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assessing the influences on female veterans in selection of
treatment location, comparing VA and non-VA settings**

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Bethany J. Ferry
Exploring Mental Health Treatment
for Female Veterans in the U.S.:
Assessing the Influences on Female
Veterans in Selection of Treatment
Location, Comparing VA and Non-
VA Settings

ABSTRACT

The purpose of this quantitative survey based study was to learn why women veterans choose VA versus non-VA mental health treatment when they need care. The study was designed to gain insight into choices that women veterans make when selecting mental health care treatment centers, and what motivates them in this choice. Women cited a number of barriers to treatment, particularly regarding accessing treatment through the VA. These barriers included limited appointment times, high turnover of providers, insufficient numbers of veterans and female veterans as providers, and feeling uncomfortable in the treatment environment.

**EXPLORING MENTAL HEALTH TREATMENT FOR FEMALE VETERANS IN THE
US: ASSESSING THE INFLUENCES ON FEMALE VETERANS IN SELECTION OF
TREATMENT LOCATION, COMPARING VA AND NON-VA SETTINGS**

A project based on an independent research
investigation which fulfilled partial requirements
for the Master's in Social Work degree

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2016

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CHAPTER I

Introduction

Women have long been part of military operations, with their official entry into the Armed Forces starting in 1901 (Women Military Timeline, retrieved 2015). Women have entered service in greater numbers and in increasingly diverse fields including their recent official entry into combat operations. Women currently comprise the single fastest-growing group among veterans (Returning Service Members, n.d., para. 1) With their fast growing numbers, the proportion of women veterans who need post deployment services has also grown, and with this growth has come greater demand for specific treatment for women.

Women experience many of the same combat-related disorders as men, including Post-traumatic stress disorder, traumatic brain injury, and military sexual trauma. However, women are not seeking treatment through the VA at nearly the same rates as men. This study will examine the treatment venues woman are utilizing, including Vet Centers, private practice clinicians, community mental health centers, spiritual leaders or churches, and the VA, to assess the strengths and limitations of each setting in providing optimal treatment outcomes for women veterans. This information may then be used to address limitations of treatment in each respective setting, and to encourage expanding the use of successful practices across settings, exploring further the barriers to women's care.

Research has begun to address some of the barriers to treatment for women. Previous research, such as that conducted by Mattocks, Haskell, Krebs, Justice, Yano, & Brandt (2012),

reported that some women voiced they would “not feel comfortable seeking VA services for their problems (p.541). Both Mattocks et. al (2012) and Di Leone, Wang, Kressin, & Vogt, (2015) found that women did not believe their ailments “deserved” treatment through the VA. Some sought treatment through private treatment settings or received no treatment at all for their deployment-related physical and mental health issues (Mattocks et al., 2012, p. 543).

Skinner (2000) reported that “most female veterans receive their care at non-VA facilities” (p. 304). Campbell & Raja (2005) explored why women may be more likely to receive their treatment in non-VA settings. They found that women were more likely to experience revictimization when seeking services through VA settings. They explained that “analysis of the individual medical secondary victimization emotion items revealed that these women were significantly more likely to report feeling guilty, depressed, nervous, distrustful of others, and reluctant to seek further help after their contact with the military medical professionals than were victims who sought help at civilian facilities” (Campbell & Raja, 2005, p. 103).

To expand on current research and assess the strengths and needs of each setting I will examine the factors which impact women’s treatment options and outcomes. The factors that will be explored in this study include distance to facility, expectations of care (whether positive expectations or negative), desire to either align with a military-associated facility (such as the VA) or to avoid a military-associated facility, limits of treatment options due to healthcare coverage, and concerns for privacy.

This study uses a brief survey format to assess each of these areas. The study is primarily quantitative, with some brief areas for specific qualitative feedback. The study will ask specifically about the veterans experiences related to each location that a veteran has accessed.

While research has explored some issues within the current system, such as revictimization and female veteran's beliefs that they are not entitled to VA services, there is no known research that explores women's experiences of treatment within the variety of settings that they may receive care. A variety of mental health settings offer specific benefits and limitations in their service, and it is the object of this study to examine the relative strengths of each system, including the perception of care received and the outcome of treatment for the veteran. Comparing women veteran's experiences within each system will provide insight into each system's relative strengths, and support continued growth within the systems to provide the best possible services to returning vets. Ultimately, this study addresses the goal of many women veterans, and of many deeply invested providers: to provide the best possible care to our returning veterans.

CHAPTER II

Literature Review

The chapter begins with a section that summarizes literature about both the general health care needs of women veterans, and the more specific and unique health care needs of women veterans. Following the general health care review, I present a summary of literature about the reasons that motivate women veterans to seek mental health services. Finally, I will focus on literature about location choices women veterans make when they choose their care, and some of the underlying reasons known to influence these location choices

Women Veteran's Healthcare

Women veterans are a critical component of the military. Women veterans make up approximately 10% of the total veteran population, and they are 11.6% of the OIF/OEF veteran population (Women Veterans Healthcare). The demographics of women veterans vary slightly from that of male veterans; female veterans are more likely to be young and black than are their male counterparts (Women in the U.S. Military). They are also more likely to have experienced poverty, and to be single (Miller & Ghadliani, Maguen et. al). Similar to their civilian counterparts, women veterans experience the need for comprehensive healthcare. This includes supports for general health care issues such as annual physical examinations, and care for more gender-specific issues such as pap smears, hormonal birth control, and annual OB/GYN exams.

Comprehensive healthcare for women veterans is critical, and there is a need for continued assessment of the services that are currently available, including where gaps in

services may occur. Currently, healthcare for women includes specialized care provided by the federally funded Department of Veteran's Affairs (VA) healthcare system. The VA system was predated by a number of different providers; the National Home, the Public Health Service, and the Veteran's Bureau. Access to the National Home was extended to women veterans beginning in 1928 (About VA). The VA as we know it now was created July 21, 1930 by executive order of President Hoover to consolidate care for the increasing number of veterans (About VA).

Women are a critical and long standing component of the military, and they are in need of comprehensive healthcare. In addition, women veterans have specific and specialized healthcare needs that vary from civilian women. Questions have been raised asking if women veterans are able to access care at the same rate as male veterans. Authors Frayne, Parker, Christiansen, Loveland, Seaver, Kazis & Skinner sought to answer those questions. They utilized a sample of 28, 048 women veterans, and 651, 811 male veterans receiving services through the VA. The majority of the sample of women were under 35 and white, followed by black, Hispanic, and "other."

Authors evaluated the general health of women veterans, and compared female veterans' health to both male veterans and female non-veterans. They used measures such as physical functioning, role limitations because of physical problems, bodily pain, general health, role limitations because of emotional problems, mental health, energy/vitality, and social function.

Results of this study suggest that veteran women have significantly more health issues in the 8 measured domains than non-veteran women. In fact, "the general population of women veteran VA patients were comparable to or worse than scores of the subset of private sector patients who had "serious chronic medical conditions" (symptomatic congestive heart failure patients, myocardial infarction survivors with recurring angina and/or severe congestive heart

failure symptoms, hypertension patients with severe congestive heart failure symptoms and/or history of stroke, and diabetes patients with severe complications” (Frayne et. al, Discussion section).

Authors addressed the question of women veteran’s ability to access care to the same degree as male veterans, and found that women had lower levels of social support than their male veteran peers, and were less likely to have assistance for things like rides to the VA for appointments.

The findings of this study underscore the need for comprehensive health care for women veterans. It also emphasizes the importance of identifying and addressing barriers to care.

Now that I have established the significant need for women veteran’s comprehensive healthcare, I move on to the work of authors Washington, Caffrey, Goldzweig, Simon & Yano. Washington et. al assessed whether the needed healthcare services existed at VA’s. They approached the assessment of service availability from a slightly different perspective. Rather than using a sample of veteran women to assess service availability, they sent surveys directly to each VA site that provided services to more than 400 women veterans. It is important to note that this census was developed in 2003 in response to legislation introduced by Congress to decrease gender-based disparities in VA healthcare.

