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Being a Female Veteran: A Grounded Theory of Coping With Transitions

LISA BURKHART, PhD, RN
Marcella Niehoff School of Nursing, Loyola University Chicago, Chicago, Illinois, USA
Research Health Scientist, Center of Innovation for Complex Chronic Healthcare (CINNCH) at Hines VA Hospital, Hines, Illinois, USA

NANCY HOGAN, PhD, RN, FAAN
Marcella Niehoff School of Nursing, Loyola University Chicago, Chicago, Illinois, USA

Female veterans, the fastest growing segment in the military, have unique pre-military histories and military experiences that are associated with post-military physical and mental health service needs. Successful treatment is contingent on a clearer understanding of the processes underlying these experiences. Data from 20 female veterans who served post–Gulf War were analyzed to generate a substantive theory of the process of women who entered, served in, and transitioned out of the military. Coping with transitions *emerged as the basic psychosocial process used by female veterans. The* Coping with transitions *process is comprised of seven categories:* Choosing the Military, Adapting to the Military, Being in the Military, Being a Female in the Military, Departing the Military, Experiencing Stressors of Being a Civilian, *and* Making Meaning of Being a Veteran-Civilian. *The results of this study provide a theoretical description of the process female veterans experience when transitioning from a civilian identity, through military life stressors and adaptations, toward gaining a dual identity of being a veteran-civilian.*

KEYWORDS *military, grounded theory, women's health, gender, mental health*

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Address correspondence to Lisa Burkhart, PhD, RN, Marcella Niehoff School of Nursing, Loyola University Chicago, 1032 W. Sheridan Rd., Chicago, IL 60660. E-mail: eburkha@luc.edu

Women make up the largest growing segment in the military (Department of Veteran Affairs, 2012, 2013). The increase in the number of women in combat began in the 1990s with a change in policy allowing females full and equal opportunity to serve in the military, including combat roles (Department of Army, 1992). Although the Veterans 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, Kleimann, Michelini, Kleimann, & Canning, 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 & Raja, 2005; Zinzow, Grubaugh, Monier, Suffoletta-Maierle, & Frueh, 2007). Therefore, it is important for both civilian and VA health and mental health care providers to understand the issues of this growing, vulnerable population.

DESCRIPTION OF THE PROBLEM

The 1990s saw a growth in female veteran research, identifying a high prevalence of posttraumatic stress disorder (PTSD) and military sexual trauma (MST) (Zinzow et al., 2007). PTSD is a complex chronic disorder associated with traumatic events, characterized by the following symptoms: recurrent, intrusive, and distressing recollections of the trauma; heightened autonomic reactivity; sleep disturbances; concentration and memory problems; anhedonia (inability to experience joy); and impaired occupational and social functioning (American Psychiatric Association, 2013). Military stressors include perceived threats and difficult living and working environments (Vogt, Samper, King, King, & Martin, 2008), as well as deployment stressors, lack of social support, and concerns about family disruptions (Vogt, Pless, King, & King, 2005). Many female and male veterans with combat exposure experience PTSD (Feczer & Bjorklund, 2009; Murdoch et al. 2003; Vogt, Vaughn et al., 2011; Vogt et al., 2008). Further research demonstrates a high incidence (40%) of MST for females (Campbell & Raja, 2005; Haskell et al., 2010; Sadler, Booth, Mengeling, & Doebbeling 2004), and an association between MST and PTSD (Murdoch, Polusny, Hodges, & Cowper, 2006). In fact, female veterans exposed to MST without combat exposure experience PTSD as often as men who were in combat (Murdoch et al., 2006).

Many women enter the military with a history of adult sexual abuse (33%) and child physical/emotional abuse (35%) (Lang et al., 2008). Although these women do not necessarily have PTSD upon entering military service, these individuals have significantly higher rates of developing PTSD

during military service and those women require more health care when they become veterans (Campbell, Lichty, Sturza, & Raja, 2006; Campbell & Raja, 2005; Haskell et al., 2010; Lee, Westrup, Ruzek, Keller, & Weitlauf, 2007; Murdoch et al., 2006; Sadler et al. 2004; Vogt, Vaughn, et al., 2011; Zinzow et al., 2007). Once diagnosed with PTSD, these women experience adverse physical diseases, psychological disorders, and social challenges. Physical problems include obesity, smoking, irritable bowel syndrome, fibromyalgia, chronic pelvic pain, polycystic ovary disease, asthma, cervical cancer, and stroke (Dobie et al., 2004). Female veterans have higher rates of psychiatric problems, including substance abuse and being victims of domestic violence (Dobie el al., 2004), alcoholism (Wallace, Sheehan, & Young-Xu, 2009), medical examination anxiety (Lee et al.. 2007) as well as eating disorders (Kimerling, Gima, Smith, Street, & Frayne, 2007), depression (Haskell et al., 2010), and increased rates of suicide (Kaplan, McFarland, & Huguet, 2009) compared to the general population. Many female veterans with PTSD also have poor quality of life, limited abilities to perform activities of daily living, and are homeless (Nunnink et al., 2010; Teh, Kilbourne, McCarthy, Welsh, & Blow, 2008). When female veterans present with these physical, psychological, and social chronic conditions, it is critical to complete a more holistic assessment to include past trauma and PTSD. Subsequent care may require mental health services.

Recognizing that female veterans have unique needs, several researchers identified and/or developed possible interventions designed to decrease symptoms of PTSD and promote well-being. These studies yielded limited results. Interventions included a telephone monitoring program (Rosen et al., 2006), a self-defense program (David, Simpson, & Cotton, 2006), PTSD educational/treatment sessions (Schnurr et al., 2009), mind–body intervention and massage treatments (Price, McBride, Hyerle, & Kivlahan, 2007), and case management for homelessness (Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008). The majority of these studies had small sample sizes and no controls. These interventions have been developed and tested in an attempt to reduce stress and/or enhance safety, but few have demonstrated statistically significant success in treating female veterans with PTSD and MST.

