JOURNAL OF VETERANS STUDIES

Exploring Barriers to Mental Health Treatment in the Female Veteran Population: A Qualitative Study

RESEARCH

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VIRGINIA TECH PUBLISHING

ABSTRACT

Although female veterans are a growing population, there remains limited research on their unique experiences specifically within the United Kingdom (UK). The limited data available indicates that female veterans are at increased risk of developing mental health disorders following their discharge from the military. However, female veterans make up a small proportion of those seeking mental health treatment. This study is the first qualitative study to explore the barriers faced by UK female veterans in accessing mental health treatment. The sample of the present study took part in a larger cohort study investigating the mental health needs of female veterans. A total of 61 female veterans responded to a qualitative item on the online survey that was investigating barriers they experienced in accessing mental health treatment compared to their male peers. Responses were analysed using thematic analysis to identify key themes in the data. Five key themes were identified: access barriers, lack of understanding from professionals, gender-related discrimination, mental health stigma, and sexual orientation-related discrimination. The current findings suggested that in addition to treatment-seeking barriers experienced more generally in the military, female veterans may face unique barriers to seeking support. With little veteran research focusing solely on the needs of women, further research is needed to better understand the barriers women face in seeking support. Further attention is also required to ensure such findings are practically implemented within veteran-specific and general mental health services.

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KEYWORDS:
female veterans; mental health; treatment barriers; military

TO CITE THIS ARTICLE:
Graham, K., Murphy, D., & Hendrikx, L. J. (2022). Exploring Barriers to Mental Health Treatment in the Female Veteran Population: A Qualitative Study. *Journal of Veterans Studies,* 8(3), pp. 151–164. DOI: https://doi.org/10.21061/jvs.v8i3.323

The female population within the United Kingdom's (UK) military is predicted to increase modestly from 10% in 2016 to 13% by 2028 (Ministry of Defence, 2017, 2019). Despite women's growing prevalence, the military continues to be regarded as a male-dominated field where stereotypically masculine traits (such as strength and aggression) continue to be privileged above traits typically associated with femininity (such as emotion and caring) (Eichler, 2017). Such views often perpetuate the minority status of women in the armed forces, resulting in women being underrepresented or missing completely from veteran research (Dodds & Kiernan, 2019). In turn, this has resulted in veteran services often being tailored to the needs of men and not being appropriately equipped to address the needs of female veterans (Forces in Mind Trust, 2017; Yano et al., 2010). Many women in fact report not feeling comfortable in seeking out psychological support from veteran services and report that their unique needs often go unmet when support is sought (Mattocks et al., 2012; Thomas et al., 2017). Such findings suggest that women may face a certain set of barriers to seeking support for mental health difficulties.

In the UK military population there is evidence showing that mental health difficulties are a significant problem. UK military personnel are twice as likely to suffer from common mental health disorders (Goodwin et al., 2015) and are at increased risk of developing posttraumatic stress disorder (PTSD; Stevelink et al., 2018), as compared to the general population. Research suggests that female veterans are likely to experience higher rates of mental health disorders and medical comorbidities than male veterans (Frayne & Mattocks, 2012). Furthermore, women are more likely to report experiencing military sexual trauma (MST) resulting in a PTSD diagnosis (Kintzle et al., 2015). Although mental health difficulties are common within UK military and veteran populations, UK veterans often underuse services, with an estimated 50% seeking help for mental health problems (Greenberg, 2014; Stevelink et al., 2019). Despite a lack of data regarding treatment seeking among UK female veterans, a US study demonstrated that female veterans represented only 6% of veterans seeking support (Friedman et al., 2011). Untreated psychological difficulties are a problem within the military and can be detrimental to veterans' long-term mental and physical health (Kessler, 2000; Schnurr & Green, 2004), quality of life (Pittman et al., 2012), and relationships (Godier-McBard et al., 2021).

Previous research has identified a number of barriers to treatment-seeking within military populations: poor recognition of mental health difficulties (Britt et al., 2012), poor experience of previous treatment (Godier-McBard et al., 2021), and mental health stigma (Gould et al., 2007). Many also face practical barriers such as problems with the availability and accessibility of services (Brown et al., 2011), and long waiting times (Damron-Rodriguez et al., 2004). However, such research has often focused on male veteran samples and there remains limited research among female veterans and the unique barriers they face in accessing mental health treatment. As such, the aim of the current study was to address this gap by investigating the barriers faced by UK female veterans in seeking mental health support. In order to protect the identities of participants, participants names have been altered throughout the paper.

