA, Natl. Ctr. PTSD, 2015).

Women Veterans and PTSD

A woman is a Veteran, as defined in a 2012 U.S. Department of Veterans Affairs brochure, “Federal Benefits,” if she served in the active military, naval or air service and separated under any conditions other than dishonorable (Dept. VA, 2012a). This includes Reserves and National Guard forces. More than 2 million women Veterans are living in the U.S. today. Women over the past 30 years have entered the military in ever-increasing numbers.

Ultimately, these women make the transition from service member to Veteran. In 2009, women comprised 8 percent of the total Veteran population in the United States (Women Vets Health Services, 2016). As of September 2009, there were 1,418,542 U.S. men and women in the active duty military. The number of women Veterans has been growing faster than the number of men. Today’s women Veterans are the best-educated and most diverse generation. They are generally younger than male Veterans and will have many opportunities to receive VA care, although they do not readily use VHA services. (Women Vets Health Services, 2016).

Women are more likely to be in the line of fire than those serving in previous wars; and that means they are also at a higher risk of having PTSD, depression and other mental health problems. It is one of the disorders most commonly diagnosed in U.S. combat troops deployed to Iraq and Afghanistan with an estimated prevalence of 5-20% of OEF/OIF veterans. There is a higher

prevalence (> 30%) in service members who experience combat exposure and are wounded. This prevalence of PTSD and depression increases with time after deployment in the readjustment period (Milliken et al. 2007; Seal et. al.2009).

Posttraumatic stress disorder affects approximately 9% of all Americans (Kessler, 2005a), but is particularly common among veterans. For example, although the 12-month prevalence of PTSD in the U.S. population is estimated to be less than 4% (Kessler 2005b), but a comprehensive analysis, published in 2014, found that for PTSD among male and female soldiers aged 18 years or older returning from Iraq and Afghanistan, rates range from 9% shortly after returning from deployment to 31% a year after deployment (Vet Stats, Feb. 2015). For many of these veterans, PTSD has become chronic and disabling, resulting in long-term impaired occupational and social functioning (Schnurr, 2009, Sayer, 2010).

Unique to the current conflicts are personnel serving longer, and often multiple deployments with shorter intervals at home between missions. Also, these extended military operations have involved more parents of young children, often in single-parent households with women as heads-of-households.

Maguen et al. in 2012, examined gender differences in combat exposure, military sexual trauma (MST), and their associations with mental health screen results among military personnel deployed in support of the wars in Afghanistan and Iraq. Data were collected as part of a pre- and post-deployment screening program at a large Army medical treatment facility. Cases included 7251 active duty soldiers (6697 men and 554 women) who presented for their pre- and post-

deployment screening from March 2006 to July 2009. Pre-deployment mental health symptoms were statistically controlled for in the analyses. They found significant gender differences in demographic variables, exposure to combat, and MST. Women reported greater exposure to MST than did men. Although men reported greater exposure to high-intensity combat experiences than women, results indicate that women are experiencing combat at higher rates than observed in prior cohorts. Men were more likely to report problem drinking, and women were more likely to report depression symptoms. Although we found few differences between women and men in the impact of combat stressors on mental health, there was a stronger association between injury and PTSD symptoms for women than for men. Their findings indicate that it would be useful for clinicians to be aware of this difference and assess for exposure to a full range of traumatic combat experiences, particularly injury, as not all types of combat experiences may be equally experienced by men and women returning from military deployments (Maguen et al., 2012).

Rates of PTSD in Women Veterans Compared to Civilian Women

Literature comparing PTSD in military women versus civilian women is limited. The most recent literature available comparing the prevalence of PTSD in women veterans with women in the civilian community are limited to two studies. In 2006, Yaeger et al., conducted a VA funded study of 230 women. During these interviews, they found women with MST had higher rates of PTSD than those with other traumas, such as witnessing atrocities; 60% of subjects with MST had PTSD compared with 43% of women in the other trauma group. Military sexual

trauma and other trauma both significantly predicted PTSD in regression analyses (P=.0001 and .02, respectively) but MST predicted it more strongly. Prior trauma did not contribute to the relationship between MST and PTSD (Yaeger et al., 2006). This finding suggests that women veterans should be screened for MST and PTSD.

The mental health consequences for women who have experienced intimate partner violence, such as major depressive disorder and (PTSD) and especially their comorbidity, have received little attention in large-scale studies and treatment protocols for affected populations. (Ocampo and Kub et al. (2006), compared the association of PTSD, major depressive disorder, and PTSD with major depressive disorder comorbidity to intimate partner violence in two large cohorts, one of military and the other of civilian women. The adjusted prevalence of mental health symptoms, especially PTSD, was higher among abused than non-abused women in both samples. Mental health symptoms were also higher among the civilian sample compared to the military sample. Approximately one-third (34%) of the abused civilian women and one-fourth (25%) of the abused military women had symptoms that met criteria for at least one of the three diagnostic categories employed in this study, compared to 18% and 15% of non-abused women in the two groups. Comorbidity of PTSD and depression affected 19.7% of the abused civilian women versus 4.5% of non-abused civilian women, whereas, for active duty military women, the prevalence was 4.6% and 4.2% for abused and non-abused, respectively. To better understand the mental health consequences of IPV and to design the most effective treatment and prevention

programs, it is essential to examine the presence of comorbidities between mental health disorders. (Ocampo, Kub, et al., 2006).

The Military Sexual Trauma (MST) Component

Women have integrated into the Armed Forces, and their specialty fields and expertise, not gender, have taken them much closer to combat. Women serving in the military come under direct fire and experience combat-related injuries and trauma and are often subjected to military sexual assaults and harassment while serving their country (Mattocks, Haskell, Krebs, et al., 2012). Common conditions [such post-traumatic stress disorder, depression, and substance abuse] linked to military sexual trauma, can lead to unemployment, poverty, homelessness, and suicide (VA National Center, PTSD, 2015; Murdoch et al., 2005).

Military sexual trauma is the term that the Department of Veterans Affairs uses to refer to sexual assault or repeated, threatening sexual harassment that occurred while the Veteran was in the military. It includes any sexual activity in which one is involved against one's will – he or she may have been pressured into sexual activities (for example, with threats of negative consequences for refusing to be sexually cooperative or with implied faster promotions or better treatment in exchange for sex), may have been unable to consent to sexual activities (for example, when intoxicated), or may have been physically forced into sexual activities. Other experiences that fall into the category of MST include unwanted sexual touching or grabbing; threatening, offensive remarks about a person's body or sexual activities; or threatening or unwelcome sexual advances

(MentalHealth.VA.gov). For this paper, MST refers to sexual assault (e.g., physical contact of a sexual nature without voluntary consent) unless otherwise noted.

Women who have suffered MST often do not report those crimes; therefore, they have limited documentation that can be used as evidence when they seek VA assistance. This often results in a denial of benefits. Even when they do report incidents of harassment or assault, perpetrator conviction rates are only 5 percent. These reports are seen as unsubstantiated. This result is especially unfair given that 78 percent of female servicemembers report some form of sexual harassment according to a DoD Survey (111th Congress, Joint Hearing, 2009, IOM, 2009).