Washington et. al asked the Director of Women’s Health Services at each VA site to respond regarding availability of specific health services for women. They assessed for nine basic services required for the primary care of women (such as Pap smears), and 12 services that are part of a comprehensive package of services one would expect to be available to address the unique health care needs of women (such as breast cancer treatment). They found that most sites

either offered the service directly at the VA, or contracted the service to local private providers. There were however gaps in specialty care and in pre-natal care (Washington et. al).

Though it is very important to assess that needed services are in fact available, using this style of assessment may leave out crucial information. It does not address whether women are aware that these services are available to them, and it also does not address what factors may interfere with a women's ability to access the care that is available. These concerns will be further addressed under "Barriers to Care."

Mental Health Needs of Women Veterans

Both men and women veterans may experience a variety of mental health symptoms related to their service. In this section we will take a closer look at the mental health diagnosis that women seek treatment for. For this review we will turn to the work of authors Miller & Ghadiali, and Maguen, Ren, Bosch, Marmar & Seal.

Miller & Ghadliani studied the specific mental health diagnosis that female veterans sought treatment for. They used a sample of 68 female veterans, the demographics of which were consistent with the demographics described of the study by Frayne et. al. They found that the most common mental health diagnosis in their sample was PTSD, followed by depression, anxiety, adjustment disorder, bipolar disorder, psychotic disorder, and personality disorder. Of the group of women they studied, they found that a number of women had attempted suicide, engaged in self-injury, and abused substances (Miller & Ghadliani). The severity of mental health needs and acuity of symptoms (suicide attempts, self-injury, substance abuse) reported in this study underscores the importance of assuring that treatment is accessible, prompt and appropriate to women veteran's needs.

While Miller & Ghadliani's study clearly illustrates that women are being diagnosed with mental health needs, it does not address whether women are receiving the same types of diagnosis, or at the same rate, as their male counterparts. This is a critical piece of understanding women veterans healthcare; in order for women to receive needed treatment it must be available, accessible, and they must have a diagnosis that allows them to participate in needed treatment programs. In the absence of appropriate diagnosis, women may not be able to participate in needed treatment even if that treatment is available. Maguen, Ren, Bosch, Marmar & Seal conducted research to examine possible gender differences in diagnosis of veterans. They utilized a sample of 701 veterans, with female vets comprising 12.4% of the sample. The racial breakdown of the sample was consistent with that of previous studies (Frayne et. al, Miller & Ghadliani).

Maguen et. al did in fact find gender-based differences in veteran's mental health diagnosis. Maguen, et. al found that female veterans seeking VA health care were more likely to be diagnosed with depression than were male veterans seeking VA health care (who had a higher likelihood of being diagnosed with PTSD and alcohol use disorder). Researchers reported the importance of the VA considering gender differences in their mental health service provisions. While Maguen et. al did not discuss this in their research, it is important for future studies to assess whether differences found here are the result of different mental health symptoms of male and female veterans, or if there is an unconscious bias on the part of the diagnosing clinician.

I have now established that women veterans are in need of health care; they are in need of mental health care; and that their mental health needs may differ from that of male veterans. We may move on in the literature to explore where women are receiving their treatment.

Where Women Seek Mental Health Treatment

Women have a number of options about where they seek care (though their options may vary depending on geographic area and barriers to care, which we will explore further in the next section). These options include private clinicians, community mental health clinics, Vet Centers, and through community spiritual spaces such as churches or synagogues. I look to the research to learn more about what treatment centers are being utilized by women.

One set of researcher's included veteran's treatment location preferences within their survey of general mental health care utilization by veterans. Elbogen, Wagner, Johnson, Kinneer, Kang, Vasterling & Beckham utilized a survey to randomly sample 1,388 post 9/11 veterans. Researchers utilized a mixed gender sample, but over-sampled women to assure adequate representation. They found that veterans sought treatment from VA facilities, non-VA facilities, and their chaplain. They found that a larger proportion of women than men sought care from only non-VA providers for both inpatient and outpatient mental health treatment. Researchers Skinner, Kressin, Frayne, Tripp, Hankin, Miller & Sullivan (2000) concurred with Elbogen et al's findings. They reported that according to their study "most female veterans receive their care at non-VA facilities" (p. 304). Unfortunately, this study did not assess what non-VA facilities are being accessed.

Research regarding treatment location preferences for women is quite limited. This does not appear to be a significant area of study based on my review of available literature. The limited information about specific locations that women veteran's access treatment emphasizes the need for this data to be collected, as it is in my survey.

As we have now established that women veteran receive services from VA providers, non-VA providers, and religious providers, we may move on to the next issue. What prevents women from accessing care if and when they need it?

Barriers to Mental Health Treatment

While on the surface it appears that treatment location options are plentiful, the reality for many women may be that a number of barriers interfere with their access to care. Elbogen et. al sought to evaluate barriers to care for both male and female veterans. A number of barriers were identified. These included stigma associated with mental health needs, belief that they should be able to handle it themselves, not knowing where to get help, not being able to get time off from work, and limited childcare. Women were more likely than men to cite childcare and work issues as barriers to care (Elbogen et.al).

Gallegos, Wolff, Streltsov, Adams, Carpenter-Song, Nicholson & Stecker conducted a study examining treatment barriers for veterans who had not sought treatment for PTSD. Veterans reported concerns about the treatment itself, about their emotional readiness for treatment, about the stigma associated with receiving mental health treatment, and logistical issues as barriers to treatment.

Suris, Lind, Kashner, Borman & Petty (2004) assessed women's likelihood to access mental health services for PTSD related to sexual assault. They utilized a convenience sample of 270 women receiving services through the VA. They sorted the women according to whether they had experienced military sexual assault, civilian sexual assault, or no sexual assault. They found that women who had experienced military sexual assault were 9 times more likely to have PTSD (Suris et al., 2004). They also found that while these women were more likely to be

diagnosed with PTSD than either of the two other groups, they were significantly less likely to access mental health services.

In a 2012 study by Mattocks, Haskell, Krebs, Justice, Yano & Brandt referenced a concern for women's willingness to access treatment. Researcher's interviews discussed women's experiences with treatment. Some women spoke of receiving helpful individual therapy, and women's-only group therapy through Vet Centers and the VA. However, some women voiced they would "not feel comfortable seeking VA services for their problems" (Mattocks et. al., 2012, p.541). Several women, in fact, reported that they did not believe their ailments "deserved" treatment through the VA, and sought treatment through private treatment settings or received no treatment at all for their deployment-related physical and mental health issues (Mattocks et al., 2012, p. 543). This insight that a key aspect of treatment seeking has to do with the subjective sense of "deserving" is very important, as it speaks to one reason why women may not seek treatment through the VA, and may (or may not) seek treatment through a community mental health center or private clinician.

The issue of "deserving" treatment through the VA is explored by Di Lione, Wang, Kressin & Vogt (2015). They framed this question around Veteran identity development for women, and explored factors of length of service and experience of service (combat exposure and sexual harassment) and their willingness to access VA services. They conducted a survey of 407 veteran women, exploring their experiences of service, their mental health, and their veteran identity. Researchers found that experience of sexual harassment correlated to decreased positive regard for their veteran identity (p. 6). Findings suggest that increased positive regard for their veteran identity positively correlated to intention to seek services through the VA. Researchers speculate that a lower positive regard for their veteran identity may decrease veterans use of VA

services (p. 7). Researchers cite the importance of creating a welcoming space for women veterans, but this does not address the issue of women's willingness to initiate services at the VA, nor does this study address the issues of women's experiences of help-seeking.