METHOD

PARTICIPANTS AND SETTING

Participants of the current study were sampled from a wider cohort study that explored the health and wellbeing of UK female veterans (Hendrikx et al, 2021). The initial wider study used closed questions to explore barriers to seeking support for mental health difficulties during and after military service. The questions surrounding the barriers to mental health treatment were "Compared to your male peers, during your military service did you feel there were more barriers to seeking help for your mental health difficulties?" and "Compared to your male peers, when you became veterans did you … find it harder to access the National Health Service (NHS) / veteran's charities if you needed support for your mental health?" The current study specifically focuses on the qualitative question that followed the closed questions, asking participants to report on any additional barriers they faced in accessing mental health support compared to male peers. The cohort study recruited participants from a list of women registered with a charity dedicated to supporting UK female veterans. The charity's database was searched identifying members who (a) were veterans, (b) consented to be contacted for research, and (c) provided a valid email address. Of the sample of 1,680 female veterans contacted via email, 750 (44.6%) took part in the study. The sample of the present study includes the 61 participants who responded to the qualitative question.

PROCEDURE

Data were collected using a self-report survey that was distributed via Survey Monkey. The larger study was approved by Combat Stress Research Committee (ref wrac 2020). Participants were informed of the study aims and were made aware that participation was voluntary. They were asked to provide consent and were provided with instructions on how to opt out if they no longer wished to

take part. Four email invitations were sent out directly from the female veterans' charity over a 6-week period, where reminder emails were sent to non-responders. Data was collected between August–October 2020.

MATERIALS

Participants provided sociodemographic information such as age, relationship status, and employment status. They also indicated the last rank they held at the end of their service. The participants responded to the item: "If you have experienced mental health difficulties, could you please tell us about any additional barriers to accessing treatment you experienced compared to your male peers?"

QUALITATIVE ANALYSIS

The qualitative methodology conducted was performed according to Braun and Clarke's (2021, 2006) reflexive thematic analysis (RTA) guidelines. RTA aims to analyse qualitative data through generating codes and themes based on the researchers own theoretical assumptions and background (Braun & Clark, 2021). RTA was used to identify key themes in the qualitative data collected regarding barriers to accessing treatment compared to male peers. An inductive approach was used when analysing the data to create codes and themes derived directly from the data itself and not based on prior theoretical understandings of the subject matter (Campbell, 2021). An inductive approach was decided upon due to the lack of research on this area in relation to female veterans therefore limiting the theoretical knowledge available. The reflexive context of the analysis according to Braun and Clarke (2021), was that it was conducted by a female researcher with no prior military experience, employed by a UK-based veteran mental health charity. The data was analysed using semantic level coding, whereby the researcher looked to develop codes and themes that explicitly reflect the surface meaning of the data rather than interpretive level coding (Campbell et al., 2021). Semantic level coding was deemed the most appropriate due to the lack of research in the area meaning interpreting the underlying assumptions behind the data would have been difficult.

The analysis was conducted in a six-step process as per Braun and Clark (2021, 2006): (a) each participants' transcript was read several times to become familiar with the data; (b) data was coded and refined to small sections of meaning defined by the researcher; (c) codes were collated to identify broader themes; (d) themes were reviewed by reading through the accompanying coded data and reviewing the entire data set that helped generate a thematic map of analysis; (e) themes were analysed further to clearly define the theme whereby it encapsulated the overall essence of the coded data; and (f) compelling data was extracted to support the key themes, the extracted data was analysed and the analysis was related to the key research aim.

PARTICIPANT CHARACTERISTICS

Table 1 provides the participant characteristics. Most of the sample were aged 61 and older (50.8% versus 49.2%), were heterosexual (68.5% versus 31.5%), were in a relationship (68.3% versus 31.7%), were currently working (75% versus 25%), and were not officers during their military service (88.3% versus 11.7%).

KEY THEMES

Five main themes of barriers to seeking mental health treatment were identified. Examples of supporting quotes are displayed in Table 2. Data gathered from the qualitative item varied with the average response consisting of 21.92 words and a standard deviation of 18.90. The five main themes identified comprised of: (a) access barriers including two sub-themes of lack of available support and lack of awareness of support; (b) lack of understanding from professionals; (c) gender-related discrimination including three sub-themes of not being recognized as a veteran,

VARIABLE	*n* (%)
Age group (years)	
20–50	10 (16.4)
51–60	20 (32.8)
61–70	23 (37.7)
70+	8 (13.1)
Sexual Orientation	
Heterosexual	37 (68.5)
LGBT+	17 (31.5)
Relationship Status	
In relationship	41 (68.3)
Not in relationship	19 (31.7)
Employment status	
Working or retired	45 (75)
Not working	15 (25)
Rank	
Officer	7 (11.7)
Other Rank	53 (88.3)

Table 1 Sociodemographic and Military Descriptives.