In researching the prevalence of MST, discrepancies in the literature were noted. Prevalence rates of MST appear to be related to some variables including data collection methods, and the definition of MST used, as well as overall purposes of studies. Among those studies that utilized face-to-face interviews, significant variability was noted in reporting of MST, which may be due to the various forms and interview formats used to obtain information (Suris & Lind, 2008). Higher prevalence rates were reported when veterans were evaluated in a treatment setting, compared to a research setting.

The Department of Defense's (DoD) Sexual Assault Prevention and Response Office estimates that 26,000 cases of sexual assault or unwanted sexual contact occurred in the military in the fiscal year 2012. Reports of sexual assault increased in three of four Military Services. In total, the DoD received

3,374 reports of sexual assault involving one or more Service members as either the victim or alleged subject (suspect) – a five percent increase over the 3,192 reports of received in the fiscal year 2011 (DoD Annual Report, 2012).

It is clear that MST is a risk factor for the development of PTSD; however, we know little about how individuals who are diagnosed with PTSD and have an MST history differ from those who are diagnosed with PTSD and do not report a history of MST. In the case of PTSD with associated MST, unless there is presumptive evidence that trauma of sufficient intensity took place, most of these claims are denied. In these cases, veterans often lack medical records and other documentation required for compensation through VA because the victims do not report the incidents. Also, until recently, the Department of Defense (DOD), allowed the destruction of rape kits after one year and of sexual harassment and sexual assault reports after as little as two years , 2014).

Those veterans whose PTSD stems from military sexual trauma, the VHA according to the Service Action Women's Network (SWAN), both the military and VHA imposes a greater procedural burden on victims to prove their claims and denies their claims at a significantly higher rates than other PTSD claimants (SWAN, Yale Lawsuit, 2014).

From 2009 to 2012, MST-related PTSD claims were approved 16-30% less than other PTSD claims. Female veterans were disproportionately represented among claimants for benefits for PTSD arising from MST. Of the nearly 16,000 veterans making MST-related PTSD disability benefits claims during these five years, 66.1% were female veterans. By contrast, female

veterans accounted for only 4.6% of the claimants for disability benefits for PTSD related to causes other than MST during this same period. SWAN also claims that the data VA provided for each VA regional office (VARO) show striking variations in the success of MST-related PTSD disability benefits claims from one VARO to another. The data also reveal that as recently as 2012, when the national grant rate for MST-related PTSD claims had risen and the gap between the grant rates for MST-related PTSD claims and other PTSD claims had narrowed nationally and at most VAROs, some regional offices continued to grant MST-related PTSD claims at rates far below the national grant rate, and far below the rates at which they were granting claims for PTSD unrelated to MST. Surprisingly the three VAROs with the lowest grant rates was St Paul Regional (Minneapolis VHA), Detroit, and St. Louis, in order of lowest to highest.

Because of their low grant rates, several of these offices merit a more in-depth look:

1. The St. Paul Regional Office (MN) had a particularly bad record on MST- related PTSD disability benefit claims in recent years, granting the lowest percentage of these claims of any VARO in 2011 and 2012. The office's 2012 grant rate for MST-related PTSD disability benefit claims (25.8%) was an improvement over the 2011 grant rate (20.8%), but overall there was a net decrease of 12.3 percentage points in the grant rate for MST- related PTSD claims at that office from 38.1% in

2008 to 25.8% in 2012.

a. In 2012, when most VAROs made progress in closing the gap between MST-related PTSD disability benefit grant rates and non- MST-related PTSD disability benefit grant rates, the discrepancy at the St. Paul Regional Office was a remarkable 35.1 percentage points.

b. The discrepancy in the grant rates at the St. Paul Regional Office actually grew each year from 2008 to 2011, from only 5.4 percentage points in 2008 to 37.1 percentage points in 2011. The 2012 disparity of 35.1 percentage points was only a slight improvement over the 2011 rate and was still unacceptably large.

2. The Detroit Regional Office (MI) had the second lowest grant rate of MST- related PTSD claims of any regional office processing 40 or more such claims in fiscal year 2012.

a. Similar to the St. Paul Regional Office, the grant rate of MST- related PTSD claims at the Detroit Regional Office decreased dramatically over time, falling from 52.4% in 2008 to 31.8% in 2012. At the same time, the discrepancy

between the grant rates for MST-related PTSD claims and non-MST-related PTSD claims had grown.

b. In 2012, the discrepancy at the Detroit Regional Office of 44.7 percentage points was greater than it had been at that regional office in any previous year in the dataset, and it was greater than any meaningful discrepancy at any other VARO across the country in 2012. The Detroit Regional Office granted 76.5% of non-MST- related PTSD benefits claims in 2012, but it granted only a 31.8% of MST-related PTSD benefit claims.

3. The St. Louis Regional Office (MO) took third place among the VAROs with the worst records for granting MST-related PTSD benefit claims in 2012 among VAROS processing 40 or more such claims. It also held the distinction of ranking among VAROs with the worst records for four of the five years.

    a. Between 2008 and 2012, there had been a net increase in the grant rate for MST-related PSTD claims in St. Louis, up from 26.1% in 2008 to 37.9% in 2012. However, the discrepancy between the grant rates for MST-related PTSD claims and non-MST-related claims also increased

every year from 2008 to 2011, from a gap of 21.9 percentage points in 2008 to 44.2 percentage points in 2011.b.

b. In 2012 this gap narrowed slightly, with 33.0 percentage points separating the grant rate for MST-related PTSD disability benefit claims (37.9%) from the grant rate for non-MST-related PTSD disability benefit claims (70.9%). (https://law.yale.edu/system/files/documents/pdf/Clinics/swan_battl eForBenefits.pdf.)

According to this lawsuit, “The VA knows the current process makes veterans who have been harmed by military sexual harassment and assault jump through more hoops than other PTSD claimants to apply for and receive PTSD disability benefits. However, they refuse to change their regulations,” said Anu Bhagwati, SWAN executive director, and former Marine Corps captain. “The result of this discrimination is that survivors of military sexual harassment and assault are denied life-saving benefits and critical income to support themselves and their families (SWAN, 2014).

A study conducted by the VA in 2004 found that women veterans who had experienced military sexual assault (MSA) were nine times more likely to have PTSD -- whether they had been in combat or not. The conclusion reads: "Although women with military sexual assault are more likely to have PTSD. Results suggest that they are receiving fewer health care services." (Martin,

2009).

According to a report by Antonieta Rico, an Iraq War veteran and the Director of Communications and Policy at the Service Women's Action Network (SWAN), written for Time Magazine, December 12, 2017, the #MeToo movement leaves women in the military out of the discussion. For military women, before #MeToo there was #NotInvisible, an attempt to draw attention to the epidemic of sexual assault in the military which continues to be largely ignored by the American public. "Now as the #MeToo reckoning sweeps other industries, from Hollywood to politics, America is once again leaving servicewomen behind." Women in the military have been speaking out about sexual harassment and assault for decades, from the early 1990s to Marines United earlier this year. Military "brass" at the Pentagon often say the right words, but have failed to eradicate sexual assault in the ranks and have failed to hold the guilty accountable. Rico states, "Scandal after scandal shows, sexual predators in the military continue to harass and assault with impunity."