Women Veterans Experience of Care

When women have overcome the many barriers to care and have in fact sought and received treatment, the next question becomes "what is women veterans' experience of mental health care?"

Women's experiences of mental health treatment may vary widely. It is important to reflect upon research in this area, and expand our understanding of themes that have emerged in research. For this we turn to authors Campbell & Raja.

Campbell & Raja (2005) report that re-victimization is part of the experience of women veteran survivors seeking help. The authors examined the occurrence and impact of revictimizing behavior (such as victim-blaming) by providers on victims. Researchers first established that when women reported being re-victimized within the "helping" system (ie military and civilian law enforcement, and medical providers), their reports were accurate. Researchers came to this conclusion as they cross-referenced women's report of victimizing behavior by a "helper" to that providers own report of their behavior. They found that the reports of victim and "helper"/victimizer were consistent. Essentially, if a woman expressed being victimized in the helping system, the victimizer corroborated her account with self-reports that included their own victimizer behavior. This is critical to understanding why women may not report and may not seek further "support" services.

Researchers further determined that re-victimization was positively correlated with an increase in post-traumatic stress symptoms. Not only did women not benefit from seeking formal

services, they were actually *worse* in some cases. Authors sampled 298 predominantly black women receiving services at the VA, using a survey tool. They examined women's experiences navigating the military and civilian law-enforcement and medical systems, and correlated women's reports of revictimizing experiences with provider's self-reported behaviors. They found a strong correlation, in that women appeared to accurately report their experiences of revictimization, as confirmed by provider's reports of their own behaviors. These incidences were significantly impactful. In fact, 83% of military sexual assault victims stated that their experiences with military legal personnel made them reluctant to seek further help (Campbell & Raja 2005).

This study provides further support for exploring differential experiences between military and civilian services. Researchers reported that "analysis of the individual medical secondary victimization emotion items revealed that these women were significantly more likely to report feeling guilty, depressed, nervous, distrustful of others, and reluctant to seek further help after their contact with the military medical professionals than were victims who sought help at civilian facilities" (Campbell & Raja, 2005, p. 103). The findings of this study demonstrate the critical importance of safe, responsive providers, and that women's experiences of treatment varies in civilian vs. military settings. The study results suggest that not only are women not helped in a significant percentage of military treatment experiences, their mental health may actually worsen.

Conclusion

In this review I have examined literature reflecting studies about the reasons women veterans seek mental health treatment, where they seek their treatment, barriers that appear to impede access to treatment, and subjective, shared experiences related to accessing treatment.

The literature across these focus areas suggest the need for additional research to understand how to best serve women veterans. My study was conducted to address some of these issues. The next chapter describes the study methodology that I used to conduct the study.

CHAPTER IV

Methodology

The purpose of this quantitative survey based study was to learn why women veterans choose VA or non-VA mental health treatment when they need care. It was designed to gain insight into choices that women veterans make when choosing health care, and what motivates them in this choice. Results from this descriptive study will be of interest to settings where women veterans are served; will inform clinicians about women veteran's treatment choices and may be of interest to women's program coordinators and leaders within the VA who are reaching out to women veterans.

Participants

The study included only female veterans who had accessed mental health services. The study was based in an online format, so study participants had to have access to the internet. As the purpose of the study was to examine mental health treatment experiences for female veterans, I excluded men, non-veterans, and women veterans who have not sought mental health services.

Recruitment

Recruitment was performed several ways. The primary recruitment source was via social media and the Snowball method. Participants viewed recruitment material through social media websites specifically geared towards veterans. I utilized my positionality as a clinician and veteran to interface with the target population and promote group participation in the survey measure.

I prepared a recruitment statement for the social media sites to post, which briefly outlined the purpose of the study, the inclusionary criteria, and the benefit to the female veteran community of participating. This post will included a statement inviting female veterans to follow the link for more information about the survey. The recruitment statement also encouraged veterans to forward recruitment and survey information to other female veterans. Permissions for posting recruitment materials and the link to the survey on social media were obtained from three veteran groups; Project New Hope, Service Women's Action Network, and Women Veterans. Project New Hope (PNH) granted permission to post recruitment material and a link to the survey on their Facebook page. Service Women's Action Network (SWAN) gave permission to post recruitment materials and a link to the survey on their Facebook and Twitter pages. The Women Veterans group also granted permission to post recruitment materials and a link to the survey on their Facebook page. A number of other social media sites with public access for posting were also utilized. These included Women Veterans Foundation, Veteran Women Igniting the Spirit of Entrepreneurship, Women Joining Forces, Women Veterans Rock, Female Veterans of America, Women Veterans of America, Women Veterans Support Services, Women Veterans Marching On, and to my own Facebook page for the purpose of snowball sampling.

I also utilized a female veteran's support group and snowball method for additional recruitment. Project New Hope runs a support group for female veterans, and they granted permission to distribute the survey to group members. To assure anonymity for this method, I emailed the recruitment statement with a link to the survey to the director of Project New Hope. He then forwarded the email to group members. In the recruitment statement, I encouraged forwarding survey information to fellow female veterans.

Data Collection

This was a quantitative, descriptive, survey-based study. Participants were directed to the survey site via the recruitment process described above. Once at the site, participants read the Informed Consent, and had the option to “Accept” (indicating consent) or exit the survey.

The first section of the survey included a set of demographic questions to describe the subject pool. Following the demographic questions, the survey captured information related to three specific choice options for mental health treatment: 1. VA; 2. Alternative locations other than the VA; 3. Combination of VA and alternative mental health treatment locations. The participant then answered a number of questions related to their experiences. The survey questions were a series of statements that the participants rated on a Likert scale to determine degree of endorsement of each item. There were also several open-ended questions to allow for more comprehensive responses. The study was estimated to take 20 minutes, with slight variation to accommodate differences in the length of response to open-ended questions. Data was collected online via an online survey program, Qualtrics.

Data Analysis

Data analysis assisted by Marjorie Postal. Descriptive statistics were used to define and describe the response sets.

Potential limitations for the data include that the survey was conducted online, requiring that participants had access to the internet, were members of the designated social media groups on Facebook, and were able to navigate the survey on Qualtrics. This may have impacted who was (and was not) able to participate in the survey.

While use of social media pages provided an access platform to a large number of veterans, it most likely excluded an important group; women who are formally considered veterans but who do not identify strongly with that marker, or who may actively avoid participation in veterans groups.

It is also important to note the potential bias of this researcher as I am a female veteran, and I have participated in internships with veterans in both VA and non-VA settings. In an effort to minimize this bias, the survey was piloted by three different individuals. One individual was prior service, one individual was from a military family, and one individual was a civilian with no military experience but with research experience. All three made meaningful contributions in fine-tuning survey questions.

Another potential limitation is that it was designed by this researcher, and has not had rigorous testing of its reliability and validity.

CHAPTER IV

Findings

In this chapter I present the results of my study based on analysis conducted using frequencies and comparative statistics. Quantitative responses to survey items are presented in terms of frequencies to describe the sample, including the military service background of the respondents. Following that, I present the results of the analysis of the locations of care and experiences of care that survey respondents identified in the survey. Next, comparisons are presented for survey responses across various subgroups that emerged from the survey respondents. Finally, I present themes of similarity and dissimilarities that emerged through data coding reflected across responses to the open ended questions offered at the end of the survey. My survey may be found in Appendix A: STUDY SURVEY.

Sample

The survey garnered 45 total responses. Of the 45 responses, 2 respondents did not agree to the Informed Consent. This left the survey with an n=43. For the purpose of analysis, data from responses were organized into two groups formed by respondents who identified their treatment locations as “VA-Only” and “Non-VA Only.” The data regarding veterans who used a combination of service providers could not be used in statistical analysis as responses in some cases were not specific to the treatment location. VA-only respondents was a total n=11, and Non-VA only respondents was n=13. The small n for these groups meant that statistical analysis was limited.