Past research has demonstrated that there are unique issues associated with female veterans, particularly in relation to MST and PTSD, but there are gaps. Women return to civilian life with many social and physical health problems. In an attempt to address these problems, intervention research has targeted health outcomes; that is, PTSD and chronic disease management, with limited success. Veterans Administration facilities now screen for MST and PTSD, and government agencies have funded research to identify and evaluate successful treatment for PTSD (Kimerling et al., 2007; Lee et al., 2007). There is a desire and available funding to help this population. What is missing is a better understanding of the context of the problem. Grounded

theory can reveal a contextual understanding of the processes that led to these health problems. The purpose of this grounded theory study is to discover the categories and processes grounded in the experience of female veterans who transitioned into, through, and out of the military.

METHODS

A Glaserian (1967, 1978) classical grounded theory method was used to explore female veteran experiences entering, serving in, and transitioning out of the military (Glaser, 1978; Glaser & Strauss, 1967). Data were collected from female veterans who served in the Gulf War and post–Gulf War era, as this marked the era when women were granted full and equal opportunity in the military. The study was approved by the University Institutional Review Board to ensure the protection of human rights.

Sample

Participants served in the Army, Navy, Air Force, and/or Marine Corps; in active duty and/or reserves/National Guard; and were enlisted and/or officers. These inclusion criteria provide a heterogeneous sample to promote variability in discovering the underlying processes. Participants were initially identified through informal networks, including both veteran organizations and professional and personal contacts, and additional contacts were identified using snowball methods, totaling 20 participants. Snowball methods identified participants living in various states. For these participants, telephone interviews were conducted to obtain data. Research has shown that phone interviews are commonly used to generate theory (Schmidt, 2010).

Procedures

Individual interviews were conducted in-person (10) or over the phone (10) from September 2010–January 2012. Participants received a consent letter, all questions were answered, and verbal consent was obtained. Interview questions were scripted to elicit experiences of transitioning into, through, and out of the military, and additional probing questions were used to reveal coping mechanisms associated with stressors (see Table 1). Interviews, lasting one to two hours, were audiotaped and transcribed verbatim. Transcriptions were verified by listening to the audiotapes to ensure data accuracy. Notes were taken during the interview and analytic memos were written after each interview and were used during data analysis. Data collection and analysis were conducted concurrently to maximize theoretical sensitivity. The initial sample consisted of eight female veterans who served in non–health care settings, as this was a new role for women in the

TABLE 1 Interview Questions

I'd like to talk about your life before you entered the military.
Describe a typical day in your life before you entered the military.
Was there any particular event(s) that stand out in those years that affect you today?
Probe: What helped you cope with [these events]? What hindered your coping?
Now I'd like to talk about your experiences entering the military.
What led you to choose to enter the military?
Describe your initial experiences when entering the military.
Describe what it was like to be a woman in the military.
Describe two experiences from your time in the military that affect you today.
Do you think you were changed from this experience? Probe: What helped you cope with these events? What hindered your coping?
Now I'd like to talk about your experiences transitioning out to the military.
Tell me your story about when you finished your military service and returned to civilian life.
What were the most challenging aspects of returning to civilian life?
What helped you when returning to civilian life?
What would have helped you during this transition?
If you had it to do over again, would you have joined the military?
Is there anything else you would like to share?

military beginning in the 1990s. Participants described their experiences of transitioning into, through, and back into civilian life in significant detail, despite the fact that some participants had experienced these transitions many years ago. Theoretical sampling led to recruiting female veterans who served in health care in primarily professional roles (4) and then staff support roles (2) so that theoretical comparisons between those who served within and external to health care could be discovered. Once clear boundaries were found between health care and non–health care experiences, additional theoretical sampling in non–health care settings where chosen to further clarify categories and subcategories

Both researchers, experienced in grounded theory methods, analyzed the data individually using constant comparison methods and subsequently compared findings to maximize trustworthiness of findings. Saturation was reached at 17 interviews, with an additional 3 interviews conducted to ensure data saturation ($n = 20$), per the Glaserian method (Glaser & Strauss, 1967). No additional categories emerged during data analysis. The sample consisted of Caucasian ($n = 13$; 65%) and African American ($n = 7$, 35%) participants. Participants served in the navy ($n = 7$; 35%), air force ($n = 6$; 30%), army ($n = 5$; 25%), and marines ($n = 2$; 10%). Participants served active duty (n = 14; 70%), reserves (n = 1; 5%), and both (n = 5; 25%). Half of the participants entered the military as commissioned officers, and 30% served in health care settings. Participants served from 2–30 years, with a mean of 16.7 years. Mean age was 45, with a range of 23-65.

RESULTS

Coping With Transitions as the Core Category

Coping with transitions emerged as the core category. This was the basic psychosocial process used by participants as they coped with transitioning from civilian role into living as a servicewoman, and transitioned out of the military, readapting to live as a veteran-civilian. Coping with transitions consists of seven phases; each phase was stressful and demanded learning new ways of coping. A schematic description of the theory with the associated categories is presented in Figure 1.