KEY THEMES IDENTIFIED	EXAMPLES OF RAW TEXT
Access barriers: Lack of support available Lack of awareness of support	"Nowhere to turn for help" "Not aware I was entitled to support"
Lack of understanding from professionals	"the general medical attitude is … you should be over it by now" "Book thrown at me" "told to man up"
Gender-related discrimination: Not recognized as a veteran Treated differently to male veterans Services are specifically designed for males	"Female veteran not recognised at my surgery" "A man would not have been treated in that way" "it is always orientated towards the male point of view"
Mental health stigma	"Felt I had to hide this and could not seek help within the service" "Treated with disdain"
Sexual orientation-related discrimination	"Discharged for being Gay made to feel worthless"

Table 2 Key Themes and Associated Quotes from raw Text.

differential treatment to male veterans, and services are specifically designed for males; (d) mental health stigma; and (e) sexual orientation-related discrimination. It is of note that within the data analysed some of the quotes fell under more than one theme therefore some quotes may appear more than once throughout the results.

THEME 1: ACCESS BARRIERS

One of the main barriers to mental health treatment was access, which was divided into two sub-themes of *Lack of Available Support* and *Lack of Awareness of Support*. Access barriers related to female veterans reporting very little or no available support in their area, therefore preventing them from accessing mental health treatment. Participants also reported that they were unsure of the support available to them as they were not given this information when seeking support.

Lack of Available Support

Participants (n = 13) highlighted the struggles they have faced in trying to access support in the UK. Participants reported that it was "extremely difficult to get help" as they felt there was "no one to help."

Nicole, a female veteran in her 70s with 16 years of service reported, "I felt unable to cope but had nowhere to turn for help. Often felt totally alone and unhappy when alone but didn't show it outside of home."

Yvette, a female veteran in her 40s with 6 years' service reported, "PTSD years after leaving the military. No help out there."

Participants also reported that when they attempted to seek support, they were often informed that support was not available in their area and therefore not accessible for them. As Emma, a female veteran in her 60s with 4 years of service noted, "PTSD female not given help, I cannot drive 20 miles for help."

It was also reported that female veterans struggled to access support as mental health services in their area were overcapacity and underfunded so were unable to take on any further referrals. Lily, a female veteran in her 70s with 6 years of service reported, "waiting for an appointment was due to lack of staff and underfunding of mental health services in this area."

Participants also reported that they felt service provision had been directly impacted by a lack of underfunding and so led to limited-service provision in addition to long wait times. Yvonne, a female veteran in her 40s with 24 years of service reported, "I could only get four free sessions." And Mary, a female veteran in her 50s with 6 years of service, stated that it was "really difficult to get any help at all, I have been waiting over 2 years."

These responses were not limited to age group but rather emerged as a barrier across age groups. A small number of veterans (n = 2) aged 61 to 70 years old specifically reported that there was "no treatment available for [them] in the 70s and 80s" and one reported, "help was not available in 1983 when [they] left."

Lack of Awareness of Support

Within the access barrier theme, a sub-theme of lack of awareness of support was identified in a proportion of the responses (n = 5). Nicola, a female veteran in her 60s with 5 years of service reported, "Never aware that I was entitled to any support." Gill, a female veteran with 5 years of service in her 60s supported this by saying "Not aware at the time that I was entitled to any particular access." Zoe, a female veteran in her 60s with 13 years of service, also reported "Didn't know there was any help."

Participants emphasized experiencing difficult feelings surrounding trying to find support for their mental health and not knowing where to turn. Catherine, in her 40s with 13 years of service reported, "Found it difficult to open up

didn't really know where to find help." Bex supported this view with "I never knew I had access to this."

Responses reflected that a lack of knowledge surrounding available mental health support prevented female veterans from accessing support. It appeared within the data that female veterans were not provided with information on where and how to access support for their mental health within the community upon discharge from the military.

THEME TWO: LACK OF UNDERSTANDING FROM PROFESSIONALS

A further key theme identified was the reported lack of understanding from professionals both within and outside the military, including general practitioners (GP) and mental health professionals. Participants reported experiencing a lack of understanding and empathy from healthcare providers (n = 12) when attempting to access support. Amanda, a female veteran in her 60s with 5 years' service, reported that "It was very difficult to get my GP to understand."