Demographics

Participants were asked to identify themselves on a number of demographic measures. These included race, sexual orientation, income, religion, number of children, marital status, and level of education.

First, the sample was asked to identify by race. Overwhelmingly, participants identified as white (89%), followed by “other” and Native American (both 5%) and Hispanic (2%).

Participants were then asked to identify their sexual orientation. The largest part of the sample identified as heterosexual (82%), followed by homosexual (13%) and bisexual (4%).

Respondents identified their income range, with the largest group (42%) earning between \$25-50,000. The next largest group (24%) earned between \$50-75,000, followed by the less-than \$25,000 group (16%) and greater than \$100,000 (13%). The smallest group was the \$75-100,000 range at 4%. Data was analyzed using chi-square to assess if there was any difference between the groups of women who used the VA-only care vs. women who used non-VA only care by their income. Due to the small n, groups were distributed into women who made more than 50,000 per year, and those who earned less than 50,000 per year. A significant difference was found (chi square (1, N=26)=4.210, p=.040, continuity corrected). The data indicated that 83.9% of the lower income group went to the VA, compared to 35.7% of the higher income group.

Data regarding religious affiliation was collected, and Christian-identified respondents comprised the largest group at 56%. This was followed by “spiritual but not religious” at 36%, and all remaining identified religious groups at 2% respectively. These included Atheist, Buddhist, Wiccan, and “other.” No respondents identified as Hindu or Muslim.

Survey participants identified the number of children that they are responsible for on a regular basis. The largest group had no children (44%), followed by 1 child at 27%. Respondents with 2 children constituted 18%, 3 children at 7%, and 4 or more at 4%. When looking for any differences in the populations of VA-only users vs non-VA only users, crosstab shows 63.6% of those with no children went to the VA compared to 53.3% of those with children. The n of these two groups was not large enough to assess whether the difference is statistically significant.

Survey participants were asked about their marital status. The largest group of survey participants were married (44%). Of the remaining participants 24% were divorced, 22% were single, 4% were separated, and 4% were in a committed relationship. When comparing the relationship status of VA-only treatment seekers vs. non-VA only treatment seekers, it appears that 72.7% of single people went to the VA-only, compared to 46.7% of married/committed people. The n of these two groups was not large enough to assess whether the difference is statistically significant.

Participants identified their level of education, which was fairly evenly distributed. Most participants had some college (29%), a Bachelor's degree (27%), a Master's degree (20%) or an Associate's degree (20%). A much smaller group had a High School diploma or GED (2%) or a PhD (2%).

Military Background

Participants were then asked to provide information about their military background. They identified their branch of service, length of time in service, time period of service, and type of discharge.

When participants identified their military service, the two largest groups were Army (51%) and Air Force (36%). The smaller groups included the Navy (11%) and Marines (2%). No participants identified as Coast Guard veterans. The overwhelming majority of veterans were previously active duty (86%), and only a few had prior service in the National Guard or Reserve (9% and 5% respectively). Service dates and length of service varied quite widely, and to capture this data I asked for actual dates of service. Because of the way I collected this data I am able to use it descriptively but not statistically. Participants reported a date range from 1973 to currently serving (2016). Length of service varied widely between 2 and 28 years of service, with many falling into the 6-10 year range. The following graph reflects the military background of participants (Figure 1).

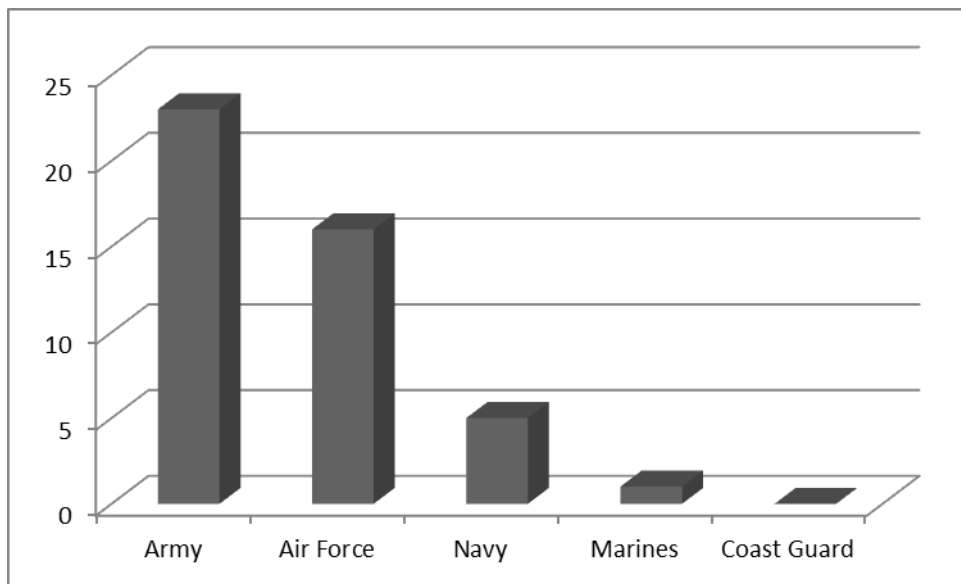


Figure 1. Military Background by Branch of Service

Women identified the campaign that they served in as well. The results were fairly evenly distributed across different campaigns from Vietnam forward (the Korean War was included as an option, but there were no respondents from that era). Iraq and Gulf Wars came in at the top,

with 45% and 31% of veterans having served in one of these campaigns. The war in Afghanistan was represented by 21% of respondents, followed by Kosovo and Vietnam, both at 7% of respondents. “Other Campaign” was identified for 33% of respondents. The following graph represents the military campaigns that survey respondents participated in (Figure 2.).

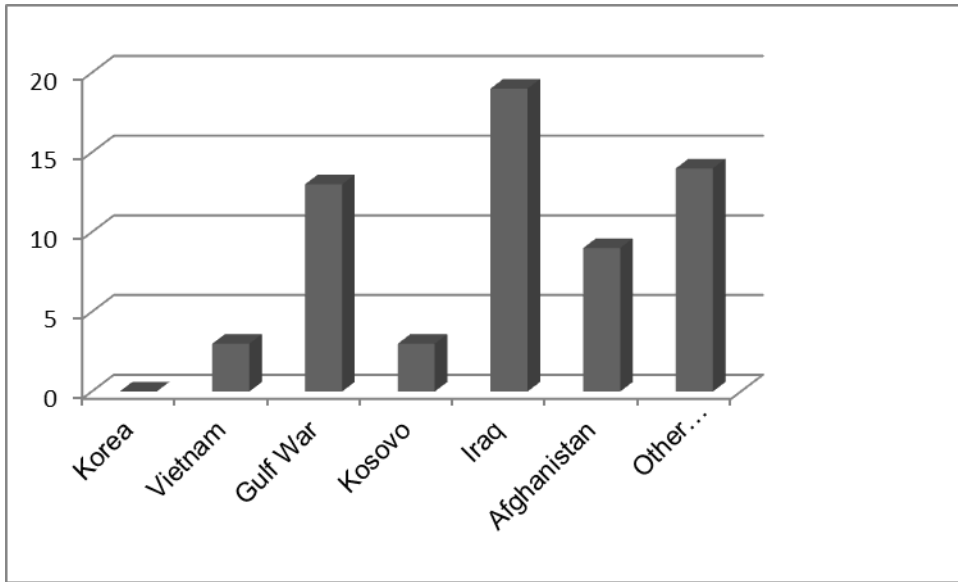


Figure 2. Respondents Military Campaign Participation

Respondents were asked about their discharge disposition, which broke down into only 2 groups; Honorable (87%) and Medical (13%).

Quantitative Findings

Mental Health Treatment

The next section of my survey dealt directly with mental health treatment. The first section related to mental health treatment asked for quantitative responses to questions about why the veteran sought treatment, at what types of treatment centers, and what their experience was of the treatment they received.