The Overall Process/Story: Coping with transitions began when participants made the decision to join the military to seek opportunities, pursue adventure, and seek safety. Their initial reaction was cultural shock that required that they adapt to the military culture and the role of becoming a servicewoman. Once a member of the military, servicewomen experienced stressors related to both being a service member and being a female service member. Being in the military included knowing military policies, experiencing the violence of war, living for the moment, and adopting the values of camaraderie and a strong work ethic. The role of being a servicewoman differed based on whether they served in health care areas or in non health care units. Those in health care did not believe they were treated differently because of being a woman. By contrast, servicewomen who served in non–health care units believed they were treated negatively because they were a female. This group of women perceived themselves being treated as inferior, and they felt demeaned, subjected to sexual assault, and felt betrayed. They described that these negative experiences resulted in their becoming hardened. Participants left the military primarily for personal reasons.

The initial transition out of the military resulted in cultural shock and feeling unprepared for civilian life, while also adapting to life as a veteran

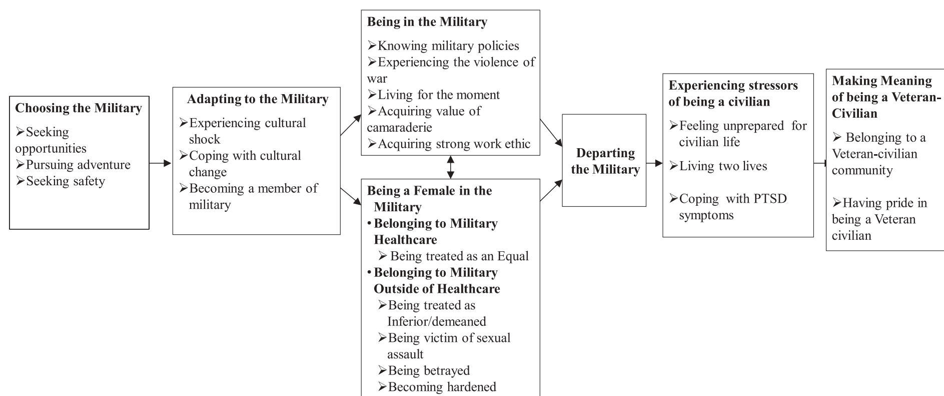

FIGURE 1 Coping with transitions from civilian to veteran-civilian.

in a civilian society. Participants also reported the stress of living with a PTSD diagnosis. In time, participants coped with their experiences by finding meaning and pride in having served in the military. Helpful coping strategies included maintaining connections with other servicemen/women and recognizing that they had personally grown as a result of their service. They felt pride in having served in the military and identified themselves as a respected leader with a strong work value. The following sections provide a detailed description of the theoretical processes and categories and subcategories. Sample data further illuminate the meaning of the categories.

Choosing the Military

Choosing the Military is the first category. Participants recalled specific reasons for entering the military that fell into one or more of the following three categories: Seeking Opportunities, Pursuing Adventure, and Seeking Safety.

Participants stated that they were *Seeking Opportunities* for their future. The military provided opportunities to pay for education, “My mom couldn’t really afford anything and I wanted to go to college,” and/or to develop a career, “The world was opening up to women, and both my parents were encouraging me to look at nontraditional careers.” Many participants grew up in military homes, and military life was viewed as a family heritage and a career opportunity. All participants entered the military during late adolescence or early young adult years and the military provided the opportunity to find independence away from home. For example, one participant explained she wanted to “take charge and do what I wanted to do instead of trying to always please my parents.”

Participants were also *Pursuing Adventure*. This included experiencing living outside their comfort zone: “I was adventurous and a little bit carefree and a little bit daring.” Participants viewed that the military was an exciting life with opportunities to travel: “I liked the idea very much of moving around that I had done as a child, living in different places in the world and in the states.” Many participants quoted the advertising slogan, “Be all you can be.”

Some participants were *Seeking Safety*, wanting the safety of a new beginning free of a life of poverty: “So freaking tired of being broke, I was tired of living day to day, the norm, I didn’t want to be, I did not want to live in the projects.” Some participants also grew up in homes where they were subjected to physical and/or sexual abuse: “I was molested from the time I was two years old until I was fourteen by a stepfather . . . no matter what was happening to me, there was nothing that was going to be as worse as that.” The military provided a safe escape.

Adapting to the Military

The *Adapting to the Military* category is a 3-step process beginning when participants entered bootcamp or officers training and ending when

they completed bootcamp/training. The subcategories in the process are Experiencing Cultural Shock, Coping with Cultural Change, and Becoming a Member of the Military.

Experiencing Cultural Shock of entry into the military described participants' initial experience. This occurred at different levels of intensity across all service branches and depending on whether they were enlisted personnel or officers. Participants who entered through bootcamp as enlisted servicewomen described the initial experience of "being yelled at," "harassed," and required to adapt to regimented activity: "Culture shock . . . very mentally tough . . . there's always someone telling you you're horrible, you're a maggot." Participants who entered as officers also experienced a "culture shock: You eat a certain way, you talk a certain way, you walk a certain way." Regardless of rank or branch, all participants experienced an initial cultural shock.

After the shock of entry, participants began *Coping with Cultural Change* of living in this new, stressful environment by numbing themselves to the experience: "I had no time to really think about it, which is probably good. . . . I was so numb. I was so blank at the time." The stress also led to weight loss. "I lost weight because I was scared to eat because I wasn't really sure what was going on and what I was supposed to be doing."

By the conclusion of bootcamp/training, participants experienced the transition and role change of *Becoming a Member of the Military*. Participants recognized that they had learned self-discipline, teamwork, and gained physical and emotional strength, transforming into servicewomen: "I am not who she [mom] sent away. I was this fighting, mean, I was great . . . mean fighting machine, I could do the PT [physical training], I could do everything. I was so excited." Participants felt pride in entering the military: "I am going to be part of my own history and it's like the feeling of being something bigger than yourself." Becoming a member of the military meant transitioning from civilian life to military life.