In the fall of 2017, the Service Women's Action Network (SWAN) surveyed more than 1,300 servicewomen about the impact their military service had on their mental health. The survey identified military sexual trauma (MST) as the number one factor negatively affecting their mental wellness. Following the survey, SWAN brought together servicewomen and women veterans from all branches and eras in a Summit in D.C. that further explored the survey results. The servicewomen who attended included a 71-year-old Navy vet who shared with us that after multiple rapes and assaults the only

way she could finish out her enlistment in the 60s was by numbing herself with alcohol on a daily basis until her contract was over. Not a lot has changed since then. SWAN continues to field calls and emails from women who tell us they were discharged after being raped or women currently serving who tell us they are scared of reporting their rape (Rico 2017).

During this survey, just over 60 percent of women indicated that military service negatively affected their mental health (most often tied to MST) and recent data bears out that fact: women veterans have higher rates of depression than non-veteran women and a shocking 250% higher suicide rate than civilian women (SWAN.org, 2014, Curtin, et al., 2016).

U.S. Senator Kirsten Gillibrand on November 16, 2017, stood with a bipartisan group of colleagues, survivors, and advocates to re-introduce the Military Justice Improvement Act (MJIA). The bipartisan MJIA would remove the sole decision-making authority over whether serious crimes are prosecuted from the military chain-of-command and give it to independent, trained military prosecutors. Gillibrand, the Ranking Member of the Senate Armed Services Personnel Subcommittee, has introduced the MJIA every year since 2013. The bill has been voted on twice on the floor of the Senate, winning a bipartisan majority vote both times but failing to overcome a filibuster threshold of 60 votes. In 2017, Gillibrand called for another vote on the MJIA to hold the military accountable for sexual assault against American service members (Gillibrand, 2017).

Top officials in the military continue to assert that they alone will fix this,

but little has changed. Last year, the Department of Defense announced a record number of sexual assaults reported against service members, and the lowest conviction rates for their assailants on record, at just 9%. The most recent Pentagon survey found that nearly 6 out of 10 survivors say they have experienced some form of retaliation for reporting the crime.

Iraq and Afghanistan Veterans of America (IAVA) published similar results:

1. Only 19% of women and 33% of men think the Department of Defense is doing a good job of addressing military sexual assault.
2. 71% of female respondents said they experienced retaliation when they reported, as did 64% of men.
3. 46% of women and 35% of men said they would be more likely to report being assaulted if, instead of a commander, a trained military prosecutor decided to move forward with the case, as the Military Justice Improvement Act would do (Jaslow, IAVA, 2017)

MST as it Relates to Military Rank

Although the numbers have risen recently, officers are rarely prosecuted for sexual assault compared to enlisted personnel. Historically, it has been extremely rare for senior military officers to face courts-martial. Leaders suspected of wrongdoing are usually dealt with behind the scenes, with offenders receiving private reprimands or removal from command with a minimum of public

explanation. That has gradually changed as the Defense Department — under pressure from Congress and the White House — has revamped its policies to prevent sexual assault and to hold perpetrators accountable (Retrieved from https://www.washingtonpost.com/world/national-security/more-high-ranking-officers-being-charged-with-sex-crimes-againstsubordinates/2016/03/19/3910352a-e616-11).

"There's not much transparency when it comes to senior- officer misconduct" said Don Christensen, a former chief prosecutor for the Air Force who now is president of Protect Our Defenders, a group that advocates for victims of sex crimes in the military. "They do not like the American public knowing what's going on, so they drag their heels in getting information out." (https://www.protectourdefenders.com/media2017/).

Recently the U.S. military has stepped up investigations of high- ranking officers for sexual assault, records show, curtailing its traditional deference toward senior leaders as it cracks down on sex crimes (DOD Survey, 2012).

Under the military justice system, senior officers are responsible for deciding whether individuals under their command should be prosecuted. Some lawmakers and advocacy groups are pushing to strip commanders of that power and to give it instead to uniformed prosecutors. The Pentagon has resisted such proposals, saying they would undermine command authority. When senior officers themselves are charged with sexual assault, it "makes it appear as if the fox was guarding the henhouse," said Christensen, the president of Protect Our Defenders, which has lobbied Congress to change the law

(https://www.protectourdefenders.com/media2017/).

Disability and Compensation Awards Process

The mission of the United States Department of Veterans Affairs is to honor and serve veterans by providing them with long-term access to quality healthcare and disability benefits (VA, About VA, 2015).

Safeguarding physical and mental health is a fundamental component of our country's initiatives to recruit, prepare, and sustain a highly capable military force and to address service-connected injuries and disabilities.

A Compensation and Pension (C & P) Examination, conducted under the auspices of the Veterans Benefits Administration, is the first step for the veterans wishing to receive service connection benefits, such as access to VA medical care or monetary compensation. Compensation may also be paid for post-service disabilities that are considered related or secondary to disabilities occurring in service and for disabilities presumed to be related to circumstances of military service, even though they may arise after service. The degrees of disability specified are also designed to compensate for considerable loss of working time from exacerbations or illnesses (VA Compensation, 2015).

Disability and Compensation for PTSD

As of fiscal year, 2013, a total of 648,992 veterans of all wars were receiving VA disability benefits for PTSD up from 386,882 in 2010, (VBA Benefits Report 2013). Veterans currently receive over 4 billion dollars annually in compensation for PTSD (VBA Benefits, 2010). PTSD is the most common psychiatric disorder for which veterans seek disability benefits through the U.S.

Department of Veterans Affairs (VA), and it is the third most compensated disorder (VA Compensation, 2015).

The approval of a claim for service-connected PTSD, as well as, other mental health problems and physical injuries result in priority access to VA health care along with financial compensation. Veterans who experience PTSD related to their service can use disability C & P to offset the costs associated with this diagnosis (VA Compensation, 2015). In the case of PTSD, the C & P process involves an examination by a licensed professional, who then renders an opinion regarding the nature of the veteran's psychiatric condition, if any, and whether his or her condition is related to events that occurred while the veteran was on active duty in the military. This opinion is then forwarded to a veteran's benefits adjudication board that weighs the professional's opinion along with other information. The adjudication board then determines the veteran's service-connected status and to his or her degree of disability. About psychiatric conditions, this process becomes more complicated because often there are few signs of the presence of a psychiatric condition that are observable by the examining clinician. The clinician is forced to rely on the self-report of the veteran about the onset of symptoms, the duration of symptoms, and the severity of symptoms.

Disability and Compensation for Women with PTSD

VA offers a range of benefits to veterans with service-related disabilities that is unmatched by civilian benefits systems, including compensation, pension, comprehensive medical care, and vocational rehabilitation. Other services

include employment counseling, education and training, home loans, assistance, and various other supports to veterans and their families (Natl Academies Press, IOM 2007).