There were further reports of female veterans receiving poor treatment from medical professionals in that they were expected to overcome their difficulties by themselves without professional support. Participants reported that this poor treatment was in large due to the fact they were female and that they felt their male counterparts would not be expected to do the same. Becky, in her 60s with 20 years of combat-related experience reported,

> the general medical attitude is that "you should be over it by now" as many years have past, and that being a woman "we were not as involved as men (in deaths or combat)," so we don't know enough to be affected by mental problems.

Participants detailed their struggles to get medical professionals to understand their difficulties. Participants also reported their fears of not being taken seriously by medical professionals. And on one report, a female veteran felt that her mental health difficulties as a result of her service, were put down to her personality. Deborah, in her 50s, reported "Anxiety, always told I was highly strung." Shannon, a female veteran in her 50s with 22 years of combat-facing service detailed,

> my pride won't let me cave in when I know I should talk to someone. Bosnia messed me up along with Iraq, and I spent my first 8 years after leaving services having anxiety where I couldn't relax and even now I feel I should be on alert for something that I think should happen but never does. I feel edgy and like there's a hole in my life. I think this is on a par with the guys, but I also feel I won't be taken seriously. So I still feel like I'm stagging on and immersed in bad memories that don't fade.

There were also reports of veterans feeling they did not want to use their GP to gain support for their mental health difficulties. Britney, in her 60s, reported, "Feel that I do not want to visit GP to go through personal issues."

Participants also suggested that professionals lacked an understanding of the severity of their difficulties, which resulted in being dismissed and a focus on pharmaceutical rather than psychological treatment. They also spoke about the difficulties of receiving medication and then being left to cope by themselves. Amanda, in her 60s with 5 years of service stated, "It was very difficult to get my GP to understand and they tried to give endless antidepressants as they thought that was the answer." Tia stated, "had a nervous breakdown then was able to get some help tablets mainly." Beatrice, a female veteran in her 60s with 3 years of service reported, "I had no idea why I was given Valium at age 18 did not receive any follow up on how I was coping."

There were further reports of a lack of understanding from military professionals, which led to unprofessional encounters where their difficulties were completely dismissed. Sarah, a female veteran in her 60s with 22 years of service stated, "I was told to 'man up' when I was struggling to drive after the van I was driving had an IED go off but I was really worried in case another one was planted."

There were other reports of a lack of understanding from military professionals which even extended to when assaultive or threatening responses. Esme, a female veteran in her 70's with 8 years of service reported,

> My last days service was at [the] Hospital, before being transferred to [a hospital]. When I signed the official Secrets Act in front of [Corporal Officer] he threw my [book of service] book at me and told me to get out.

Maria, a female in her 50s with 3 years of service stated, "was told that I would have my children took off me as father was still serving am I was having mental health issues."

THEME THREE: GENDER-RELATED DISCRIMINATION

One major theme identified was gender related discrimination, which was broken down into three sub themes: *Not Recognized as a Veteran, Treated Differently to Male Veterans,* and *Services are Specifically Designed for Males.*

Not Recognized as a Veteran

Veterans (n = 6) reported that they were not recognized as veterans like their male counterparts were and often this would lead to a lack of support for their mental health difficulties that were related to their service. There were reports that due to professionals being surprised that they had served or ignoring their veteran status, they are often not recorded as veterans in their medical records. This can be problematic as it may result in female veterans not gaining access to veteran-specific services and therefore preventing access to specialist mental health support.

Carrie, a female veteran in her 50s with 12 years of combat-facing service reported, "Female veteran not recognised at my surgery although husband has been as Male veteran. People surprised I had served." Liz, in her 50s with 3 years' service, supported this by reporting "My GP totally ignores the fact that I am a veteran and has not noted this on my medical records to my knowledge." Louise, a female veteran in her 40s with 10 years of combat-facing service recalled hearing the statement, "But you are a girl, you won't have seen anything, why are you like this?"

Veterans also reported that they were often treated as the wife of a veteran rather than labelled as a veteran themselves when seeking support. Anne, in her 50s with 4 years of combat-facing service wrote, "I was married to a soldier, so I was, like all military wives, treated as 'wife of' especially when I miscarried, this was very difficult."