Being in the Military

The *Being in the Military* category began after bootcamp/training and ended prior to deciding to leave the military and lasted from one year to decades. This category occurred concurrently with the category IV: Being a Female in the Military. Participants described five unique aspects of Being in the Military.

As a member of the military, participants described the category of *Knowing Military Policies*, which were initially taught when transitioning into the military. These clear, strict rules described appropriate behavior and promotion procedures: "Making sure we wore our uniform correctly, knew how to talk to the people, the other officers and then our hospital corpsmen and making sure we knew all the ranks and everything, too." However,

participants also learned that politics can affect how policy is applied and carried out: "The forty-line [accepted rule] is designed to put out an acceptable procedure for how things are supposed to work and the fact that, in reality, there are politics that play into it." Policies provided structure, but the politics in applying the policies was a stressor.

Participants also described *Experiencing the Violence of War* regardless of where they were assigned. Those serving in combat zones experienced being shot at or seeing others killed: "One morning we went out and we didn't get hit by anything and then . . . we drove by Point A, another convoy drove by Point A and got blown up and attacked and it's like, why didn't they do that to us because we were the first ones that drove by? . . . some soldiers got killed." Some servicewomen were assigned postmortem tasks: "I worked with a mortuary team, too. So, search and recovery. So, I've picked up body parts." All knew that violence was a possibility: "Explaining to my mom my Will and Testament and what she had to sign and I couldn't explain to her, it's not that I'm going to die, it's not that I'm going to get shot but it was kind of explaining to her just in case something happens to me." Knowing that violence was inherent in the military was an additional stressor.

Participants also described an attitude of *Living for the Moment*, which included choosing adventurous assignments and traveling: "It was my first time traveling alone. I had always been an—adventurous of the heart but to actually do this you know was freeing. I felt free." This also included being impulsive and making rash decisions. Participants observed that some women became pregnant and/or married quickly, which frequently led to quick divorces: "A lot of people make a rash decision to get married because it's you either get married or you separate and it's really hard to get back together once you separate." Living for the Moment in enjoying adventure and freedom or in finding a husband became an additional stressor.

The last two categories related to *Acquiring the Values of Camaraderie* and a *Strong Work Ethic*. Participants consistently reported that camaraderie was an important value in the military: "Camaraderie-ness of the group—knowing that I wasn't in it alone . . . that is unique to the military." Military friendships were strong: "They [sailors] are people you would do anything for, that you would die for, that's how you feel in the military that you would actually die for some people." Camaraderie gave them a strong sense of belonging.

Participants also described *Acquiring a Strong Work Ethic* in the military, including teamwork: "It's one team, one mission, one fight . . . they were constantly reinforcing to me the importance of being a good person, being above reproach, always maintaining standards as a female and not getting caught up in drugs. . . . I just think that started maybe when I started recognizing values, personal values and integrity." This work value included leadership qualities of being reliable, respected, having high expectations, and earning integrity and trust: "When I was in the military I regularly

told people I am a soldier first, everything else was second. . . . Being a soldier. Being a good soldier. Being a good leader. Being a responsible individual. Being physically fit. Being a good marksman. Being reliable. Being somebody that people can count on and if you are leader, somebody that takes responsibility." Living up to high values and working hard toward a common goal served to be the fulfillment of their hope to "be all you can be."

Being a Female in the Military

Being a Female in the Military is a process that began during bootcamp and ended prior to leaving the military. This category of Being a Female in the Military consisted of two subcategories. The first subcategory described the female experiences of *Belonging to Military Health Care*. Participants who worked within military hospital environments held professional (e.g., nurse, physical therapy) and non-professional (e.g., staff support) roles, demonstrating that the culture of health care affected professionals and staff alike: Participants described Being Treated Like an Equal: "I didn't feel like there was anything different about being a female being treated any different than the men." They did not feel they were treated differently than men and stated that women were valued: "Our opportunities for different leadership positions and advancement were equal in the health care field to men."

The second subcategory described participants as *Belonging to Military Outside of Health Care* (e.g., military police, logistics). These participants experienced interactions with fellow service members, officers, and senior officials that were different than in health care environments. While women in health care environments believed they were treated equally, women outside of health care did not believe they were treated as equals. There were four subcategories that described the subprocess of Belonging to Military Outside of Health care: Treated as Inferior/Demeaned, Being a Victim of Sexual Assault, Being Betrayed, and Becoming Hardened.

Most participants described situations where they were *Treated as Inferior/Demeaned* and lived in an environment that included levels of harassment, verbal abuse, and sexual innuendoes: "I knew I was going to be challenged, every single day. . . . It seemed very much a boys club where they can use the verbal abuse, they can have the inappropriate pictures, do maybe the inappropriate touching." They stated that this environment was allowed and maintained by both peers and superiors. Not all servicemen behaved this way, but this behavior was tolerated at all levels within their environment: "They treat us like they don't want us there. They treat us like we're second class citizens . . . just bullying type behavior." This threat of being emotionally and/or sexually abused was a chronic stressor.

Participants believed being viewed as inferior by servicemen led to *Being a Victim of Sexual Assault*. Participants stated that sexual assault,

including inappropriate touching, attempted forced sexual intercourse, and forced sexual intercourse, occurred: “He grabbed me and I was in shock. I was just completely in shock. I just wasn’t expecting it or anything. It was just I kept on screaming no . . . he actually put me in the shower and washed me up and then left.” The perpetrators were servicemen, officers, or commanding officers from higher or lateral ranks downward: “He reached down and grabbed my ass and I’m like, ‘Get away,’ and I walked out of his office . . . You’re going to an EEO [Equal Employment Opportunity] officer and they do this. Who can you trust?” This behavior did not occur vertically upward; that is, servicemen did not sexually assault their female superior: “If somebody is going to mess with somebody; if a bully is going to mess with somebody they are messing with somebody junior to them. They are not going to mess with a senior officer.” Not all participants were sexually assaulted, but they all knew women who were sexually assaulted and believed this behavior was pervasive.