There cannot be a discussion of the gender aspects surrounding PTSD and compensation and pension (C&P) without discussing MST and the vast discrepancy between the diagnosis and compensation of combat PTSD compared to non-combat PTSD related to MST. Military Sexual Trauma is the term used to describe physical assault, sexual assault, stalking, or harassment that occurs during active duty (Hall, Sedlacek, Berenbach, & Dieckmann, 2007).

According to the IOM 2007, available research suggests that female veterans are less likely to receive service connection for PTSD and that this may be a consequence of the relative difficulty of substantiating exposure to noncombat traumatic stressors—notably, military sexual assault (MSA). The IOM committee believes that it is important to gain a better understanding of the sources of this disparity and to better facilitate the substantiation of MSA-related traumas in both women and men when they do occur. It, therefore, recommends that VBA gather more detailed data on the determinants of service connection and rating level for MSA-related PTSD claims, including the gender-specific coding of MSA-related traumas for analysis purposes, and develop and disseminate reference materials for raters that more thoroughly address the management of MSA-related claims. Training and testing on MSA-related claims should be a part of the certification program recommended above for raters who deal with PTSD claims (Natl Academies, IOM 2007).

The number of PTSD claims filed by female veterans is growing. In 2008, female veterans filed 5.5% of all PTSD claims, up from 2.73% in 2002. Since 2002, over 600,000 disability claims filed with the VA have been for PTSD (VBA, 2009). Since that time more than 600,000 disability claims filed with the VA have been for PTSD (VBA, 2009).

According to VBA in 2009, 243,632 women Veterans received compensation from VA for a service-connected disability, representing about 16 percent of the total population of women Veterans. Thirty-nine percent of women Veterans receiving compensation had a combined disability rating of 50 percent or higher. The top three primary service-connected conditions for women Veterans (PTSD, low back pain, and migraines), accounted for 15 percent of all service-connected disabilities for women Veterans in 2009 (VBA, 2009).

CHAPTER IV: ETHICAL CONSIDERATIONS

The Culture at Veterans Health Administration and Barriers to Care are Influencers of Gender Disparity and Inequality for Women Veterans

This section explores the domains of gender, disparity and health inequality, and the military association in the population of women veterans. How they are related to women veterans, access to, and use of health care services at VHA is also explored; with suggestions for improvement.

Health disparities are systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups; they may reflect social disadvantage, but causality need not be established (Bravemen et al., 2011). This definition, grounded in ethical and human rights principles, focuses on the subset of health differences reflecting social injustice, distinguishing health disparities from other health differences also warranting concerted attention, and from health differences in general. Health disparities include differences that occur by gender, race or ethnicity, education or income, disability, living in rural localities or sexual orientation. Disparities in health and its determinants are the metric for assessing health equity, the principle underlying a commitment to reducing disparities in health and its determinants*;* health equity is social justice in health. (Braveman et al., 2011). A central aspect of the most accepted definitions is that not all differences in health status between groups are considered to be disparities, but rather only differences which systematically and negatively impact less advantaged groups are classified as disparities (Braveman et al., 2011). The National Institutes of Health defined health

disparities as differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States (Dehlendorf et al., 2010).

The concepts of health disparities and health equity are rooted in deeply held American social values and pragmatic considerations, as well as in internationally recognized ethical and human rights principles (US Dept, Health, Human Svcs 2020, 2010). Drawing on ethical and human rights concepts, fundamental principles underlying the concepts of health disparities and health equity include the following:

- *All people should be valued equally.*
- *Health differences adversely affecting socially disadvantaged groups are particularly unacceptable because ill health can be an obstacle to overcoming social disadvantage.*
- *The resources needed to be healthy (i.e., the determinants of health, including living and working conditions necessary for health, as well as medical care) should be distributed fairly.*
- *Health equity is the value underlying a commitment to reduce and ultimately eliminate health disparities (U.S. Dept Hlth Human Svs, Healthy People 2020, 2010).*

Addressing the problem of gender inequality with women veterans requires actions both outside (The Military) and within the health sector (VHA)

because these gender power relations operate across a spectrum of human life and in convoluted ways. Gender relations of power constitute the root causes of gender inequality and are among the most influential of the social determinants of health (Sen, Otlin, 2009). They operate across many dimensions of life affecting how people live, work, and relate to each other. They determine whether people's needs are acknowledged, whether they have a voice or a modicum of control over their lives and health, and whether they can realize their rights (Sen, Otlin, 2009).

The 1980 census was the first census in which American women were asked if they had previously served in the armed forces, and 1.2 million women said yes. It was not until after the 1980 census that women who had served in the Women's Army Auxiliary Corps during World War II (WWII) were granted veteran status (Natl Ctr. Vets Analysis & Stats, 2011). Because the sociohistorical context of women's experience in the military has differed from men's and has changed over time, women's sense of identity with their veteran status may vary markedly. *Identity* is broadly defined as an "individual's self-concept that derives from his/her knowledge of membership in a social group together with the value and material significance attached to that membership" (Howard, 2000). *Veteran identity* is a new concept, defined as a "veteran's self-concept that derives from his/her military experience within a socio-historical context" (Harada et al., 2002, p. I-118).

In 1982, the GAO conducted a study that investigated female veterans and their access to VA benefits (Weiss & Ashton, 1994). As a result, in the early

1980s, the VA's assistant chief medical director brought the unique medical needs of women veterans to the attention of the Committee on Veterans' Affairs and directed all VA medical centers to provide gender-specific healthcare to women (Weiss & Ashton, 1994). Despite these efforts, female veterans continue to access the VA's benefits and services less than do their male counterparts (GAO, accessed April 2018).

Despite extensive efforts on the part of both military and VHA, leadership to enhance access to mental health services for military personnel and veterans, research findings indicate that many returning war veterans do not seek out needed services (DAV, 2014). Thus it is critical to identify factors that interfere with the use of mental health services for this population, and where possible, intervene to reduce barriers to care.

Barriers to Care for Women at VHA

Anh-Luu et al., in 2003, conducted a qualitative study exploring the diversity of women veterans' identity and military service. These women were placed in 2 groups: WWII/Korean Conflict and the Vietnam/Persian Gulf group and were interviewed and videotaped. Problems and dissatisfaction were raised during the discussion of benefits. Many women felt that there was a paucity of information regarding both who is eligible for benefits and the services that are available specifically for women veterans. Moreover, when they were able to find out about eligibility, they had a difficult time accessing the resources. One woman recalled, "Uncle Sam didn't take care of me in the way I think the army should have." Others complained of the poor customer service they received or thought that there were too many administrative problems, such as paperwork, to

deal with. As a woman from the Vietnam/Persian Gulf group said,

> *They're [theVA] not informing you. You go around in circles. They sent me on a big maze, when I could have just went from Ato Z. I'm like, What's going on here? Don't you people know each [other] here? You know, what's going on here? I just don't get it. There's something wrong here, very, very wrong here. It's really hurting as a veteran.*

One woman said, "How can you recruit women veterans to come to your health care system when you don't even treat the major functions of their bodies?" The women shared their frustration with the inequality apparent in the health services at the VA. Although men are able to get vasectomies, hysterectomies are not available to women; there are prostate cancer services but no breast cancer services. Nor is there prenatal care. "We have babies when we get out. The VA will not help you have a baby," one woman said. As expected, the Vietnam/Persian Gulf group had more frustrations with the lack of obstetrics and prenatal care than did the WWII/ Korean Conflict group because many in the former group are younger and have more recent experience with VA health care in terms of pregnancy.