Participants reported that professionals have explained that this lack of recognition is due to the fact that female veterans did not serve in a conflict area and would not have seen combat first-hand. It appears that professionals often do not understand the roles female military personnel take and the experiences they go through leading to the development of mental health difficulties. Jennifer, in her 50s with 1 year of service reported, "The general attitude is that as I didn't serve in a conflict arena, I have no reason to suffer from any mental health issues." Tara, in her 20s with 6 years of combat-facing service wrote, "I have felt that females are not recognised as veterans like males are."

Differential Treatment to Male Veterans

Veterans also reported receiving differential treatment (n = 3), and often being treated poorly, by services compared to their male counter parts when seeking support for their mental health. Participants wrote about the difficulty they have had with being treated equally to male veterans when attempting to seek support. A continuation of Esme's account previously cited was, "I was suffering from a breakdown. I wasn't dishonourably discharged. I'll never forget that day. A man would not have been treated in that way." Siobhan, in her 50s with 2 years of service, reported when reaching out to professionals, "when faced with any female problem, are dismissive and condescending." Participants also reported this went as far as reporting that veteran services refused support as they did not believe that women could be affected the same way as men. Mandy, a female veteran in her 50s with 14 years of service stated,

> Was told by a national charity that I could not have PTSD because I was a woman and woman did not serve in combat. He changed his mind when he heard of my service as a [searcher for weapons and bomb making material in Northern Ireland].

It appears this difference in treatment may well link with a lack of knowledge and understanding from professionals on the military experiences of female veterans. Veterans reported that health care professionals did not understand the role of females in the military and what military service entailed. These reports were backed up by reports of some attitudes changing when presented with new evidence that females do have an active role within the military.

Services are Specifically Designed for Males

A further barrier identified was the lack of services that aim to support female veterans due to the treatment design (n = 4). Veterans reported that they felt veteran specific services were often tailored to suit male veterans and little thought was given to design a service to incorporate the view of female veterans.

Siobhan, a female veteran in her 50s with 2 years of service, stated "Everything is by and for MEN." Martha, in her 40s with 22 years of combat-facing service reported, "I find with everything you try and access it is always orientated towards the male point of view." Gwen, in her 60s with 13 years of combat-facing service also reported "male white heterosexual accepted as the norm in my day."

It appears that the perception of the military as a male-only environment has contributed to a lack of knowledge of that role females take in the military and the difficulties they can then face post-discharge. It appears this lack of knowledge may lead to services focusing solely on the needs of male veterans and therefore excluding female veterans' needs.

THEME FOUR: MENTAL HEALTH STIGMA

A further key theme identified was the barrier of perceived mental health stigma that veterans experienced when attempting or thinking about seeking support (n = 7). Participants reported fears around not being taken seriously, and often having to hide their difficulties from the military. As well as participants reporting that they chose where to seek support as they felt seeking support within the military would have led to stigma.

Katie, in her 50s with 4 years of service reported, "Depression and anxiety. Felt I had to hide this and could not seek help within the service." Joanna, a female veteran in her 50s with 30 years of combat-facing service reported, "Accessed civilian GP to avoid declaring any issues with stigma in service."

Participants reported that they often felt they received poor treatment as a result of mental health stigma when they revealed mental health difficulties within the military and veteran services. A further continuation of Esme's account was "I felt I was treated with distain." Rachel, a female veteran in her 50s with 8 years of service stated,

> Experience of service in the final 3 years, which included being sectioned when I was experiencing onset of MS caused me to feel entirely divorced from the military and veterans groups until I found [a local support group]. By that time I was a [manager] and professional adviser in [public services] with 3 degrees including a Masters and post-graduate diploma but had been written off in service as useless.

Sharon, in her 70s with 2 years of service wrote, "Nervous breakdown after death of husband at 30 and being forced out of married quarter."

Participants also reported their fears surrounding seeking support due to the potential consequences of services knowing. Maria, in her 50s with 3 years of service stated, "was told that I would have my children took off me as father was still serving am I was having mental health issues." There were also reports of self-stigma as a barrier to seeking support for their mental health. And as a result, participants reported their struggles with having to cope with their difficulties by themselves. Tina, a female veteran in her 50s with 22 years of service reported,

> Not sure about barriers, my pride won't let me cave in when I know I should talk to someone. Bosnia messed me up along with Iraq, and I spent my first 8 years after leaving services having anxiety where I couldn't relax and even now I feel I should be on alert for something that I think should happen but never does. I feel edgy and like there's a hole in my life. I think this is on a par with the guys, but I also feel I won't be taken seriously. So I still feel like I'm stagging on and immersed in bad memories that don't fade.