Participants who were sexually assaulted or knew someone who was sexually assaulted learned that reporting the incident led to being further victimized, blamed, and traumatized. For most participants, the offender had been considered a friend or was a superior officer, which led the participants feeling a sense of *Being Betrayed* by people they had trusted. Participants consistently stated that the way they were treated after reporting the sexual assault was worse than the initial attack: “I wasn’t really hurt other than a couple of bruises but the traumatizing stuff really didn’t have to do with the event, the assault itself, but all the skepticism and the bad words and the foul treatment and the traumatizing treatment afterwards.” Those who reported an incident of sexual assault were marked by superior and fellow service members as troublemakers, and this label followed them from assignment to assignment: “The bottom line, ‘get her before she gets you,’ and it was hell.”

This consistent stigmatization led to *Becoming Hardened*: “You have to learn how to like be hardened, especially being a female it’s like the ratio is 15:1.” Participants felt unsafe, resulting in needing to be wary of their peers. “I would see what was going on and always watching around me—watching my back.”

Departing the Military

Departing the Military emerged as the fifth category**.** Participants gave clear reasons for leaving the military. Most of the participants cited personal reasons including concern for their children: “My oldest was getting ready to start school and they wanted us to go to Guam, and I didn’t really want to move and so, we decided that my husband would stay in the military and that I would get out of the military.” Others wanted a normal life in the civilian sector: “I realized I didn’t want to be a 60-year-old woman with cats and nothing else in my life . . . it was time to get out and find a job

that allowed me to have a life and date in a healthy way." Some participants served their 20 years and were ready for retirement from the military: "I'm excited to retire. . . . We call it the Golden Handcuffs." Personal needs and desires were more important that continuing a military career.

Experiencing Stressors of Being a Civilian

Experiencing Stressors of Being a Civilian was the process of transitioning to civilian life upon discharge from the military. This category consisted of three subcategories: Feeling Unprepared for Civilian Life, Living Two Lives, and Coping with PTSD Symptoms.

The first subcategory, *Feeling Unprepared for Civilian Life*, occurred upon discharge and included cultural shock of having difficulties meeting the necessities of life, establishing financial stability, finding employment, and navigating the civilian systems (e.g., health care services, social systems): "I didn't even know how to find a doctor, how to go to a doctor, how to make an appointment, how to find a dentist, nothing because all that stuff in the military is completely different." Participants experienced different levels of preparedness for experiencing this transition depending on their support systems: "I didn't have a support system. I didn't have family and friends. I didn't know anybody. . . . So, it was difficult and it was very humiliating because I didn't know how to go to anybody and say I needed help."

The second subcategory, *Living Two Lives*, was a time of learning that the civilian and military sectors are separate with different social mores and values, discovering identity issues, and feeling a sense of disconnection. "When I got back I didn't realize there was such a divide between the military and people that had never served." Differences included dress and behavior: "When I first got out the military, I had a hard time with woman, civilian women. They didn't understand why I looked so militant. 'Why do you walk straight up? Why do you walk so?'" Participants found that maintaining relationships with old civilian friends was difficult because they did not have similar interests and life experiences: "I think talking to my friends from college, from childhood, I think those conversations became a little more laboring for me to have." Several participants claimed to have identity issues: "that makes you sad because you're just like, who am I? You have all of these identity issues. . . . Mainly being a woman, you have to try to teach yourself to be assertive but not to be overly assertive because when people see an overly assertive female they think oh God what happened to her." Some felt a difference in work values: "I have noticed in working among the civilian world that civilians who have never been in the military, many of them don't tend to have the same type of self-discipline or commitment to getting things done, whatever it takes." All participants described stressful experiences of feeling disconnected with civilian life. Participants adapted by maintaining this separation living as a veteran in a civilian world. These

strategies included hiding their military experiences: “In applying for the position you know you have to be careful not to mention your past . . . you can only say so much because you don’t want people to think that you’re domineering or, you know, struggling to be a female.” Others withdrew into alcohol abuse and/or seclusion: “I just went into seclusion. . . . I will deal with this on my own and it was hard. I would say that is like I hit rock bottom.” All participants described varying degrees of stressors transitioning into the civilian sector.

Many participants stated they were diagnosed with PTSD and described what they went through in the third category, *Living with a PTSD Diagnosis*. They shared experiences of sporadic symptoms of anxiety attacks, anger, depression, and aggression: “I had pretty bad anxiety, very depressed. I just felt extremely alone . . . when I got really upset and I had a glass in my hand and I started breaking the glass without realizing that it was cutting my wrist. It started cutting my wrist.” Others described a heightened sense of awareness: “I’m always scanning and not looking at the car in front of me but cars like on the side and in the rearview mirror. . . . I still have a heightened sense of awareness . . . I hate crowds.” A PTSD diagnosis was an additional stressor.

Making Meaning of Being a Veteran-Civilian

Making Meaning of Being a Veteran-Civilian. Many participants described giving meaning to their military career as a time of reflection and reconnection to military values as helpful to cope with this transition. Not all participants reached this phase of transition, as some were interviewed soon after leaving the military. Two subcategories described this process: Belonging to a Veteran-Civilian Community and Having Pride in Being a Veteran-Civilian.