Other frustrations were that there are no counseling services available for miscarriages and abortions; these women had to turn to outside sources. The women also suggested the need for counseling for post-traumatic stress syndrome specifically for women. The women's recommendations also encompassed the need to increase outreach services and information about eligibility and benefits.

When asked about how their veteran identity influenced their decisions to come to the VA for health services, the women voiced mixed reactions. One

woman from the Vietnam/Persian Gulf group said that she had been so traumatized by her experience in the military that she purposively chose not to come to the VA hospital: “It took me a long while to benefit from VA health. I was so traumatized by the military. I didn’t want to see anything military.”

The findings indicate that the concept of veteran identity is relevant to the use of VA health services. Women in the military have had reason to question their veteran identity, especially those who served in WWII. Decades later, some of these women still did not know if they were considered veterans. Furthermore, the value and material significance of the women’s veteran identity varied from those of men because, as the participants from the Vietnam era cohort noted, the lack of health care services related to their needs as female veterans made this benefit less valuable (Anh-Luu et al., 2003). The reason for highlighting this study from 2003, is to show that women veterans presently have some of the same issues with the culture and barriers to care at VHA that existed for women in 2003, although VHA has addressed many of these concerns. For example, most VA Medical centers now have mammography and breast cancer services to include surgical services.

Significant demographic changes in the composition of female military personnel for OIF/OEF have taken place. Most noticeably female veterans are more likely to be younger, of color, exposed to combat, reporting high rates of sexual harassment, sexual assault, and experiencing mental health issues when compared to previous female military cohorts (Frayne et al., 2007, Murdoch et al., 2006).

Study of Barriers for Women Veterans to VA Health Care

In 2015, the VHA conducted an independent study called the “Barriers to Care” Survey. VHA contracted with Altarum Institute to execute this survey of women veteran users and women veterans non-users over a given period, over 21 VISNs. Altarum collaborated with a team from the Women’s Health Services office. This was a 45-minute telephone interview.

One woman’s interview for The Barriers to Care Survey:

> *“That sometimes they let me down as far as with certain circumstances especially when I applied for my disability and I had to explain my situation. Basically they make it seem like it's made up and just because they can't find information on their end or I'm having a hard time getting to where the situation has occurred they think that I'm telling a lie but it is actually happened. And nobody understand what I go through because they're not in my shoes. When you say something, they twist it around or say something positive and basically build you up and break you back down based on basically assumptions. That's probably why I haven't been back to see my doctor because I just don't feel like, I feel ten times worse leaving than when I went there. So I figured I'll just wing it on my own.”*

The Nine Barriers Addressed:

- The perceived stigma associated with seeking mental health care services
- The effect of driving distance or availability of other forms of transportation to the nearest medical facility on access to care
- The availability of childcare while using VA services
- The acceptability of integrated primary care,

women's health clinics or both

- The comprehension of eligibility requirements for, and the scope of services available under hospital care and medical services
- The perception of personal safety and comfort in inpatient, outpatient, and behavioral health facilities
- The gender sensitivity of health care providers and staff to issues that particularly affect women
- The effectiveness of outreach for health care services to women Veterans
- The location and operating hours of health care facilities that provide services to women Veterans

Results:

Barrier 1. A significantly higher percentage of system users reported having received information related to VA services than did non-users. Only 51% of non- users felt that they had enough information on eligibility for VA services.

Barrier 2. Most system users (67%) report having received information on Women's Health Services, compared to only 21% of non-users. Across VISNs, there is a significant disparity with the percentage reporting having seen information specific to women's care. For users, the range is 56%-83%, and for non-users it is 31%-52%.

Barrier 3. The majority of women, whether in urban or rural settings, indicated that finding transportation was not problematic. Overall, only

10% indicated that finding transportation is either very hard or somewhat hard. However, there is an additional burden on those Veterans with higher disability ratings. The most common reasons for bypassing the nearest VA were *the women's services I need are not available* (16%), and *I do not feel the providers are good* (12%). The scores are generally very good for women receiving an appointment in the timeframe needed.

Barrier 4: Access. The communication about appointing may be a barrier that needs more attention. Even if satisfactory appointment times are available, if the communication and confirmation of appointments are not handled effectively, patients will be highly dissatisfied, and this could discourage use of the VA system.

Barrier 5. When queried about the possibility of on-site childcare, three out of five women (62% overall) indicated that they would find on-site childcare *very helpful*. In general, many women would like on-site childcare, but this is not a significant factor in whether they choose to utilize VA care.

Barrier 6. When asked about the importance of receiving care from a clinic just for women, users placed greater importance on having clinics for women only (60% for users, 47% for non-users). Women who had previously experienced threat or force of sex felt more strongly, with 57% stating it was *very important* or *somewhat important* to have women-only clinics (versus 47% who did not have

that experience). About having one single provider for all care, 75% of respondents rated this as *very important* or *somewhat important*. Open-ended comments from respondents noted that women's clinics often had only one female provider and that appointments with that provider frequently backed up. This would indicate a possible shortage of female providers available to provide women-specific care.

Barrier 7. Culture. The changing demographics of the VA population makes it imperative that the culture evolves not to simply accommodate women Veterans, but to actively embrace their needs and respond accordingly. The women Veterans using the VA system who are most satisfied with their primary care provider are those who receive comprehensive care in a women's clinic.

Barrier 8: Mental Health Stigma. More than half of women Veterans (52%) indicate they have needed mental health care. A significantly higher proportion of users, compared to non-users, reported avoiding VA because of past sexual trauma (19% of users vs. 8% of non-users).

Barrier 9: Safety and comfort (users only). Women from all demographic categories agreed that the safety and comfort factors in VA facilities were adequate. By Service era, more recent Veterans (OEF/OIF-Present era) felt that facilities were less safe and comfortable overall. By disability rating, satisfaction with safety and

> comfort steadily decrease as disability level increases. As may be expected, women with experiences of unwanted sexual attention or threat or force of sex feel less safe and comfortable in VA facilities than women who did not have these experiences. Overall, the more comfortable women are with the safety and comfort of a facility, the more likely they are to use VA services.

Women from the OEF/OIF-Present era reported significantly less satisfaction with safety and comfort compared to women from other eras. The inpatient measure with which they felt the least comfortable was the ability to secure the door to their room at night. Top concerns identified include the inability to *secure the door to their room at night, having access to a private bathroom*, *showering during their stay,* and the *speed of the admissions process*.

The study highlighted actionable areas where VA can invest effort and resources to improve comprehension, access to care, and delivery of services in ways that will influence women Veterans' decisions to seek care through VA (Woman Veterans Report, 2017).