Initiating Treatment

When respondents were asked about the reason they initially sought treatment, PTSD (57%) and depression (55%) were the two most significant factors in initiating treatment. This was followed by MST (39%), and “Other” (23%). The remainder of respondents selected either substance abuse or Traumatic Brain Injury, comprising 7% of respondents each. The following graph represents the mental health reasons that prompted participants to initiate treatment (Figure 3.).

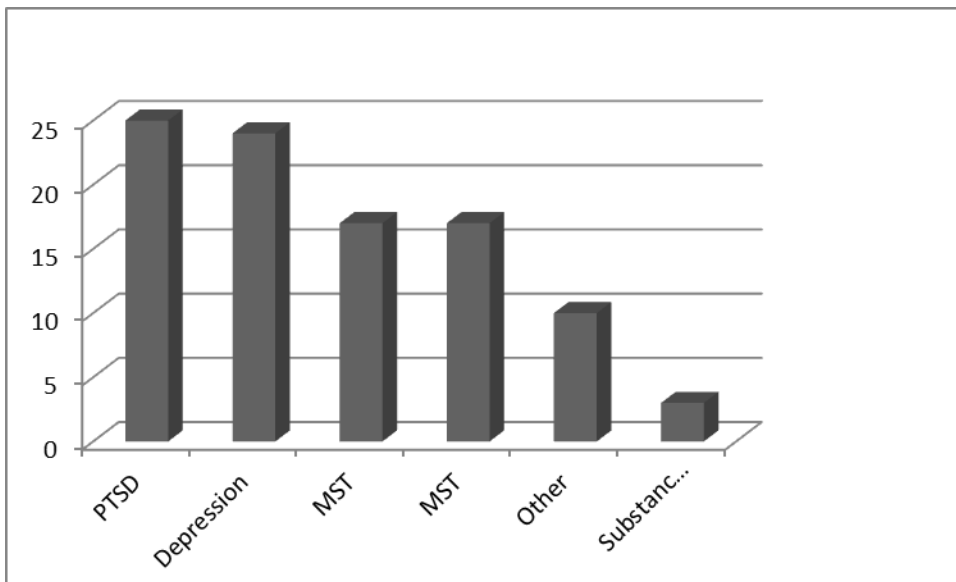


Figure 3. Reason for Initiating Treatment

Treatment Location

Respondents then identified their selected treatment center type, “VA only,” non-VA only,” or “both VA and non-VA.” The two largest groups were VA-only (41%) and “both VA and non-VA” (39%), followed last by “non-VA only” with 25%.

Experience of Care

Veterans were asked to rate on a five-point Likert Scale from “strongly disagree” to “strongly agree” how well they felt that their mental health provider understood the particular issues of female vets. The scale showed a median of 2.82 with a standard deviation of 1.26. This question was followed by a second question also rated on a 5-point scale, and asked if they preferred to receive their treatment at a military-aligned facility. In this instance, the mean fell at 3.02, with a standard deviation of 1.15. When asked about if veterans felt they deserved treatment at their selected facility, most “agreed” or “strongly agreed” with this statement producing a mean of 4.14 with a standard deviation of .95. Veterans were also asked to rate their ease in making appointments, and most agreed that they were able to easily schedule appointment with their selected provider (mean of 3.18, SD 1.3). Most veterans also agreed that the treatment location was convenient (mean 3.43, SD 1.19).

Veterans were asked to rate their experience on a scale from “very satisfied” to “very dissatisfied” for each center that they received treatment at. Respondents selected from treatment centers including private mental health provider, community mental health clinic, VA, spiritual center (such as a church, mosque, synagogue, etc), Vet Center or other location. Community mental health clinics and spiritual centers both had a mean of 6.85, though community clinics had a SD 1.76, while spiritual centers had a SD of 1.98. Vet Centers rated at a mean of 6.7, with an SD 2.09, and private mental health providers a mean of 5.69 with a mean of 1.97. The VA had the lowest mean at 4.45, but with the largest standard deviation of 2.39 encompassing the most ratings of both “very satisfied” and “very dissatisfied.”

Qualitative Findings

The second section of the survey asked for qualitative responses regarding their experience of care and what they feel could be improved in the interest of mental health treatment for female veterans.

Factors that Influenced Care

Veterans were asked to respond qualitatively about factors that influenced their care. The responses largely focused on VA care, and the most prominent themes were around appointments. This included the wait to get an appointment, limited time with providers during an appointment, and appointments being unavailable during non-business hours. One woman explained her struggle with appointments, saying “Appointment was scheduled 6 weeks out and then they cancelled it and rescheduled for another 4 weeks out. Then it was double booked and not able to be seen. The next available appointment was 7 weeks out.” Another woman stated “The VA only had appointments during working hours, from 0900-1500 hrs. Therefore I had to seek appointments with a provider outside the VA who could see me when I wasn't working.”

Experiences with Providers

The second theme that emerged was regarding veteran’s actual experiences with providers. This loosely split into two categories; veterans reporting positive experiences with their provider, and veterans reporting negative experiences with their provider. In the group that reported positive experiences with their provider, veterans identified their provider as a social worker. In the group that identified a negative experience, veterans identified their provider as a psychologist or psychiatrist. One woman discussed her experiences with both types of providers, stating:

“My counselor was a LCSW, I felt like she took the time to understand me. When I worked with psychologists I felt like they didn't really care and were more concerned with trying to make additional diagnoses. So I would say social workers are more genuine and empathetic.”

A number of veterans did not specify the type of provider in their response, but reported that they did not feel helped, and/or did not have the same goals for treatment as their provider did. For example, “I sought help for depression & current issues with my family & the young lady they had me seeing only wanted to discuss my rape...”

Improving Treatment

Veterans were then asked how treatment could be better tailored to their needs, and were provided space to respond. Their responses reflected a dominant theme of a desire for greater treatment options. Veterans expressed a desire for more options in treatment types, suggesting more CBT, CPT, meditation, grounding techniques, women’s groups and other gender-specific treatments, and support for VA-funded private clinical treatment. Women also asked for logistical support, such as offering child care so women can attend treatment, and for extended treatment hours: “The VA could offer evening or weekend appointments for veterans who have traditional (e.g., 0900-1700 hrs) jobs. The VA could offer childcare for single parents needing appointments.” Women expressed a desire for support in navigating the VA system, “I wish I would have had a patient advocate...someone who showed me around the hospital and what paperwork I needed to fill out...the VA system is crazy complicated...it needs to be simple”. They also expressed frustration at feeling that their experiences were not heard or validated by their provider, for example “The VA needs to accept that women also have combat PTSD and

constantly just assuming all are problems are from being raped completely dismisses our service.”

Reflections on Other Issues

The final survey item asked women vets to reflect on any other issue that they feel was missed in other survey questions, and were provided space for response. This question only gathered a handful of responses. There was great variation in responses to this question. Responses included requests for “More female veteran counselors,” less turnover of providers (short tours for interns), reiteration of concerns regarding access to appointments (scheduling constraints and paperwork stressors), and a desire to feel safe and comfortable in their treatment setting.

Summary

In conclusion, women veterans provided key information regarding their mental health treatment. Women veterans are receiving treatment at a variety of settings, with the largest group of respondents reporting use of both VA and Non-VA treatment settings. Women reported the greatest satisfaction with treatment at non-VA settings, specifically at community mental health clinics, spiritual centers, and Vet centers. Lower income women were more likely to use VA services, with higher-income women selecting alternative treatment. Women reported that their care was impacted at the VA by long wait times to get appointments, appointment availability limited to business hours, high turnover of treatment providers, and a desire for more female providers. Women expressed that VA treatment could be improved by offering childcare during appointments, women-only treatment areas, diverse and non-traditional treatment options, appointments during non-business hours, improved support in navigating the VA system, more

female veteran providers, and by supporting and validating both the combat and military sexual traumas that may be experienced. Women consistently reported a desire for a safe, supportive treatment environment.

