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Exploration of the Decision-Making Process to Access and Utilize Healthcare in Women Veterans

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Exploration of the Decision-Making Process to Access and Utilize Healthcare in Women Veterans

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Previous research described the barriers that women veterans (WVs) encounter during their decision-making to access and utilize healthcare services (Hamilton et al. 2013; Haskell, 2011& Washington et al. 2011).The decision-making process for accessing and utilizing healthcare in VA and non-VA health systems by women veterans is not described in the literature. Using a grounded theory approach (Strauss et al., 1998) and embedding the Decisional Conflict Scale (DCS) to assess for decisional conflict, this study explored how and why women veterans decide to access and utilize healthcare. A purposive sample of women veterans (n = 26) was recruited through women veteran service organizations. Twenty-six semi-structured telephone interviews were conducted. *The G.R.I.T. Theory of Decision-Making by Women Veterans,* (grit, resilience, insight, and trust) emerged from the data as an explanatory theory with five major themes: being vulnerable, navigating the system, digging deep, managing my life as a veteran, and encountering barriers. The core concept, having inner resolve, reflects the foundation through which women veterans rely on for decision-making. Together the categories and core concept evoked grit. According to the GRIT theory, having inner resolve is central to finding strength while vulnerable, navigating the web of healthcare, continuing to dig deep while managing the role as a woman veteran in a civilian world, and mitigating barriers to accessing and utilizing healthcare. Results from administration of the DCS indicated that decisional conflict does not affect their decision to access and utilize healthcare. The GRIT theory has

broad implications. Interprofessional education led by schools of nursing that includes veteran centric curriculum content will assist healthcare providers (HCPs) to understand the unique and specific needs of women veterans. Nurses and HCPs who interact with women veterans may recognize the inner resolve and grit in this population and leverage it to facilitate healthcare decision-making. Future studies to expand on the theoretical components of the G.R.I.T. theory are warranted to continue the explanation of how the inner resolve of women veterans can be enriched.

This dissertation by Corinne Ann Lee fulfills the dissertation requirement for the doctoral degree in Nursing Science approved by Janice Agazio, PhD, as Director, and by Deirdre Carolan-Doerflinger, PhD, and Janet Selway, DNSc, as readers.

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Janice Agazio, PhD, Director

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Dedication

"A journey of a thousand miles begins with a single step"- Lao Tzu

The journey towards completion of this dissertation was accomplished through many steps in different places with different experiences, and including so many people. My parents, Frank and Marion Minniti walked beside me on my first single step. Their guidance and encouragement to follow my heart and heed the call to serve, care, and console those in need from a tender young age, provided me with the confidence to believe that anything I pursued was attainable. I am thankful for my sister Nicole Minniti Bohl who is always ready to deliver a cheer and with such huge belief in her big sister's accomplishments.

Accompanying me on every single step throughout this journey was my husband Gerry, whose humor and patience allowed me to feel that this was just another reachable goal. Our children, Conor and Cecelia have been incredibly understanding and patient as they watched me work towards what seemed at times, to be an insurmountable goal. I am certain their observation of my journey inspires them to "never give up" and believe that anything is possible when you put forth your heart, mind, and soul.

I also want to thank my dearest friends who would listen to me talk about my coursework and then finally my dissertation on runs, over coffee, and whenever I needed their ears and shoulders. Their genuine interest and encouragement conveys true friendship. To my colleagues at Sacred Heart University, College of Nursing for instilling their wisdom, experience, and faith in me throughout this journey.

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Finally, this dissertation journey would not have occurred without the 26 women veterans who participated in this study to share their personal stories of sacrifice and hardship for our country. I am in awe of each and every one of you! Through our conversations, your inner resolve and indomitable spirit of warriorship and survival conveyed true grit and dedication to serving our country. Thank you for volunteering to be a loud voice for the other women veterans who also deserve to receive access to quality and equitable healthcare for their physical, moral , and soul injuries, wherever they may choose!