The Disabled American Veterans (DAV) conducted an unprecedented report in 2014 called "Women Veterans: The Long Journey Home," which is a comprehensive study of the many challenges women face when they leave military service. The stories and statistics that support this report made clear that women veterans face a homecoming that is remarkably different from their male counterparts. Post-9/11 women veterans not only express different concerns and stressors than their male counterparts, but they also desire a different way in

which to process those emotions and thoughts (DAV, 2014, DOD, 2011, Street, et al., 2009).

In 2009, Tanelian and Jaycox conducted a telephone survey of 1939 respondents out of 3771 eligible households and identified many barriers that inhibit getting treatment for their mental health problems. In general, respondents were concerned that treatment would not be kept confidential and would constrain future job assignments and career advancement. About 45 percent were concerned that drug therapies for mental health problems may have unpleasant side effects, and about one-quarter thought that even good mental health care was not very effective (Tanelian et al., 2009).

Nationally, VA also has over a dozen women-only residential and inpatient programs. VA also has similar programs for Veterans who experienced MST and provides free care for all mental and physical health conditions related to a Veteran's experiences of MST. For example, a VA service-connected disability rating is not required. Neither is the Veteran required to have reported the incident when it happened, nor to have other documentation that it occurred. To accommodate female Veterans who do not feel comfortable in mixed-gender treatment settings, many facilities throughout VA have women-only programs or have established specialized women's treatment teams.

Recommendations

Today, there is a growing recognition, among health professionals, researchers, and policymakers, of the widespread and profound implications of gender-based inequities in health. There is also emerging evidence that integrating gender considerations into interventions has a

positive effect on health outcomes across various domains (Boerder et al., 2004).

There needs to be more focus on educating women veterans about their eligibility status and the services that are available to them using outreach strategies. VHA should address the specific health care needs of women veterans; this can be achieved through policy and program development.

Health policies that take into account the differences in women's and men's healthcare needs, as well as their social vulnerabilities-such as unequal access to power-into consideration will be more successful than those that do not take into account these differences. Recognizing and addressing the causes of gender inequities in health and health promotion is crucial when responding to the healthcare needs of women veterans and women everywhere. Inherent in both these concerns is the desire to increase the satisfaction of women veterans concerning their use of VA healthcare services.

The VA must continue to address gender-specific concerns that women veterans have about its healthcare services. Although a few VA facilities offer comprehensive health care services to women, including separate full-time clinics specifically designated for women, others may offer these services only on a contractual or part-time basis. As the demand for and use of gender- specific services grow, there needs to be an increase in facilities such as outlying clinics in rural areas. The primary

solution to increasing services is to obtain additional funding to establish these health care programs. The VA must make these programs a priority in its budgeting, which is no easy task, given budget constraints in the Federal government.

Barriers to Care for Women Veterans in the Private Community

Although the Veteran's Administration (VA) offers health and mental health care to both male and female Veterans, approximately 83% of female Veterans choose to receive care in civilian health care systems, as they view the VA primarily as a resource for men (Washington et al., 2007; Westermeyer et al., 2009). However, health and mental health care providers in the civilian sector may fail to understand the unique needs of these women, and, at times, have exacerbated trauma experienced during their military service through secondary victimization (Campbell and Raja, 2005; Zinzow et al.,2007). Therefore, it is vital for both private and VA health and mental health care providers to understand the issues of this growing, vulnerable population.

Watkins and colleagues, in 2016, conducted a study and found that the quality of care provided by the VA to Veterans with mental and substance use disorders consistently exceeded the quality of care provided by the private sector for the performance indicators examined, sometimes by large margins. The findings presented here are consistent with prior reports that VA performance consistently exceeds that of non-VA comparison groups for process-based quality measures. Studies that

assessed recommended processes of care almost always demonstrated that the VA performed better than non-VA comparison groups. Studies that assessed risk-adjusted mortality found similar rates for patients in VA and non-VA settings (Trivedi et al., 2011).

Barriers or Disincentives to Recovery

Many of the studies on the barriers to recovery for persons with mental disorders have been conducted on civilian populations receiving support from programs administered by the Social Security Administration. Research from the fields of disability, economics, health care, and labor studies has documented the wide variety of barriers to recovery and more broadly, to career advancement and economic security that can affect people with disabling mental disorders.

In the civilian population, these barriers include low educational attainment, unfavorable labor market dynamics, low productivity, lack of appropriate vocational and clinical services, stigma in seeking services, labor force discrimination due to disabling conditions or race and ethnicity, failure of protective legislation, work disincentives caused by private and public disability policies, linkage of health care access to disability beneficiary status, and ineffective work incentive programs (IOM, 2009).

In 2007, The Committees of National Research Council and Institute of Medicine of the National Academy of Sciences were charged with examining the barriers or disincentives to recovery and to “directly assess how PTSD compensation might influence beneficiaries’ attitudes and behaviors in ways that might serve as barriers to recovery.”

These issues can also be prevalent in the non-military populations and civilian compensation programs. The committee was specifically asked to evaluate the evidentiary basis for various influences of compensation on treatment and recovery (Natl. Acad. Press, 2007). In recent years, however, because of the dramatic increase in the numbers of veterans seeking and receiving awards for PTSD, the possibility of service-connected disability being awarded because of exaggerated or fraudulent claims has become an increasing concern (VA, 2005b; Murdoch et al., 2003 A., B., C).

Their extensive findings and recommendations after examining journals, articles and reports are listed below.

Findings:

- The most effective strategy for dealing with problems with self-reports of traumatic exposure is to ensure that a comprehensive, consistent, and rigorous process is used throughout the VA to verify veteran-reported evidence.
- In the absence of a definitive measure, the most effective way to detect inappropriate claims is to require a consistent and comprehensive state-of-the-art examination and assessment that allows the time to conduct appropriate testing in those specific circumstances where the examining clinician believes it

would inform the assessment.

- Research reviewed by the committee indicates that PTSD compensation does not, in general, serve as a disincentive to seeking treatment.
- It is not appropriate to require across-the-board periodic reexaminations for veterans with PTSD service-connected disability.

Recommendations:

- VA should consider instituting a set, long-term minimum level of benefits that would be available to any veteran with service-connected PTSD at or above some specified rating level without regard to that person's state of health at a particular point in time after the C&P examination.
- The determination of whether and when reevaluations of PTSD beneficiaries are carried out should be made on a case-by-case basis using information developed in a clinical setting. Specific guidance on the criteria for such decisions should be established so that these can be administered in a fair and consistent manner.
- The VBA should conduct more detailed data gathering on the determinants of service connection, and rating level for MSA-related PTSD claims, including the gender-specific coding of

MSA-related traumas for analysis purposes.

- The VBA should develop and disseminate reference materials for raters that more thoroughly address the management of MSA-related claims. Training and testing on MSA-related claims should be a part of the certification program for raters who deal with PTSD claims.
- More research is needed on the as yet unexplained gender differences in vulnerability to PTSD, which could help identify useful sex-specific approaches to prevention and treatment, and on more effective means for preventing MST and sexual harassment (Natl. Acad. Press, 2007).