In the following chapter, findings will be discussed in terms of literature reviewed and new information that emerged from the study. The next chapter will end with conclusions of the study.

CHAPTER IV

Discussion

In this chapter I present a discussion of the key findings of my study. These findings explore what factors influence the treatment location choices made by women veterans. I will discuss the quantitative responses to survey items, and how these results relate to this population and to prior literature. Following that, I present a discussion of qualitative responses and the nuanced and specific feedback that women provided about their experiences of care. I will discuss similarities and differences that emerge from the data as relates to prior research and to the larger population of women veterans. Finally, in the Conclusion section of this paper, I will explore both the strengths and limitations of my research, and directions for future work. I will discuss how the findings of this study can be incorporated into everyday clinical practice and into larger policy changes so that we may best serve this population.

DISCUSSION OF KEY FINDINGS

Quantitative

In my research I explored what treatment locations women veterans are currently using. I found that the largest group, by a very small margin, is comprised of women who receive services through VA programming only (41%). This is very closely followed by women who use a variety of treatment locations, encompassing both VA and non-VA sites (39%). The smallest group, at 25%, is made up of women who engage in treatment through non-VA sites only. These findings represent a slightly higher rate of engagement in VA services than has been shown in

prior studies. Elbogen, Wagner, Johnson, Kinneer, Kang, Vasterling & Beckham found that veterans sought treatment from VA facilities, non-VA facilities, and their chaplain, but that women veterans were more likely than men to receive care only from non-VA providers. Researchers Skinner, Kressin, Frayne, Tripp, Hankin, Miller & Sullivan (2000) concurred with Elbogen et al's findings. They reported that according to their study "most female veterans receive their care at non-VA facilities" (p. 304). Additional research found that some women did not believe their ailments "deserved" treatment through the VA, and that women sought treatment through private treatment settings or received no treatment at all for their deployment-related physical and mental health issues (Mattocks et al., 2012, p. 543).

These studies were conducted a number of years ago, and it is possible that an effort to encourage women to receive treatment through the VA has had some success. However, these findings should be considered cautiously based on the small n represented.

For the purpose of analysis, data from responses were organized into two groups formed by respondents who identified their treatment locations as "VA-Only" and "Non-VA Only." The data regarding veterans who used a combination of service providers could not be used in statistical analysis as responses in some cases were not specific to the treatment location. The issue of collecting data from veterans who did not fit into one of these two categories was complex; to exclude this group based on the difficulty of incorporating their responses (essentially gathering some data I would not be able to use) was set aside in the greater interest of reflecting the reality of women's treatment experiences. This reality, as reflected in the data, includes that a large number of women receive treatment at both VA and non-VA treatment centers.

I explored a number of demographic factors in my survey to determine what impact different demographics might have, if any, on treatment choice. I found several factors that were specifically correlated to treatment choice. These factors included income, marital status, and number of children for which the veteran is the primary caretaker.

Women who earned less than 50,000 dollars per year used VA-only services at a rate of almost 84%. This number differed significantly from the percentage of women earning over 50,000 dollars per year; only 35.7% of higher-income veterans used the VA exclusively. While the data cannot tell us why this disparity exists, it is important to note its presence. There is no known research that examines the correlation between income and treatment choice.

Treatment location choices also varied by marital status. The majority of single women, 72.7%, used VA-only services. A much smaller percentage of married women used VA services exclusively, at 46.7%. Though it is unclear what exactly the relationship is between marital status and access to care, it should be noted. Currently there is no other known research that examines the correlation between relationship status and treatment location choice against which to compare these findings.

Whether or not women were responsible for the care of children was also a factor in treatment location choice. The majority of women with no children used VA services exclusively (63.6%). This varied by approximately 10 percentage points from women with children who used VA services exclusively (53.3%). This is consistent with the findings of Elbogen et al, who reported that women were more likely than men to cite childcare as a barrier to care.

Women were asked to identify what type of mental health issue initially prompted them to seek treatment. Participants reported PTSD (57%) and depression (55%) as the most

significant factors in initiating treatment, followed by MST (39%), and “Other” (23%). The remainder of respondents selected either substance abuse or Traumatic Brain Injury, comprising 7% of respondents each. Miller & Ghadliani reported similar findings in their study. In their sample of 68 female veterans, they found that the most common mental health diagnosis in their sample was PTSD, followed by depression, anxiety, adjustment disorder, bipolar disorder, psychotic disorder, and personality disorder.

Qualitative

Women veterans were asked to provide open-ended responses to several questions regarding their experience of care, and what they feel could be improved in the interest of mental health treatment for female veterans. Several key factors emerged in women’s qualitative responses about the factors that influence their care. The themes that emerged included issues around appointments, concerns regarding providers, and difficulties navigating the VA system. These concerns are consistent with the findings of Gallegos, Wolff, Streltsov, Adams, Carpenter-Song, Nicholson & Stecker, who reported that logistical issues posed a significant barrier to care for women veterans.

Appointments

Women reported struggles in accessing treatment at the VA related to the extensive wait time to get an appointment, the short periods of time allotted to spend with providers, and the lack of availability of appointments during non-regular business hours. Elbogen et. al reported findings consistent with data gathered in my study. They found that not being able to get time off from work for appointments was a significant barrier to care.

These factors are certainly a reality for many women receiving VA services, according to this data. What is not known is the number of women that may have discontinued care due to difficulties around appointments. It is also not known from this data how many women may have moved from a VA setting to a non-VA setting as a result of this barrier, though this issue was discussed by one veteran:

The VA only had appointments during working hours, from 0900-1500 hrs. Therefore I had to seek appointments with a provider outside the VA who could see me when I wasn't working.

Research by Miller & Ghadliani reinforced the need for prompt, convenient, and accessible care, reporting that a number of women had attempted suicide, engaged in self-injury, and abused substances.

Providers

Women veterans clearly stated a need for warm, empathetic, trustworthy, and consistent mental health providers. They discussed the absence of any of these factors as a barrier to therapeutic progress. One veteran summarized this collection of concerns related to providers in this way:

I sought help for depression & current issues with my family & the young lady they had me seeing only wanted to discuss my rape. Also, my psych doc's & counselors kept changing. Sometimes monthly! How can I trust someone enough to share deeply personal issues when I don't feel comfortable? Especially when I know the person won't be around long enough to learn my name? I gave up. Now I don't try to discuss anything. Just get my med prescription & leave.

Mattocks, Haskell, Krebs, Justice, Yano & Brandt found in their study that women reported they would “not feel comfortable seeking VA services for their problems,” and these concerns were reiterated in the findings of my study.

Suggested Changes

Respondents had no shortage of suggestions regarding how mental health treatment, and in particular the VA, could better meet their needs. Many suggestions addressed logistical barriers to care including more access to appointments, childcare availability during appointment times, and assistance with navigating the VA. Other suggestions were directed at the development of therapeutic relationships with providers, and the barriers to that alliance. In this vein, women suggested the use of more female veterans as service providers, more female psychiatrists, and a greater alliance between clinician and veteran that includes joint development of treatment goals and a clear understanding on the part of the clinician of the needs of the particular veteran.

Key Findings and Current Literature

Mattocks, Haskell, Krebs, Justice, Yano, & Brandt (2012), reported that some women voiced they would “not feel comfortable seeking VA services for their problems (p.541). While the specifics of this finding is unclear, the general concern about accessing safe and understanding treatment within the VA was certainly reflected in responses in this study. For example, women provided feedback that they felt a women’s-only wing or center is needed, inferring that the lack of a women’s-only space negatively impacts their experience at the VA. This could be increasing women’s efforts to access care outside the VA. Skinner (2000) reported that “most female veterans receive their care at non-VA facilities” (p. 304). This was not consistent with the

findings of my study, though a large group (39%) identified that they received treatment at both VA and non-VA settings.