In the first subcategory, participants consistently found *Belonging to a Veteran-Civilian Community* helpful to regain a sense of connection: “I think just having that common ground with the people I actually went over there with helped me transition. Again, knowing they were going through the same thing I am.” They felt comfort in being with others who have common beliefs and values and the sense of camaraderie acquired in the military: “The connection of the network of other military veterans is very important. They kind of keep you in focus.” All participants found military connections healing.

The second category, *Having Pride in Being a Veteran-Civilian*, was a time of reflecting on their military service and feeling pride, respect, and inner strength from serving in the military: “I feel very proud of what I did. I feel like being in the military has helped me to be a successful civilian, and I am a veteran.” Those participants found meaning and purpose in their military career and felt a great accomplishment with their career; they expressed

a sense of continued belonging to the military: "Well I think living a life of service is valuable. You know that the idea that it's a public service. I mean I think that speaks for itself. . . . This is a special club and community that you instantly belong to and have a role in." During this final phase, female veterans reconciled that they were veterans living in the civilian sector.

DISCUSSION

This grounded theory study provides a comprehensive description of the process of coping with transitions for female veterans. Findings from this study offer a description of the stressors participants experienced from transitioning into, through, and out of the military and their attempts to cope with these stressors. Better understanding of these experiences can provide greater insight when assessing, treating, and/or referring female veterans to health care and social services.

Findings also revealed that civilian and military sectors are widely separate, following different psychological and social rules. Transitions are difficult in bridging these two worlds. Values and lifestyles are different for women in the military and civilian sectors, and the experiences of adapting and coping to life in the military and back to civilian life are stressful. This qualitative study adds to the literature by providing a fine-grained description of the stressors many servicewomen experienced across their military career, revealing unique experiences through transition points. A unique finding was the different ways women were treated by virtue of the units in which they were serving. Those women who worked in health care were treated as peers while those who served outside of health care were treated as inferior and singled out for certain kinds of harassment and abuse because they were women.

Another interesting finding is that when encountering stressors, the women used a limited number of coping mechanisms. Either the servicewomen chose to avoid coping strategies by focusing on the present during their initial transition into the military and when experiencing the violence of war, or the women became hardened when experiencing sexual trauma and betrayal. These stressors were never dealt with, leading to further maladjusted coping strategies of seclusion or hiding their military background upon returning to civilian life, thereby contributing to PTSD. The only helpful coping strategy was camaraderie, which was consistently viewed as a positive influence.

This study also provides insight into the unique experiences of female veterans throughout their military career at developmental transition points. As all participants entered during late adolescence, Erikson's developmental theory (1959) provides additional insight into interpreting the findings. Erikson's psychosocial theory of development states that late adolescence

is the developmental phase of Identity versus Role Confusion, when adolescents are in the process of identity formation. This study describes the transition of being a civilian adolescent to becoming a young adult servicewoman and dealing with role confusion again upon returning to civilian life. Upon entering the military, females experience this developmental milestone early in their military career, beginning in bootcamp or officers training. Identifying as a servicewoman is reinforced while serving in the military. Participants' identity became challenged when they re-entered civilian life. Life patterns and values of military and civilian life were different, particularly in relation to camaraderie, rules of behavior, and work ethic. This created confusion that led to living two lives as veteran and civilian. The only way participants could maintain their identity within the civilian sector was to re-establish connections with the military, friends from the military, and veteran groups.

This study underscored the previous research findings related to military life, including significant differences in female sexual harassment, anxiety, and lack of social support in the military, as well as the prevalence of MST (Street, Vogt, & Dutra, 2009; Vogt, Smith, et al., 2011). The findings in this study expressed that MST was a traumatic event and implicated the military culture of female inferiority as the context of the violence. By comparison to the actual traumatic event, the blaming, skepticism, targeting them as promiscuous by male peers and superiors was even more traumatic. Participants knew that military policies and procedures were in place to protect servicewomen, but were not enforced in order to protect servicemen's careers and to support the value of camaraderie for men over women, resulting in servicewomen feeling betrayed.

Since completing the analysis, additional research has been published related to female veteran health, indicating that female veterans are physically sicker. They report having poor health overall (Pierce, Lewandowski-Roomps, & Silverschanz, 2011), higher LDL cholesterol levels (Vimalananda, Miller, Palnati, Christiansen, & Fincke, 2011), smoke tobacco at higher rates than men (Farmer, Rose, Riopelle, Lanto, & Yano, 2011), and avoid cancer screening (Yee et al., 2011). These women are also more frequently victims of intimate partner violence (Dichter, Cerulli, & Bossarte, 2011), and some are caught in a web of vulnerability leading to homelessness (Hamilton, Poza, & Washington, 2011). Female veterans suffer from more health-related disorders and engage in risky health behaviors more than civilian females. Better understanding the stressors and adaptive coping mechanisms associated with transitioning into, through, and out of the military can provide a deeper context for these physical and psychosocial issues.

In 2011, the Center for Women's Veterans sponsored a summit to look at female veteran issues, and also during that time, has expanded outreach to provide benefit information and resources. The VA also expanded exit seminars for all military personnel and has offered separate meetings for

women. This initiative addresses the initial shock of transitioning to civilian life (Department of Veteran Affairs, 2013), but it is unclear how successful these initiatives are in minimizing stress or promoting positive coping mechanisms. The VA also has supported initiatives to provide separate primary care clinics for women staffed with female providers, along with online services, specialty care including military sexual trauma, and complementary holistic therapies (Washington, Yano, and Horner, 2006; Yano et al., 2010). More research is needed to evaluate the effectiveness of these initiatives.