CHAPTER V: Discussion and Recommendations

VA Progress

VA has responded to the growing number of women Veterans by developing a wide range of mental health services to meet their unique needs. Available services include psychological assessment and evaluation, outpatient individual and group psychotherapy, acute inpatient care and residential-based psychosocial rehabilitation. Specialty services target problems such as PTSD, substance use problems, depression, and homelessness (VA, Barriers to Care, 2015).

VA also has outpatient, inpatient, and residential specialty services for Veterans who experienced military sexual trauma (MST), and provides free care for all mental and physical health conditions related to a Veteran's experiences of MST. Veterans may be able to receive this free MST-related care even if they are not eligible for other VA care. For example, a VA service-connected disability rating is not required. Neither is the Veteran required to have reported the incident when it happened, nor to have other documentation that it occurred.

Veterans may be able to receive this free MST-related care even if they are not eligible for other VA care. For MST specialty services, many of VA's standard requirements are now waived as of 2014, (VA, Barriers to Care, 2015).

Leadership from the National Women's Health Services (WHS) policy office at VA and support from leaders in multiple local, regional and national offices, VHA has taken proactive steps to enhance the quality of

care women Veterans receive. At every VHA facility, there is now a full-time Women Veterans Program Manager who advocates for the healthcare needs of women and who reports to top facility leadership. In late 2008, WHS launched a five-year plan to fundamentally redesign VHA's women's healthcare delivery system, with comprehensive primary care as a cornerstone of the new policy. By the fiscal year 2012, in addition to a full-time Women Veterans Program Manager, every healthcare system in the country had at least one designated women's health primary care provider. Efforts to enhance these providers' proficiency in women's health include a national Women's Health Mini-residency program, with over 2,200 providers trained to date (Frayne et al., 2014).

The Department of Defense (DoD), the Department of Veterans Affairs and Congress, have moved to study the issues related to how health care is handled, quantify the problems, and formulate policy solutions (Tanelian and Jaycox, 2009). Moreover, they have acted swiftly to begin implementing the hundreds of recommendations that have emerged from various task forces and commissions. Policy changes and funding shifts are already being implemented for military and veterans' health care in general and mental health care in particular (Tanelian et al., 2009).

For years, the argument that women are physically and mentally different than men barred women from serving in many capacities in the

armed services. Now that women serve in most military roles understanding those physical and mental differences is the key to providing women Veterans with appropriate, high-quality care (VA, WVHS, 2011).

In 2008, the VA's Women's Health Services launched a 5-year women's health care redesign plan to ensure that women veterans receive comprehensive primary care from skilled providers, performance measures are reported by gender to VA leadership, and feedback is given to providers. In 2011, gender disparity improvement was included as a performance measure in the Healthcare Leadership Annual Performance Plan. This plan included the provision of equitable, high-quality care to women and included both gender-specific and gender-neutral care (Whitehead et al., 2014).

Whitehead et al., in 2014, examined data from the VA Office of Analytics and Business Intelligence Quarterly gender reports for trends in gender disparities in gender-neutral performance measures from 2008 to 2013. The VA office tracked 23 gender-neutral clinical measures as part of established VA- Department of Defense clinical practice guidelines. These included measures of screening rates for mental health and substance abuse. They analyzed this data for trends in gender disparities on depression and PTSD screening. Veterans Affairs performance evaluation indicates high-quality care delivery (averaging better than the private sector), but a persistent gap existed by gender, including gaps in

clinical prevention measures and mental health screenings.

Since 2008, the VA has seen a decreasing trend in gender inequities on most “Health Effectiveness Data and Information Set” performance measures, with near elimination of the disparity for depression and PTSD screening. They surmised that the VA’s data reporting by gender, leadership involvement, electronic reminders, and population management dashboards have likely had an impact on improving gender inequities by drawing attention to the gender disparities in clinical performance.

VA Women's Veterans Health Strategic Health Care Group (WVHS) in 2011, found that VA policy mandates that all facilities track and record vital information about VA services provided to women Veterans, and a spike in VA research on women's health has yielded vital information about the effects of military service on women Veterans. WVHS develops and distributes reports, training, and best practices to shape VA health policy and practices as they relate to women. Some of their findings of women Veterans:

- 37% of women Veteran VHA outpatients used mental health services in 2009.
- 12% of these women had more than six mental health visits compared with 7% of men.
- OEF/OIF/OND women Veteran VHA users are more likely than their male counterparts to have

musculoskeletal and skin disorders, mild depression, major depression, and adjustment disorders and require more frequent primary care visits.

- In 2009, 47% of women versus 42% of men had at least three primary care visits at VA facilities; 15% of women had six or more (Womens Health.va.gov).

The Center for Women Veterans (Center) is heading a MyVA initiative for FY 2017 that specifically impacts women Veterans--"Equitable Services for Women Veterans." This initiative provides the Center with an exciting new avenue to make progress in reducing disparities in wait times, outcomes, and utilization between men and women Veterans, (Women Veterans Report, 2017).

Institutional Advocates

Across the nation, all VA medical centers have women Veterans program managers who are designated individuals to advise, advocate for, and assist women Veterans with their health care needs. Also, all regional offices in the Veterans Benefits Administration have women Veteran's coordinators to advocate on behalf of women Veterans.

Homelessness

In 2009, VA announced a plan to end and prevent homelessness among Veterans and their families. While the overall number of homeless Veterans is declining, the number of homeless women Veterans is

increasing. This led the Department of Labor to introduce the Trauma-Informed Care for Women Veterans Experiencing Homelessness guide and approximately $8.6 million in reintegration grants for homeless women Veterans and Veterans with children. Among women, military service is associated with a two to four times increased likelihood of experiencing homelessness. Among women Veterans, several factors have been found to be associated with the experience of homelessness, including unemployed, disabled and low-income; to have experienced military sexual trauma (MST); to be in fair or poor health; to have diagnosed medical conditions, and to screen positive for an anxiety disorder or PTSD.

Outreach and Education

VA is improving its outreach to women Veterans by making women more visible in VA publications, marketing materials, posters, and messages. The Department created a social media directory (www.va.gov/opa/socialmedia.asp) that links the user to all VA organizations currently using Facebook, Twitter, YouTube, Flickr, and blogs. The Center for Women Veterans has recently enhanced its social media presence, by posting regular blogs on gender-specific initiatives and informing women Veterans about access services and benefits that may be unfamiliar to them. The Center continues to disseminate and collect information relevant to women Veterans, by conducting outreach at events and among work groups. In 2016, the Center implemented a new email subscription service through GovDelivery, so women Veterans and

other Stakeholders can learn about updates on the topics and services impacting women Veterans—such as events, research, and other relevant news on benefits and services.

VA is diligently working to educate women Veterans about the benefits and services for which they may be eligible. VHA's Women's Health Services conducts monthly campaigns to raise awareness of women Veterans' health care needs, and the high-quality care VA provides through toolkits that include items such as brochures, fact sheets, FAQs, health campaign materials, and videos for download (VA, Women's Veterans Report, 2017).