CONCLUSIONS

Strengths

My study engaged women veterans using a method that allowed anonymity and consent. By utilizing a social media platform women were able to choose to participate, or not, without pressures that could arise if the study was conducted through more official channels such as on a military base or through a VA.

No data regarding a participants name or any other identifier was collected, allowing women to respond without concern that their responses could be linked to them in any way.

Limitations

This study was limited by several factors. These factors included a small sample size, skewed racial demographics, and inability to analyze some data for women who received services in both setting types (VA and non-VA).

The survey was posted to a number of veteran social media sites with recruitment material. As I had posted on a number of large platforms I anticipated a reasonable number of respondents. I did not account for the limitation of the short period of time that the survey was available. I also did not anticipate that the sample would not reflect the larger veteran racial demographic. The sample also did not accurately reflect the population of different branches of service, and was very heavily weighted towards Army and Air Force veterans. It is not known how these variances may have impacted the generalizability of data collected, but must be considered.

Another limitation was that not all data collected could be used. Some data collected for women who received treatment at both VA and non-VA centers was unusable as it was unclear in some places whether women were responding regarding one treatment center or another. This was a limitation of the survey, and to have alleviated that limitation would have meant a much longer and more cumbersome survey.

Implications for Practice and Policy

Women veterans have been clear in their responses what is important to them in a treatment setting. It is important that the input from women veterans is considered and implemented if we sincerely strive to improve women veteran's mental health care. Implementation can include small but meaningful changes in clinical practice such as introducing a veteran to a new provider in person, or walking with a veteran to their next stop and explaining to them what the role is of the person you are bringing them to. It could include supporting a veteran in setting up their next appointment prior to leaving, or letting them know when walk-in hours are available.

Implementation can also include larger changes such as identifying a women's-only treatment space, and creating a drop-in child care center for women to use while they are seeing their providers. Researchers Di Lione, Wang, Kressin & Vogt (2015) also cite the importance of creating a welcoming space for women veterans. Expanding hours would also increase accessibility for many. Focusing on hiring female veteran personnel and working towards improving retention of female veteran providers (thereby increasing continuity of care) would also be important changes.

Implications for Future Study

Several demographic variables emerged in correlation to differing use of the VA specifically including income, marital status, and number of children for which the veteran is the primary caretaker. Though the correlation is apparent the reason for the correlation and the causal relationship (if any) is unclear. These relationships could be explored further and a greater understanding of how these demographics impact treatment could lead to additional interventions to support access to care.

Recreating this survey over a longer time period, and targeting more diverse veterans social media pages would allow for additional data gathering to support important improvements in service to women veterans. Gathering a larger sample could provide a group of participants that more accurately reflect the larger women veteran population.

Additional study could explore more specifically the population that was largely left out of this survey; women veterans who receive treatment at multiple sites. This could yield valuable information regarding nuances in treatment experiences by targeting participants who have had direct experience in multiple settings.

Closing Comments

This survey explored the factors that impact women's decisions in selecting one treatment setting over another. It has provided the clinical community with valuable insight. Women discussed frankly the practical barriers that they face in accessing treatment. They also discussed the more subjective aspect of mental health care in discussion of relationships with providers. The requests that women veterans have made through this survey are both reasonable and implementable. If we are to improve engagement with women veterans, and provide them

with the mental health services that they deserve, we have only to listen and follow their direction.

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Appendix A.

Study Survey

Smith College School for Social Work

Bethany Ferry

Exploring Mental Health Treatment for Female Veterans in the U.S.: Assessing the Influences on Female Veterans in Selection of Treatment Location, Comparing VA and Non-VA Settings

Thank you for participating in this voluntary survey. This survey is designed to help assess where women veterans choose to receive mental health care, and to learn about what motivates this choice. Your responses will be anonymous and no identifying information will be collected. I'm a Smith School for Social Work Masters (MSW) degree student and a veteran; this study is being conducted as part of the requirements of my MSW at Smith. I may be contacted by email at bferry@smith.edu. I am supervised by Elaine Kersten, and she may be contacted at ekersten@smith.edu.

Results of my study will help gain insight into the choices women veterans make about where to go for health care given the choice between private health care, or health care available in the Veteran's Administration health care system. Through the study, I hope to learn why women veterans choose alternatives to VA mental health care.

I. Demographics

1.) Racial/Ethnic identity:

- African American
- Asian American
- Hispanic American
- Jewish American
- Native American
- South West Asian American
- White American

Other _____

2.) Sexual orientation:

--Homosexual

--Heterosexual

--Other _____

3.) Income:

Less than 25,000.

25,000-50,000

50,000-75,000

75,000-100,000

Greater than 100,000

4.) Religious Affiliation:

Atheist

Buddhist

Christian

Hindu

Muslim

Spiritual, but not a member of an organized religion

Wiccan

Other _____

5.) Marital Status:

Single

Married

Separated

Divorced

6.) Number of Children you are the Primary Caretaker for: _____

7.) Level of Education:

High School/GED

Some College

Associates Degree

Bachelor's Degree

Masters

PhD

3.) Branch(es) of Service:

Air Force

Army

Coast Guard

Marines

Navy

4.) Type of Service:

Active Duty

National Guard

Reserve

5.) Dates of service: _____

8.) In which conflict(s) did you serve?

Korean War

Vietnam War

Gulf War

Kosovo

Iraq

Afghanistan

Other campaign: _____

8.) Type of Discharge:

Honorable

General

Medical

Other than Honorable

Dishonorable

Other: _____

II. Reason for Treatment and Location(s) Selected.

1.) Specifically, what first brought you to seek mental health treatment?

- PTSD
- Military Sexual Trauma
- Substance Abuse
- Anxiety/Depression
- Traumatic Brain Injury
- Other: _____

2.) Where did you seek mental health treatment?

- Veterans Administration (VA)
- Non-VA
- Both VA and Non-VA

(If participant selects “Non-VA” or “Both VA and Non-VA,” they will be prompted to this subsequent question)

**3.) I received treatment at the following Non-VA locations:
(check all that apply)**

- Community mental health center
- Private clinician
- Spiritual center (ie church, synagogue, mosque, etc.)
- Vet Center

(Participants will answer the following questions for each location selected. For example, if participant selects “VA” only, they will answer these questions one time for the VA. If they select “Non-VA”, “Private clinician” and “Spiritual Center” they will answer this same set of questions twice, once for “Private clinician” and once for “Spiritual center.”)

1. I felt my mental health provider(s) had a good understanding of issues faced by female veterans.
Likert scale 1-5
Strongly agree-strongly disagree
2. I prefer to receive my mental health care at a military-aligned facility.
Likert scale 1-5
Strongly agree—strongly disagree
3. I feel I deserve to receive mental health care from my selected provider.
Likert scale 1-5

Strongly agree—strongly disagree

4. I was able to easily schedule appointments:

Likert scale 1-5

Strongly agree-strongly disagree

5. I felt the treatment location was convenient.

Likert scale 1-5

Strongly agree—strongly disagree

6. I felt confident that my treatment was private and confidential.

Likert scale 1-5

Strongly agree—strongly disagree

7. I felt my treatment was beneficial.

Likert scale 1-5

Strongly agree—strongly disagree

8. If you received treatment at more than one type of treatment center please rank in order of preference: Select “N/A” for treatment centers that you did not use at all.

Community-based mental health clinic

Private mental health clinic

Spiritual Center

VA

Vet Center

Other _____

9. How could treatment have been better tailored to meet your needs? Please explain: _____

10. Is there anything else you would like to add that has not been addressed in this survey? _____

Thank you for your participation. Your input is highly valued. Your responses will join those of other servicewomen regarding experiences of mental health services. Gathering information about what is helpful to women in obtaining supportive mental health care is a critical step in understanding the unique needs of female veterans. This is also important in advocating for changes that may improve the support available for women who served.