Since female veterans seek health care in both civilian and veteran health care sectors, findings can provide both VA and civilian health care professionals with a better understanding of servicewomen's social and mental health needs and insight into care practices. VA health care has developed protocols to address MST-related PTSD, but the civilian sector may be unaware of these issues. This research provides a context to better understand the unique experiences and needs of female veterans to assist in assessment, diagnosing, and referring to appropriate social and health care services.

Limitations of the study include that the study focused solely on female veteran transitions into, through, and out of the military. It does not include male experiences or male perspectives. Also, all participants entered the military during adolescence, but re-entered civilian life at different times in their lives.

CONCLUSION

Military and civilian cultures are not only different, but segregated. Veterans can choose to receive care in the VA or civilian sectors. More female veterans are opting for the latter. Many VAs are partnering with civilian providers to help reach female veterans through community-based agencies. Social workers, in particular, should assess for MST as a standard protocol when working with female veterans who were assigned to non–health care settings. Health care professionals in the civilian sector may not understand the complexity of the unique experiences and needs of female veterans. That is, many female veterans are avoiding the conflict of experiencing the violence of war, MST, and betrayal, while simultaneously feeling a deep pride and enduring camaraderie from peer veterans. They express feeling that they have grown more as a result of their military career; that is, they have experienced personal growth as a result of their multiple transitions. These findings share important insights, identifying stressful experiences, predisposing factors that could lead to PTSD, and highlight the boundaries between military and civilian cultures to help support the health of this growing population.

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REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Campbell, R., Lichty, L.G., Sturza, M., & Raja, S. (2006). Gynecological health impact of sexual assault. *Research in Nursing and Health*, *29*, 399–413.

Campbell, R., & Raja S. (2005). The sexual assault and secondary victimization of female veterans: Help-seeking experiences with military and civilian social systems. *Psychology of Women Quarterly*, *29*, 97–106.

David, W.S., Simpson, T.L., & Cotton, A.J. (2006). Taking charge: A pilot curriculum of self-defense and personal safety training for female veterans with PTSD because of military sexual trauma. *Journal of Interpersonal Violence*, *21*(4), 555–565.

Department of the Army. (March 27, 1992). *Army policy for the assignment of female soldiers* (Army Regulation 600-13). Washington, DC: Department of the Army.

Department of Veterans Affairs, Health Services Research Division. (2012). Retrieved from http://www.hsrd.research.va.gov

Department of Veteran Affairs, Women's Veteran Program. (2013). Retrieved from http://www.va.gov/womenvet/

Desai, R.A., Harpaz-Rotem, I., Najavits, L.M., & Rosenheck, R.A. (2008). Impact of the seeking safety program on clinical outcomes among homeless female veterans with psychiatric disorders. *Psychological Services*, *59*(9), 996–1003.

Dichter, M.E., Cerulli, C., & Bossarte, R.M. (2011). Intimate partner violence victimization among women veterans and associated heart health risks. *Women's Health Issues*, *21-4S*, S190–S194.

Dobie, D.J., Kivlahan, D.R., Maynard, C., Bush, K.R., Davis, T.M., & Bradley, K.A. (2004). Posttraumatic stress disorder in female veterans: Association with self-reported health problems and functional impairment, *Archives of Internal Medicine*, *164*, 394–400.

Erikson, E.H. (1959). *Identity and the life cycle*. New York, NY: International Universities Press.

Farmer, M.M., Rose, D.E., Riopelle, D., Lanto, A.B., & Yano, E.M. (2011). Gender differences in smoking and smoking cessation treatment: An examination of the organizational features related to care. *Women's Health Issues*, *21-4S*, S182–S189.

Feczer, D., & Bjorklund, P. (2009). Forever changed: Posttraumatic stress disorder in female military veterans, a case report. *Perspectives in Psychiatric Care*, *45*(4), 278–291.

Glaser, B.G. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.

Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York, NY: Aldine.

Hamilton, A.B., Poza, I., & Washington, D.L. (2011). "Homelessness and trauma go hand-in-hand;" Pathways to homelessness among women veterans. *Women's Health Issues*, *21-4S*, S203–209.

Haskell, S.G., Gordon, K.S., Mattocks, K., Duggal, M., Erdos, J., Justice, A., & Brandt, C.A. (2010). Gender differences in rates of depression, PTSD, pain, obesity, and military sexual trauma among Connecticut war veterans of Iraq and Afghanistan. *Journal of Women's Health*, *19*(2), 267–271.

Kaplan, M.S., McFarland, H.B., & Huguet, N. (2009). Firearm suicide among Veterans in the general population: Findings from a national violent death reporting system. *Journal of Trauma Injury, Infection, and Critical Care*, *67*(3), 503–507.

Kimerling, R., Gima, K., Smith, M.W., Street, A., & Frayne, S. (2007). The Veterans health administration and military sexual trauma. *American Journal of Public Health*, *97*(12), 2160–2166.

Lang, A.J., Aarons, G.A., Gearity, J., Laffaye, C., Satz, L., Dresselhaus, T.R., & Stein, M.B. (2008). Direct and indirect links between childhood maltreatment, posttraumatic stress disorder, and women's health. *Journal of Behavioral Medicine*, *33*, 125–135.

Lee, T.T., Westrup, D.A., Ruzek, J.I., Keller, J., & Weitlauf, J.C. (2007). Impact of clinician gender on examination anxiety among female veterans with sexual trauma: A pilot study. *Journal of Women's Health*, *16*(9), 1291–1299.

Murdoch, M., Hodges, J., Hunt, C., Cowper, D., Kressin, N., & O'Brien, N. (2003). Gender differences in service connection for PTSD. *Medical Care*, *41*(8), 950–961.