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Chapter One

Introduction

In 2015, women represented the fastest growing segment of the U.S. veteran population (Hamilton, Poza, & Washington, 2011; Kehle-Forbes et al., 2017; Montgomery & Byrne, 2014; United States Department of Veteran Affairs [USDVA], 2017). The total veteran population in 2015 was about 21.7 million (USDVA, 2017). About 2 million, or 9.4%, of the total veteran population were women veterans (WVs). The conflicts in Iraq (Operation Iraqi Freedom [OIF]) and Afghanistan (Operation Enduring Freedom [OEF]) have encouraged an increase in the presence of women veterans (Mattocks, Haskell, Krebs, Justice, & Yano, 2011); projected growth expected to be 16.3% of the total veteran population expected by 2043 (USDVA, 2017). Further, the overall veteran population was predicted to decrease approximately 1.5% per year, while the women veteran population was predicted to increase at a rate of 1% per year (USDVA, 2017).

Women veterans (WVs) serve in every branch of the military engaged in roles that included military nurses, combat positions, fighter pilots, gunners, warship commanders, and military police (USDVA, 2012). The expansion of women's roles in the military have resulted in an increase in the number of post-deployment physical, psychological, emotional, and psychosocial challenges (Crompvoets, 2011; Fitzgerald, 2010; Johnson et al., 2013), particularly when the ban in direct combat roles was lifted in 2013 (Calhoun et al., 2016). Previous studies (Burrelli, 2013; Kehle-Forbes et al., 2017; Kelly et al., 2008; Kimerling, Street, Gima, & Smith, 2008; Maguen, Luxton, Skopp, & Madden, 2012) have reported a strong association between combat exposure and the development of psychological problems. Women veterans described in these studies described a higher physical and mental health burden in women veterans compared to their non-veteran counterparts and either equal or worse than male veterans

(USDVA, 2017). Moreover, women veterans with psychological problems, including Post-Traumatic Stress Disorder and Military Sexual Trauma (MST), may decide to delay seeking healthcare (Crompvoets, 2011; Haskell et al., 2011; Kehle-Forbes et al., 2017; Maguen et al., 2012; Street, Vogt, & Dutra, 2009; Wagner, Dichter, & Mattocks, 2015; Washington, Bean-Mayberry, Riopelle, & Yano, 2011). The perceptions of these physical and mental healthcare needs may influence WVs from accessing and receiving necessary healthcare services (Street et al., 2009). Calhoun et al. (2016) reported the association between MST with higher rates of mental health disorders. Seventy percent of the women in their study experienced some level of combat exposure and 15.7% reported MST occurring during their deployment in Iraq or Afghanistan, however, they reported that 50% of the women reporting MST had not sought healthcare.

In an effort to improve access to healthcare and discourage a delay in seeking access to healthcare, the Veterans Affairs Healthcare System (VAHS) has made efforts to improve the experiences of women veterans and improve their access to care (Crompvoets, 2011; Hamilton, et al., 2013; Haskell et al., 2011; Johnson et al., 2013; Kehle-Forbes, 2017; Kelly et al., 2008; Vogt, 2006; Washington et al., 2011). In 2010, the Veteran's Administration (VA) mandated gender-sensitive primary care for women that included women's health clinics with dedicated women's healthcare providers, female chaperones for gynecological exams, dual mental health and primary care provider locations, and other accommodations (Kehle-Forbes et al., 2017). But, due to variability in services available throughout the VAHS, 39% of WVs access healthcare services but later discontinue their care (Hamilton et al., 2013; Kehle-Forbes et al., 2017; Maguen et al., 2012).

An abundance of literature exists that described possible barriers to accessing and then utilizing healthcare by WVs at both VA and non-VA healthcare settings. Some factors described in the literature included WVs lack of knowledge about eligibility and availability, fear of stigmatization, and concern about confidentiality (Crompvoets, 2011; Johnson et al., 2013; Kehle-Forbes et al., 2017; Maguen et al., 2012). Other reasons cited in the literature included location and scheduling and childcare options that posed conflicts in appointment scheduling (Bastian et al., 2015; Swords to Plowshares Institute for Veteran Policy Institute for Veteran Policy, 2016).