Elle, in her 50s with 4 years of service wrote, "I have suffered from depression and anxiety for many years. I try to not have any medication and deal with it myself."

THEME FIVE: SEXUAL ORIENTATION-RELATED DISCRIMINATION

A smaller proportion of veterans (n = 2) reported that they were treated unfairly due to their sexual orientation, which contributed to their difficulties and was a barrier to seeking support. Melissa, a female veteran in her 50s with 12 years of combat-facing service stated, "No one to help when I was discharged for being gay made to feel worthless after 12 years of service. My sexual orientation did not effect [*sic*] me from doing my job as a soldier." Gwen, in her 60s with 13 years of combat-facing service reported, "Male, white, heterosexual accepted as the norm in my day. I suffered totally from having to hide my sexuality and not being able to be 'me.'"

DISCUSSION

This study explored the barriers faced by female veterans within the UK in receiving support for their mental health. To the best of the author's knowledge, this study is the first to explore the barriers to help-seeking faced by solely female veterans within a UK sample. The qualitative analysis identified five main themes of barriers to treatment-seeking: access barriers, lack of understanding from professionals, gender-related discrimination, mental health stigma, and sexual orientation-related discrimination.

The study revealed access barriers for female veterans in seeking treatment for their mental health. Theme one included two subsections: lack of support available to female veterans and lack of awareness of the support available to them. Such findings are in line with research among male veterans demonstrating that such barriers do not appear exclusive to females (Brown et al., 2011; Koblinksy et al., 2017; Murphy & Busuttil, 2015). Findings of the present study were also in line with previous studies demonstrating long wait times created barriers in seeking mental health treatment for veterans (Owens et al., 2009). Pinder and colleagues (2010) acknowledged that the lack of communication between services and military personnel continues to threaten the progress currently being made in the National Health Service (NHS) to increase military mental health care. Unsurprisingly, the current findings also revealed that female veterans aged 61 to 70 years old reported difficulties in accessing support post-service. During the 70s and 80s the military viewed soldiers with mental health problems as "cowards lacking moral fibre" (Rozanov et al., 2019), and there was little psychiatric support available post-discharge, as mental health difficulties were believed to be related to pre-existing conditions rather than as a result of military service (Wessely, 2006). Although the military have more recently employed efforts to promote

mental health by delivering psycho-education stress management at set intervals during service (Greenberg et al., 2008) as well as providing third-location decompression (TLD) (Fertout et al., 2011) which includes rest, relaxation, as well as self-reflection and signposting to relevant services (Jones et al., 2011). It is worth noting, accessibility and availability continue to be a barrier for UK veterans, as the NHS is the main provider for veteran mental health care and recent budget cuts in the NHS have impacted the provision of mental health services (Cummins et al., 2018).

The present study revealed that a lack of understanding from professionals may create another barrier to female veterans seeking support. A lack of understanding from professionals is also reported as a common barrier among male veterans where experiences of feeling invalidated may prevent them from seeking treatment (Haskell et al., 2011). However, it can be argued that this effect is amplified in the female veteran population due to the misconceptions held around female experiences in the military. Female military personnel and veterans continue to be treated as a minority in the military where their military experiences are often not taken seriously (Ingelse & Messecar, 2016). This is due in part to the widely held gender stereotypes still present within the military where women are seen as gentle and emotionally expressive (Archer, 2013; Diekman & Eagly, 2000), and have, historically, reported hostility due to not meeting the required masculine attributes (Ebbert & Hall, 1994; Francke, 1997). Evidence suggests that the public also uphold the outdated belief that females only serve in non-combat and less "risky" roles, which results in female veteran experiences often being downplayed and misunderstood (Disabled American Veterans, 2014; Street et al., 2009). It is plausible that such beliefs around the "suitability" of females in the military may also be mimicked by civilian health care professionals, as they do not have a lived experience that represents the contrary (Morgan et al., 2015), which may result in the differential and unfair treatment of female veterans by NHS professionals. Unfortunately, such beliefs are also often internalized by female veterans and results in their believing that their difficulties are not severe enough or important to warrant support (Mattocks et al., 2012; O'Brien & Sher, 2013). It is plausible that this internalized disbelief may also relate to concerns surrounding legitimacy of problems and being labelled as a malinger by professionals (Britt et al., 2011; Keeling et al., 2017).