Murdoch, M., Polusny, M.A., Hodges, J., & Cowper, D. (2006). The association between in-service sexual harassment and post-traumatic stress disorder among Department of Veterans Affairs disability applicants. *Military Medicine*, *171*(2), 166–173.

Nunnink, S.E., Goldwaser, G., Heppner, P.S., Pittman, J.O.E., Nievergelt, C.M., & Baker, D.G. (2010). Female veterans of the OEF/OIF conflict: Concordance of PTSD symptoms and substance misuse. *Addictive Behaviors*, *35*, 655–659.

Pierce, P.F., Lewandowski-Romps, L., & Silverschanz, P. (2011). War-related stressors as predictors of post-deployment health of air force women. *Women's Health Issues*, *21-4S*, S152–S159.

Price, C.J., McBride, B., Hyerle, L., & Kivlahan, D.R. (2007). Mindful awareness in body-oriented therapy for female veterans with post-traumatic stress disorder taking prescription analgesics for chronic pain: A feasibility study. *Alternative Therapies*, *13*(6), 32–40.

Rosen, C.S., DiLandro, C., Corwin, K.N., Drescher, K.D., Cooney, J.H., & Gusman, F. (2006). Telephone monitoring and support for veterans with chronic posttraumatic stress disorder: A pilot study. *Community Mental Health Journal*, *42*(5), 501–508.

Sadler, A.G., Booth, B.M., Mengeling, M.A., & Doebbeling, B.N. (2004). Life span and repeated violence against women during military service: Effects on health status and outpatient utilization. *Journal of Women's Health*, *13*, 799–811.

Schmidt, L. (2010). Making sure: Registered nurses watching over their patients. *Nursing Research*, *59*(6), 400–406.

Schnurr, P.P., Lunney, C.A., Forshay, E., Thurston, V.L., Chow, B.K., Resick, P.A., & Foa, E.B. (2009). Sexual function outcomes in women treated for posttraumatic stress disorder. *Journal of Women's Health*, *19*(10), 1549–1557.

Street, A.E., Vogt, D., & Dutra, L. (2009). A new generation of women veterans: Stressors faced by women deployed to Iraq and Afghanistan. *Clinical Psychology Review*, *29*, 685–694.

Teh, C.F., Kilbourne, A.M., McCarthy, J.F., Welsh, D., & Blow, F.C. (2008). Gender differences in health-related quality of life for veterans with serious mental illness. *Psychiatric Services*, *59*(6), 663–669.

Vimalananda, V.G., Miller, D.R., Palnati, M., Christiansen, C. L, & Fincke, B.G. (2011). Gender disparities in lipid-lowering therapy among veterans with diabetes. *Women's Health Issues*, *21-4S*, S176–S181.

Vogt, D.S., Pless, A.P., King, L.A., & King, D.W. (2005). Deployment stressors, gender, and mental health outcomes among Gulf War I veterans. *Journal of Traumatic Stress*, *18*, 271–284.

Vogt, D.S., Samper, R.E., King, D.W., King, L.A., & Martin, J.A. (2008). Deployment stressors and posttraumatic stress symptomatology: Comparing active duty and national guard/reserve personnel from Gulf War I. *Journal of Traumatic Stress*, *21*(1), 66–74.

Vogt, D., Smith, B., Elwy, R., Martin, J., Schultz, M., Drainoni, & M.L., Eisen, S. (2011). Predeployment, deployment, and postdeployment risk factors for posttraumatic stress symptomatology in female and male OEF/OIF veterans. *Journal of Abnormal Psychology*, *120*(4), 819–831.

Vogt, D., Vaughn, R., Glickman, M.E., Schultz, M., Drainoni, M.L., Elwy, R., & Eisen, S. (2011). Gender differences in combat-related stressors and their association with postdeployment mental health in a nationally representative sample of US OEF/IOF veterans. *Journal of Abnormal Psychology*, *120*(4), 797–806.

Wallace, A.E., Sheehan, E.P., & Young-Xu, Y. (2009). Women, alcohol, and the military: Cultural changes and reductions in later alcohol problems among female veterans, *Journal of Women's Health*, *18*(9), 1347–1353.

Washington, D.L., Kleimann, S., Michelini, A.M., Kleimann, K.M., & Canning, M. (2007). Women veterans' perceptions and decision-making about Veterans Affairs health care. *Military Medicine*, *172*(8), 812–817.

Washington, D.L., Yano, E.M., & Horner, R.D. (2006). The health and health care of women veterans. *Journal of General Internal Medicine*, *21*(S3), S3–S4.

Westermeyer, J., Canive, J., Thuras, P., Thompson, J., Crosby, R.D., & Garrard, J. (2009). A comparison of substance use disorder severity and course in American Indian male and female veterans. *American Journal on Addictions*, *18*(1), 87–92.

Yano, E.M., Hayes, P., Wright, S., Schnurr, P.P., Lipson, L., Bean-Mayberry, B., Washington, D.L. (2010). Integration of women veterans into VA quality improvement research efforts: What researchers need to know. *Journal of General Medicine*, *25*(Suppl 1), 56–61.

Yee, E.F.T., White, R., Lee, S., Washington, D.L., Yano, E.M., Murata, G., Handanos, C., Hoffman, R.M. (2011). Mental illness: Is there an association with cancer screening among women veterans? *Women's Health Issues*, 21–4S, S195–S202.

Zinzow, H.M., Grubaugh, A.L., Monier, J., Suffoletta-Maierle, S., & Frueh, B.C. (2007). Trauma among female veterans: A critical review. *Trauma, Violence, & Abuse*, *8*(4), 384–400.