While previous studies have described specific barriers to accessing or delaying access to care, a shortage of research existed to explain how WVs decided to initially access and then return for follow-up healthcare, despite the availability of healthcare services provided by VA and non-VA healthcare providers. Exploring how women veterans decided to access and continue to follow-up with healthcare in either the VA or non-VA setting can provide healthcare providers, particularly nurses, with the opportunity to develop and implement services and interventions that supported their unique healthcare needs. Moreover, an abundance of quantitative studies exist that have tested theories and examined relationships among variables including specific barriers and facilitators that influenced a WVs decision to access and utilize healthcare (Brooks, Dailey, Bair, & Shore, 2016; Cohen et al., 2009; Duggal et al., 2010; Fontana, Rosenheck, & Desai, 2010; Hamilton et al., 2013; Haskell et al., 2011; Kelly et al., 2008; Vogt et al., 2006; Washington et al., 2006; Washington et al., 2013). However, a dearth of qualitative exploration exists that might elucidate and explain the decision-making process used by WVs to access and continue to utilize healthcare. To fill this gap in the literature, a grounded theory approach using Straussian methodology and an instrument (Decisional Conflict Scale,

DCS) that explores factors involved in the decision-making process were the instruments used to gather and analyze data for this study.

Background

Introduction to the population of Women Veterans

Gender. In 2017, women represented approximately 9.4%, or 2.2 million, veterans and comprised almost 14.5% of active duty forces and 18% of reserves in the United States and Puerto Rico (Koblinsky, Schroder, & Leslie; 2017; USDVA, 2017). Their population is expected to increase at the rate of approximately 18,000 women per year over the next 10 years (USDVA, February 2017).

Race. Current racial composition among women veterans includes Caucasian (67%) African-American (25%,) Hispanic (8%), and Asian (less than 2%). The percentage of Hispanic women representing the military is expected to grow commensurate with the increase in the general Hispanic population (USDVA, 2017).

Age. The median age of women veterans was 50. Women between the ages of 17 to 24 comprised the smallest segment of WVs, whereas, women 45 to 54 years old represented the largest segment of WVs (USDVA, 2017).

Education. Twenty-one percent of all women veterans had earned a high school diploma or less as their highest level of education, compared to 40% of non-veteran women. Requirements for consideration to serve in the armed forces today require a high school diploma, although some branches will accept a General Educational Development (GED). Statistical reports (USDVA, 2017) indicated that more WVs attained a Bachelor's degree (20%) and slightly fewer earned an advanced college degree (14%).

Marital status/dependent children. Women veterans were more likely to have ever married compared to non-veteran women. In 2015, 84% of WVs were either married, divorced, widowed, or separated, compared to 72% of non-veteran women. The rate of divorce for WVs is almost twice that of non-veteran women (23.4% compared to 12.6%) with the highest rate of occurrence among those aged 55-64 years. Twenty-nine percent of women veterans with children under the age of 18 are between 25 to 44 years old (USDVA, 2017).

Income and employment. In 2015, women veterans 17 to 64 years old had higher employment rates (34%) than non-veteran women (16%). WVs (10%) were less likely than non-Veteran women (15%) to be living in poverty. The median household income for WVs aged 35-44 was $65,463 compared to non-Veteran women ($58,465). Of the employed WVs, 49.5% were employed in management and professional roles compared to 40.9% of non-veteran women (USDVA, 2017). Swords to Plowshares (2016) reported that 6% of WVs are unemployed.

Poverty and homelessness. The statistical data from the USDVA on the incidence of women veterans living in poverty reported that 10% of were living in poverty compared to 15% of non-veteran women (USDVA, 2017). However, WVs living in poverty represented the largest age group between 17 to 24 years of age. Swords to Plowshares (2016) reported that WVs were the fastest growing cohort of the homeless population. Experiences from military service, such as physical and mental health issues, difficulty with transition to civilian life, and unresolved pre-military challenges, often explain their homelessness. Montgomery (as cited in USDVA, 2016) provided data that found 4,338 women who represented 9.1% of the entire veteran homeless population. Further, it has been estimated that 1–2% of all women veterans and 13–15% of women veterans living in poverty experienced homelessness over the course of a year (USDVA, 2016). Risk factors included younger age, being unmarried, unemployed and having a recent history of

significant mental health issues including MST, depression, and Post-Traumatic Stress Disorder (PTSD).

Service to our country. Although women were not recognized as members of the armed forces until 1901, their involvement in the military pre-dates the Revolutionary War when women served on the battlefield as nurses, water bearers, cooks, laundresses and saboteurs (USDVA, 2017). Despite Army regulations banning women from enlisting in the service, those women wanting to join in battle circumvented the rules by dressing as young men or boys. It was not until World War I, when physical examinations became mandatory, that women abandoned their masquerading strategy. Through tenacity and determination to serve our country, more than 23,000 women nurses in the Army and Navy served on active duty during this conflict. The remaining branches of the military soon followed and created roles, with the exception of combat roles, that allowed women to serve alongside their male counterparts. The period of time between World War I (WWI) and World War II (WWII; 1914-1945) was not a period of equal opportunity for women, and once again, women were marginalized.