VBA has developed a Web page with information specific to women Veterans' benefits, including education and training, home loans, and employment. These initiatives for women Veterans are helping to break down barriers between women Veterans and VA. For example, many women Veterans do not identify themselves as Veterans, which may affect their likelihood to seek VA benefits and resources.

Surveys

VA conducted the National Survey of Women Veterans in 2009. The goal of this survey was to obtain a nationally-representative sample to identify the current demographics, health care needs and barriers, and VA experiences of women Veterans. The population demographics highlights the need for VA services that are gender, age, and culturally appropriate. These data were used by the Advisory Committee on Women Veterans to write their 2010 report entitled, "Women Veterans—A Proud Tradition of Service," which made ten

overarching recommendations and rationales to enhance VA's services for women Veterans. VA is actively pursuing the creation of surveys and the use of survey data as a way to gain valuable information about women Veterans for current and future initiatives.

CHAPTER V: Conclusion

Because of their role in the military and society, women live with unique challenges. Women are strong and heroic, but because of the magnitude of the challenges faced, they may well need support during post-military readjustment periods. The challenges of transition to post-military life affect women differently than men and, accordingly, women should receive specialized attention from VA and the communities where they live. These needs are varied and complex, spanning the areas of healthcare, reduction and, eradication of sexual assault, employment, and housing (DAV, 2015).

Early mental health treatment after military deployment may reduce chronic mental health problems (Maguen, Luxton, Skopp, & Madden, 2012). Some studies have even suggested that conventional mental health treatment and evaluations while in the combat environment would be of benefit (Rundell, 2006).

PTSD Diagnosis

During 2014 when I initiated my thesis, it was my impression that women veterans were diagnosed with PTSD a lot less often than male veterans. That discrepancy is still present, but the gap is closing based on the literature. Although the effects of PTSD in women veterans is getting more attention, there is still a great deal of work to be done. New programs and additions to current programs are beginning to make inroads into the mental health issues suffered by many female veterans. The stark differences in both cause and effect of PTSD in male and female veterans are finally getting the attention it deserves.

PTSD Disability & Compensation

The data also reveal that as recently as 2012, when the national grant rate for MST-related PTSD claims had risen and the gap between the grant rates for MST-related PTSD claims and other PTSD claims had narrowed nationally and at most VAROs, some regional offices continued to grant MST-related PTSD claims at rates far below the national grant rate, and far below the rates at which they were granting claims for PTSD unrelated to MST. However, now Veterans may be able to receive this free MST-related care even if they are not eligible for other VA care. For example, a VA service-connected disability rating is not required. Neither is the Veteran required to have reported the incident when it happened, nor to have other documentation that it occurred. Veterans may be able to receive this free MST-related care even if they are not eligible for other VA care. For MST specialty services, many of VA's standard requirements are now waived as of 2014, (VA, Barriers to Care, 2015).

Research

Researchers should continue to address military sexual traumas, the disparity in the diagnosis of PTSD, and further decipher the dynamics of comorbidity of other mental health disorders in women with PTSD. Also, more research is needed on how these mental disorders impact family and occupational functioning for women veterans after their return from military deployments and at the completion of military service.

Barriers to Care

Meeting the goal of providing care for these service members will require

system-level changes, which means expanding the nation's focus to consider issues not just within DoD and the VA, from which the majority of veterans will receive benefits, but also across the overall U.S. health care system, in which many will seek care through other, employer-sponsored health plans and in the public sector (e.g., Medicaid). System-level changes are essential if the nation is to have the resources it needs to meet its responsibility not only to recruit, prepare, and sustain a military force but also to address service-connected injuries and disabilities.

Leadership from the National Women's Health Services (WHS) policy office in VA Central Office and support from leaders in multiple local, regional and national offices, VHA has taken proactive steps to enhance the quality of care women Veterans receive.

Changing the Culture at VA

VA has implemented several initiatives to improve on healthcare delivery to women veterans and to eliminate barriers to care, but there is still much work to be done to change the male-oriented culture at VA. For example, receptionists assume that women are here with a male patient husband or when your name is called, it's with a "Mister". Even as women veterans are trying to access veteran health services, they report being harassed by their fellow veterans in VA facilities (SWAN, 2014).

The of the DOD's mission should include transforming military culture by securing equal opportunity and the freedom to serve in uniform without gender discrimination, harassment or assault, and to reform veterans' services to ensure

high quality health care and benefits for women veterans.

VA and DOD must continue to address and change the culture that ignores or minimizes women's service and their contribution to our military mission, so that they can fully benefit from the array of services that have been established for veterans, including for those who served in combat theaters and other hardship deployments; And, must work collaboratively if women are to have smooth access to high-quality medical care, mental health programs and readjustment benefits discussed throughout this paper.

Iraq Afghanistan Veterans Association, the leading post-9/11 veterans' organization, launched "She Who Borne the Battle," a groundbreaking campaign to recognize and support women veterans. In honor of Deborah Sampson, a woman who disguised herself as a man in order to fight in the Revolutionary War, IAVA partnered with bipartisan members of Congress on the Deborah Sampson Act to address gender disparities at the VA and ensure women veterans get the care they need. The campaign importantly also makes a bold request of the VA— to finally change its outdated and exclusionary motto to reflect the fact that women are indeed veterans, too. IAVA believes that VA must prove their commitment to creating a culture that acknowledges and respects the service and commitment of women veterans by changing the motto (Jaslow, IAVA, 2017).

Although not officially recognized as members of the armed forces

until 1901, the involvement of women in the military dates back to the Revolutionary War. Each year, the population of women Veterans grows steadily due, in part, to the increasing number and proportion of women entering and leaving military service. Women Veterans possess traits that are valued in military service: sacrifice, sound judgment, courage, and patriotism.

Personal Experience

For some-including myself-the military was a time of opportunity, personal and professional growth; For others, it was the beginning of their inability to sustain relationships with family and friends, as well as maintaining their jobs to support themselves and their families. Women Veterans can portray a wide range of emotion regarding their military service. I spent 21 years as an Army Nurse Corps Officer. During OIF, I considered retiring from the Army, but I still had one goal that I had not accomplished; serving in a combat environment to take care of the wounded.

I initiated my thesis in 2014. As time passed, I realized that the focus of writing this paper was not to publish, but to allow myself to truly heal from my own “wounds of war.” Since that time, I have struggled in my writing on this topic. I was diagnosed with PTSD in 2006 after I returned from OIF and even though this has been a painful process for me, reliving my traumatic experiences over and over, it has also been a catharsis for me. My hesitation in finishing my thesis is related to my PTSD. A lack of self-confidence, fear of rejection, and fear of audiences has plagued me since my traumatic experiences. Until my experience

in OIF, I would not have described myself as having those traits. It was a severe struggle for me, but my mental health has improved immensely with writing my thesis and with some intense counseling.

I first told my story during one of Dr. Steve Miles' classes on "Death and Dying." (Appendix 1). Even though I was reluctant to talk about my PTSD, reading my letter to the class was also an avenue of self-healing.

CHAPTER VII: References

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