If you have any additional comments or concerns, I may be contacted by email at bferry@smith.edu. I am supervised by Elaine Kersten at ekersten@smith.edu. **This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).**

Appendix B.

Recruitment Statement

Calling Fellow Women Veterans!

I am a female veteran, and a Master's of Social Work student at Smith College. I am conducting a survey of women vets for my thesis. I am studying the experiences of female veterans and mental health treatment. This is an important part of understanding what is working well and what improvements could be made to improve mental health care for women vets. If you are a female veteran, have accessed mental health treatment, and are interested in learning more about my survey, please click on the link.

If you have friends and colleagues who are also female vets, please feel free to forward survey information to them as well. Make your voices heard!

Link to Survey: https://qtrial2015q4az1.az1.qualtrics.com/SE/?SID=SV_5gKw26V7naLaHJP

Appendix C.

Informed Consent



2015-2016

Consent to Participate in a Research Study

Smith College School for Social Work • Northampton, MA

.....

**Title of Study: Exploring Mental Health Treatment for Female Veterans in the U.S.:
Assessing the Influences on Female Veterans in Selection of Treatment Location,
Comparing VA and Non-VA Settings**

Investigator(s): Bethany Ferry, bferry@smith.edu

.....

Introduction

- **You are being asked to be in a research study of the experiences of female veterans who seek mental health treatment at the VA, non-VA services or a combination of both.**

- You were selected as a possible participant because you are a female veteran who has sought mental health treatment.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

● The purpose of the study is to learn about choices that women veterans make when deciding to seek mental health supports and services. Mental health treatment can include but is not limited to such conditions as depression, Military Sexual Trauma, Post-Traumatic Stress Syndrome (PTSD) or any other mental health issue/condition.

The information gathered will contribute to our understanding of choices female veterans make about where they seek mental health treatment

● This study focuses on the locations female veterans choose, and why they choose the specific location. Female veterans may choose support from a number of different treatment locations, including the Veteran Administration, private clinicians, churches and more. As a researcher, a Social work student, and a fellow female veteran, I am curious about why women choose one treatment location over another, and what women think of the treatment when they receive it. Learning the answers to these questions will inform the treatment field about what motivates women veterans to choose one location over another and why.

● This study is being conducted as a research requirement for my master's in social work (MSW) degree at Smith College School for Social Work.

● Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- **If you agree to be in this study, you will be asked to do the following things:**

First, you will be asked a set of pre-screening questions to ensure that you are eligible to be part of the study. If you are not, you have my thanks for your willingness to participate, and will not receive additional questions. If you are eligible you will be taken to the survey, and initially asked to answer a set of demographic questions designed to describe the study pool. Finally, you will be asked a set of questions designed to learn about location choices you make when choosing mental health services and why you choose the location over another. Finally, you will be asked some open ended questions in which you can add comments.

No questions will be asked about the specific nature of the mental health conditions for which you seek treatment.

Completing this survey will take approximately 20 minutes. This study is conducted entirely online via a survey program called Qualtrics.

Risks/Discomforts of Being in this Study

- **There are no reasonable foreseeable (or expected) risks of participating in this study. However, every individual is different, and it is important to remember that *all***

of these survey questions are optional. In the unlikely event that answering questions makes you feel please stop the survey and contact your mental health provider if necessary. Alternately, please contact the Veterans Crisis Line at 800-273-8255.

Benefits of Being in the Study

- **The potential benefits of participation are that you may reflect on what lead you to choices about where you receive your mental health treatment.**
- **The benefits to social work/society include learning about what motivates women vets to choose specific locations for their mental health**

Confidentiality

- **This study is anonymous. The survey is set up in such a way that all identifying information (e.g. email address) is “swiped” from the survey. We will not be collecting or retaining any information about your identity.**

Payments/gift

- **You will not receive any financial payment for your participation.**

Right to Refuse or Withdraw

- **The decision to participate in this study is entirely up to you. You may choose to withdraw at any time in the study without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled.**

You have the right not to answer any single question, as well as to withdraw completely at any point. If you choose to withdraw, data gathered will remain in the system, but I will eliminate all incomplete surveys. As noted above, there is no way for me to know the identity of anyone who initiates the survey process .

Right to Ask Questions and Report Concerns

- **You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study at any time feel free to contact me, Bethany Ferry at bferry@smith.edu or by telephone at (xxx) xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.**

Consent

Agreement to participate in this study is provided by checking the box below. If you check this box, you will be taken to the survey. If, after reading the consent, you choose not to participate, you can exit by clicking ‘Escape’

Thank you for your interest.

I agree to participate in this study

Appendix D.

HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 4, 2016

Bethany Ferry

Dear Bethany,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink that reads 'Marsha Kline Pruett'.

Marsha Kline Pruett, Ph.D.
Co-Chair, Human Subjects Review Committee

CC: Elaine Kersten, Research Advisor

Human Subjects Review Board Approval Letter

Appendix E.

Protocol Change Form 1.

**2015-2016
RESEARCH PROJECT PROTOCOL CHANGE FORM
Smith College School for Social Work**

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

Exploring Mental Health Treatment for Female Veterans in the U.S.: Assessing the Influences on Female Veterans in Selection of Treatment Location, Comparing VA and Non-VA Settings

**Bethany Ferry
Elaine Kersten**

.....
Please complete the following:

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

- 1.) Due to limited survey participation I am requesting to post recruitment material and survey link to the following public Facebook Groups. No prior authorization is needed by the groups for posts by the public.

Women Veterans Foundation
Leave No Female Veteran Behind
Veteran Women Igniting the Spirit of Entrepreneurship
Women Joining Forces
Women Veterans Interactive
Women Veterans Rock
Female Veterans of America
Women Veterans of America
Women Veterans Support Services
Women Veterans Marching On

- 2.) I am also requesting permission to post recruitment materials and survey link to my own Facebook page for the purpose of snowball sampling.

.....

I understand that these proposed changes in protocol will be reviewed by the Committee.

I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.

I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: Bethany Ferry

Name of Researcher (PLEASE PRINT): Bethany Ferry **Date:**
 2/15/16

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

****Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.*

.....

Appendix F.

Protocol Change Approval Letter 1.



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 15, 2016

Bethany Ferry

Dear Bethany,

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett'.

Marsha Pruett, PhD
Co-Chair, Human Subjects Review Committee

CC: Elaine Kersten, Research Advisor

Appendix G.

Protocol Change Form 2.

**2015-2016
RESEARCH PROJECT PROTOCOL CHANGE FORM
Smith College School for Social Work**

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:
Exploring Mental Health Treatment for Female Veterans in the U.S.: Assessing the Influences on Female Veterans in Selection of Treatment Location, Comparing VA and Non-VA Settings

**Bethany Ferry
Elaine Kersten**

.....
Please complete the following:

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

1. Due to limited survey participation I am requesting to post recruitment material and survey link to the following additional public Facebook Groups. No prior authorization is needed by the groups for posts by the public.

Massachusetts Women Veterans
The Center for Veterans and their Families at Rush
Veterans Today
Veterans for Peace
Women Veteran Social Justice Network
Dysfunctional Veterans
The Veterans Site
Veterans Empowered to Protect African Wildlife
Veterans of Foreign Wars Department of Connecticut
Student Veterans of America

.....
X I understand that these proposed changes in protocol will be reviewed by the Committee.

X I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.

X I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: Bethany Ferry

Name of Researcher (PLEASE PRINT): Bethany Ferry **Date:**
2/28/16

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

****Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.*

.....

Appendix F.

Protocol Change Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 29, 2016

Bethany Ferry

Dear Bethany,

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in cursive script that reads "Marsha Kline Pruett".

Marsha Pruett, PhD
Co-Chair, Human Subjects Review Committee

CC: Elaine Kersten, Research Advisor