During WWII, Congress passed a bill that granted women full military status. The Women's Army Corps (WAC) was formed with other military branches soon establishing similar corps (USDVA, 2017). Following the end of WWII, 280,000 women of the approximately 12 million military members remained in the Armed Forces and recruiting for women ceased because of the lack of provision for postwar recognition. Passage of the Armed Services Integration Act in 1948 granted women recognition as permanent military servicewomen, but with the restriction of rank. The shortage of male recruits for the Korean War meant that women became an appealing population for service. Over 120,000 women were recruited and served in the Army, Navy, Air Force, and Marine Corps; approximately one-third

of them served in health care provider roles. During the Vietnam War, 90% of all women in service were nurses (USDVA, 2017). Overt recognition of the presence and contribution of women in the military continued to face challenges, particularly following the decision to cap female enlistment at 2% (Street, Vogt, Dutra, 2009).

The beginning of the Gulf War (GW; also called Operation Desert Shield) began in August 1990 and ended in June 1991 (USDVA, 2017). This conflict marked the beginning of increased responsibility and roles for women. More than 37,000 military women represented the almost 7% of U.S. forces in the Persian Gulf and the highest percentage of women serving in military combat in U.S. history (Washington et al., 2013). During GWI, 22.8% of women compared to 12.2% men served, whereas in GWII, 32.3% of women served compared to 14% of all men who served (USDVA, 2017). Moreover, the significance of women's visibility in this conflict was overshadowed by their dual role as mother and warrior. Although women were not permitted to serve in combat roles, a fine line between combat and non-combat roles existed and women were exposed to similar service-related atrocities as their male counterparts who served in combat

(Fontana et al., 2010; Katz, Bloor, Cojucar, & Draper, 2007). Many women who returned home and began their transition to civilian life experienced the physical and mental effects of combat exposure, including increased risk for PTSD, depression, and substance abuse (Swords to Plowshares, 2016).

Gulf War/Pre-911. The Gulf War conflict occurred between August 1990 and June 1991 (USDVA, 2017). The average age of women serving in this conflict was 46 and represented the highest percentage of women in conflict in military history (Washington et al., 2013). Despite serving in roles similar to their male counterparts, this was the first military campaign where mothers with children were deployed (USDVA, 2017). While women did not serve in direct

combat roles at this time, their exposures included hearing chemical alarms and physical exposure to burning trash that emitted chemicals and other environmental toxins. Exploding missiles in friendly territory presented significant mental and physical health challenges for women during this conflict. One out of every five females deployed to the Gulf War II was given a PTSD diagnosis (USDVA October, 2012). Similar to MST, PTSD often presents as a co-morbid condition, including depression and substance abuse (Haskell et al., 2011; Katz, Huffman, & Cojucar, 2017; Maguen, Ren, Bosch, Marmar, & Seal, 2010). Reportedly, depression was more common among women veterans and alcohol abuse more common among male veterans during the Gulf War II. Women veterans between the ages of 18 and 34 were three times more likely to commit suicide compared to their civilian counterparts (Conrad, Armstrong, Young, & Hogan, 2015; McFarland, Kaplan, & Huguet, 2010). Despite the availability of the Gulf War Registry health exam (USDVA, 2017) to find possible long-term health problems, the long term consequences for WVs of this conflict remain unknown.

Women veterans experienced challenges and vulnerability in previous conflicts, a fact that continued when the U.S. responded to the worst attack in our country's history on September 11, 2001. Men and women from all branches of the Armed Forces were deployed to fight for our freedom in Afghanistan (OEF) and Iraq (OIF). Women represented more than 11%, or 299,548, service members of the forces deployed in support of the operations between September 2001 and February 2013 (USDVA, 2017). These women veterans represented the largest cohort of women veterans to date.

OEF/OIF Women Veterans. Women represented the fastest growing cohort within the U.S. veteran population (Hamilton et al., 2011; Montgomery et al., 2016; USDVA, 2012); approximately 280,000 women have served in Iraq and Afghanistan, representing almost 12% of

all deployed forces (USDVA, 2017). The percentage of women veterans from OEF and OIF will continue to increase as women return from their final days of service.