Participants reported not being recognized as veterans by health care professionals, which in turn may prevent individuals from being able to access veteran-specific services. These results echo that of US female veterans who feel they are not recognized as veterans and that their military related experiences are not taken seriously (Ingelse & Messecar, 2016; Koblinsky et al., 2017). This is particularly problematic, as some veteran-specific NHS services can only be accessed via a GP referral, which requires their veteran status to be recorded (Strong et al., 2018). As such, female veterans may be left to seek support from mainstream services, which have historically been ill-equipped to manage veteran-specific difficulties due to being too "complex" for primary care but "not severe enough" for community services (Macmanus & Wessely, 2013). This is particularly problematic for female veterans, as evidence indicates they have unique mental health needs separate to those of males (Conard & Sauls, 2014; Haskell et al., 2011), which are already reportedly difficult for UK mainstream services to meet (Jones, 2018).

Participants reported further gender related discrimination when seeking support for their mental health. Participants reported experiencing differential treatment, and often times unfair treatment, when compared to male veterans when seeking mental health support from military and health care professionals. This barrier may be reflected in differences in treatment for male and female veterans. For example, Feczer and Bjorkland's (2009) research found that male veterans received a much higher rate of PTSD diagnoses from veteran services compared to females. This difference was particularly apparent where females developed PTSD following a sexual assault, where they were far less likely to receive a diagnosis than male veterans, suggesting a clear gender bias in the treatment received. This is a significant finding as 14 to 43.1% treatment-seeking female veterans are estimated to experience sexual assault during military service (Butterfield et al, 1998; Sadler et al., 2005; Suris et al., 2007) and are significantly more likely to experience Military Sexual Trauma (MST) 15% compared to 0.7% for men (Kimerling et al., 2010), which is a rate significantly higher than male veterans (Martin et al., 2000). Furthermore, female veterans have been found to experience significantly higher rates of PTSD following military service compared to male veterans (Tolin & Foa, 2008), or at least PTSD and depression rates on par with male veterans (Hoge et al., 2007). Moreover, these reports may be because experiences and difficulties of female veterans are minimised or misunderstood by health professionals (Disabled American Veterans, 2014) and often female veterans report a lack of recognition from health care professionals that they may have experienced the same trauma as male veterans, i.e., combat-related trauma (Godier-McBard et al., 2021). This inequality between the treatment of male and female veterans may be reflective of attitudes that women are secondary to men in the military due in part to the collocation policy (a policy which prohibits women from holding positions where they will be physically working in ground combat; Morris, 1995). Another factor to consider with respect to the gender-

based difference in treatment may be that female veterans who have experienced gender-based violence and trauma during service feel unwelcomed and uncomfortable in veteran services, due to being surrounded by large groups of men which can lead them to feeling "triggered" (Kehle-Forbes et al., 2017, p. 6). Furthermore, veteran support services in the UK continue to be male dominated by men from previous generations (those who served pre-2000s) who do not understand the unique experiences of female veterans (Godier-McBard et al., 2022). As a result, female veterans reported feeling unheard and unconsidered by support services (Godier-McBard et al., 2022), which reflect further findings of the current study from theme two around experiencing a lack of understanding from professionals when seeking support.

The findings revealed further gender-related discrimination barriers, namely that veteran services are reportedly tailored towards males. The difficulty associated with female veterans accessing male-centric services is that they often feel uncomfortable or unwelcome (Edwards & Wright, 2019; Jones, 2018; Thomas et al., 2017) and that they are not meeting the needs of women (Kehle-Forbes et al., 2017; Kimerling et al., 2015). Consequently, this can lead to female veterans underutilizing veteran services (Thomas et al., 2017) and instead utilizing mainstream NHS services that have been developed to be more gender sensitive (Abel & Newbigging, 2018). However, as previously stated, NHS services often lack the specific knowledge and understanding required to appropriately support the female veteran population, and so may lead to many female veterans being turned away from accessing treatment. As a result, the reintegration process back into civilian life may be hindered and female veteran's mental health difficulties may be sustained (Kang & Bullman, 2008; Maguen et al., 2014).

As was identified in the current study, previous research has demonstrated that self-imposed and social stigma related to mental health treatment is common within the military population and can cause veterans to avoid seeking support (e.g., Blais & Renshaw, 2013; Mittal et al., 2013; Ouimette et al., 2011). There is a persisting association between military culture and mental health stigma (Iversen et al., 2010; Iversen et al., 2011), which may be particularly important within the female population as the stigma around female weakness may discourage help-seeking (Godier-McBard et al., 2021). Although mental health stigma is reported as one of the biggest barriers to accessing treatment for male veterans (Hoge et al., 2004), it was one of the least frequently reported themes in the current study. This may be explained by the increasing acceptability of mental health difficulties within female populations (Bradbury, 2020). As the theme in the present study was identified within a sample where majority were aged 51+, these views may be reflective of an older generation, and therefore, perhaps highlight a generational stigma that is slowly changing given the recent initiatives introduced by the UK Armed Forces to promote mental health (The Defence Committee, 2019). Another plausible explanation for the limited reporting of mental health stigma is that the research question asked participants to reflect on the barriers they faced in comparison to male veterans, and thus mental health stigma may be more of a general barrier rather than a female-specific one.