The Gulf War era provided women with the opportunity to serve alongside their male counterparts in combat-related positions. Street et al. (2009) speculated that this resulted in similar military responsibilities for WVs in OEF and OIF. Although WVs served in a range of combat-related roles, including military police, medics, truck drivers, helicopter pilots and explosive ordinance technicians, the nature of military action during OEF and OIF excluded no one from safe zones. Women were placed at greater risk of combat exposure and experienced more potentially traumatic events than that had in prior military conflicts. Participation in the aforementioned roles resulted in women engaging in combat experiences, including searching for improvised explosive devices (IEDs) and providing security for combat convoys (Mattocks et al., 2012). Their combat-related traumatic experiences exceeded that of previous WV cohorts. The traumatic experiences to which WVs of this conflict were exposed resulted in greater psychological trauma than any other cohort of WVs (Haskell et al., 2011; Kelly et al., 2011; Street et al., 2009). Participants in these studies indicated that 20% reported PTSD, 14% reported depression, and others have experienced anxiety, alcohol abuse, and other behavioral health conditions (Haskell et al., 2011; Kelly et al., 2011; Street et al., 2009).

The historical summary of women's participation in the U.S. Armed Forces depicts the valiant role that women have undertaken while often being marginalized in a male-dominated institution.

Women Veterans

Women have officially served in the U.S. military since the creation of the Army Nurse Corps in 1901 (USDVA, 2017). Despite women's service in the U.S. military, they were excluded from being considered veterans (2017.

Women veterans remained a secret cohort until Congress granted formal recognition for women who served in the Women's Army Auxiliary Corps (WAAC) during World War II (USDVA, 2017). While this recognition created the opportunity for women to access programs and benefits through federal and state governments, the VA, and other Veteran Service Organizations (VSOs), issues of access, exclusion, and improper management of health care accompanied this new status. Women experienced marginalization within the historically male-dominated military institutions. They did not receive equal access to VA benefits, complete physical examinations, gynecological care, and remained misinformed of benefits guaranteed to them under law (USDVA, 2017). In addition, official recognition for women veterans did not ensure access to these benefits. Women veterans still grappled with obtaining needed services from an institution/organization designed for and dominated by males.

Establishment of Veteran Benefits

The provision of care to veterans predates the founding of the United States. Passage of a law in 1636 granted disabled soldiers in Plymouth, Massachusetts communal and governmental healthcare. The Continental Congress of 1776 offered an incentive to increase Army enlistments by promising payment to soldiers injured during service. By the 19th century, widows and children of veterans became eligible for benefits. As casualties continued to climb in the Civil, Indian, and Spanish-American Wars, Congress expanded benefits, services, and payment to soldiers and their families. In 1930, Congress authorized the establishment of the U.S. Veteran

Administration. Since its inception, the VA attained a position on a Cabinet level within the federal government (USDVA, 2017).

Today, a common misconception exists that all veterans regardless of length of time, role in the military, honorable or dishonorable discharges, are eligible to receive full healthcare benefits within the VA. However, specific eligibility requirements exist and include specific lengths of service and types of discharge. Due to the specificity of these requirements, which apply to all veterans, as well as the complicated eligibility process for receiving care at the VA, less than 50% of veterans received healthcare services within the VA system (National Center for Veterans Analysis and Statistics, 2015).

Use of VA Healthcare by Women Veterans

Although women have been recognized as a "veteran" and have received access to programs and benefits through the federal and state governments, VA, and other VSOs, issues of access, exclusion, and improper management of health care accompanied this new status (USDVA, 2015). Women veterans still grappled with obtaining needed services from an institution built around and dominated by males.

The number of women veterans accessing the VA healthcare system has increased to 80% over the past decade, yet comprised only 6.5% of VA healthcare users (Bergman, Frankel, Hamilton, & Yano, 2015). Although the VA continues to emphasize the importance of timely and continued access to healthcare to ensure optimal health outcomes (Kehle-Forbes et al., 2017; Washington et al., 2011), some women veterans continued to utilize healthcare services outside of the VA (Hamilton et al., 2011).