Although there have been changes to reduce sexual orientation discrimination within the military by abolishing the ban on homosexuals (Belkin & Evans, 2000), individuals identifying as LGBTQ+ continue to face discrimination in the military and there remains a lack of research investigating their experiences during service (Zaretti, 2018). The present study mirrors previous findings that female veterans often conceal their sexuality to avoid being victimized (Poulin et al., 2009) and are likely to underutilize veteran services due to concerns of being stigmatised (Lehavot & Simpson, 2013).

LIMITATIONS

There are a number of limitations to this study. Being one of the first studies to consider barriers to treatment-seeking within an all-female population in the UK, the sample size was relatively low (N = 61). This likely limits the richness of the data and the number of potential themes that could be identified. Another limitation is that the female veterans that were asked to take part were already involved with a specific female veterans' charity, and therefore the sample may be biased. Future research should look to examine responses from a variety of sources such as NHS veteran patients, other UK-based charities, and the UK military. Furthermore, it is important to acknowledge that out of the 1,680 that were sent the email, 750 took part in the survey and only 61 chose to respond to the qualitative question. The response rate is surprising given that the question asked for participant's response "if you have experienced mental health difficulties." Despite significant rates of mental illness within the female veteran population, a significant proportion having mental health difficulties and therefore feel they do not need support (Stecker et al., 2013). Such findings may be evident within the response rate of the current study. An alternative explanation may be that the female veterans that did not answer as they did not feel they faced female-specific barriers to treatment.

Due to the self-report nature of the study, the results were limited in terms of information regarding the impact of ethnicity. Unfortunately, there was a high level of missing data, and as such, the decision was made to

exclude this variable from analyses. Further research is needed to understand the possible intersections between gender, race, and barriers to mental health treatment among female veterans. Within predominantly male veteran research, ethnic minorities report a larger deterrent effect of stigma on seeking support for their mental health (Clement et al., 2015). However, there is limited research on this relationship within the female veteran population. Moreover, there was also a lack of information on participants' service in the military such as years since their service and service era. A final limitation is that the data collected for the present study involved the use of a single item. Further research using methods such as interviews are necessary to gain further insight into factors contributing to the barriers female veterans face. Nonetheless, as one of the first studies of its kind, the present study provides initial indication of some of the barriers female veterans face in seeking and accessing support.

CONCLUSION

The present study revealed that while female veterans may face many of the same barriers that male veterans face in seeking mental health support, UK female veterans may face a number of gender-specific barriers. The data highlights key areas for further investigation and improvement to dismantling the barriers faced by UK female veterans. For example, the US has taken steps within Veteran Health Administration (VHA) services to implement gender-sensitive services that has increased the use of the VHA by female veterans (Vance et al., 2020). Although the UK has a different structure, it could look to implement similar gender-sensitive strategies particularly given the extra funding veteran services has received within the NHS (National Health Service England, 2016). In addition, advertising efforts of available veteran services could be made that specifically targets female veterans would also be of benefit (Mellotte et al., 2017). Such efforts could help combat barriers such as lack of awareness of available support and may combat veteran stigma of help-seeking. Finally, such barriers could be addressed by delivering appropriate training of military and veterans within services as a way of targeting the commonly held beliefs around mental health within the military population (Dickstein et al., 2010).

ACKNOWLEDGEMENTS

With thanks to the Women's Royal Army Corps for their help in facilitating the project, recruiting participants and recommendations on the survey.

COMPETING INTERESTS

The authors have no competing interests to declare.

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TO CITE THIS ARTICLE:
Graham, K., Murphy, D., & Hendrikx, L. J. (2022). Exploring Barriers to Mental Health Treatment in the Female Veteran Population: A Qualitative Study. *Journal of Veterans Studies*, 8(3), pp. 151–164. DOI: https://doi.org/10.21061/jvs.v8i3.323

Submitted: 24 November 2021 **Accepted:** 18 July 2022 **Published:** 12 October 2022