Washington et al. (2011) described WVs preference to use non-Veterans Affairs Healthcare System (VAHS/VA) as opposed to VA healthcare systems. Earlier studies also

reported the specific reasons for non-VA healthcare use (Crompvoets, 2011; Johnson et al., 2013; Kehle-Forbes et al., 2017; Maguen et al., 2012). Moreover, previous literature reported that 1 in 5 women veterans felt unwelcome in the VA and would often forgo pursuing healthcare at their nearest VA (Kelly et al., 2008; National Center for Veterans Analysis and Statistics, 2015; Vogt, 2006). Pursuit of healthcare in a non-VA healthcare setting may not prove satisfactory for WVs because many of those organizations lack veteran-centric knowledge. The lack of appropriate knowledge and skills may deter subsequent pursuit of healthcare (Crompvoets, 2011; Johnson et al., 2013; & Kehle-Forbes et al., 2017). This presents a pressing issue during a time when WVs constituted the highest proportion of military service members than at any other time in U.S. history and present with a myriad of unmet healthcare needs (Duggal et al., 2010).

Despite the 2010 VA mandate to improve WVs access and care satisfaction, variability and inconsistency in policy implementation at the VA has resulted in uneven access to necessary healthcare services (Bastian et al., 2015; Kehle-Forbes et al., 2017). Furthermore, this mandate focused on primary care rather than mental healthcare, such as treatment for PTSD and MST, even though rates for these psychological issues continued to escalate as women remained deployed (Kehle-Forbes et al., 2017). In 2015, the VA published the report "Study of Barriers to Care for Women Veterans" in which data from the 2010 VA mandate were provided. Of about 8,500 female veterans interviewed, 72% who had used the VA for some services said they did not use the VA clinic nearest to their home for primary care. Of those, 16% described the unavailability of gender-specific services at that clinic and 12% felt the quality of the healthcare providers did not meet their expectations. Another 60% of respondents said they placed great importance on receiving care from a women-only clinic. Sixty-two percent of survey respondents said they would find on-site child care very helpful (USDVA, 2015). Kehle-Forbes et al. (2017)

posited the possibility of continued healthcare access and utilization issues by WVs despite culture changes and environmental modifications. Studies that explained how and why WVs decided or decided not to access healthcare despite the available options remains insufficiently represented in the literature. Understanding the decision-making process and relevant factors generated new knowledge that has the potential to improve healthcare experiences for women veterans.

Use of Non-VA Healthcare by Women Veterans

Despite ongoing efforts to improve the quality and specificity of healthcare services for women veterans, the VA continues to demonstrate fragmented progress (Fitzgerald, 2010)). As noted previously, inconsistency in availability and level of service may vary across VAHS locations. According to Tsai, Mota, and Pietrzak (2015), recent national estimates from a VA report suggested that 20-24% of women veterans used VA healthcare services. Additionally, the introduction of the Veterans Choice Act in 2014 resulted in an increase in the use of non-VA healthcare services (National Center for Veterans Analysis and Statistics, 2015). Several factors discussed in the extant literature described some reasons why women veterans may not access and utilize these services. Other literature on women veterans use of non-VA healthcare services reported a range of usage between 70%- 83% of WVs accessing healthcare in a non-VA practice setting (Burkhart & Hogan, 2015; Fitzgerald, 2010; Johnson et al., 2013: USDVA, 2015). Additionally, more than 70% of OEF and OIF women veterans returned home to the care of non-military healthcare providers (Fitzgerald, 2010).

According to previous studies (Crompvoets, 2011; Fitzgerald, 2011;), a common reason for seeking healthcare in non-VA settings is the availability of gender-specific healthcare services. Interestingly, many WVs realized that their healthcare issues extend beyond gender

(Crompvoets, 2011; Fitzgerald, 2011). They suggested that their issues as military women were unique and most often, non-VA healthcare providers lacked the appropriate knowledge to manage commonly occurring health care issues among women veterans. Further, Street et al. (2009) suggested that it may be the WVs perception of their needs, perhaps affected by recent military experiences, that influenced their seeking and receiving healthcare services from non-VA healthcare providers.

Decision-Making Challenges

Current literature alludes to the historical challenges of decision-making by women veterans within the context of accessing and/or utilizing healthcare at VA and non-VA healthcare settings. Previous studies (Hamilton et al., 2013; Haskell et al., 2011; Washington et al., 2011) described attrition rates for continued healthcare utilization at the VA and reasons for less than satisfactory healthcare experiences at non-VA healthcare settings. Vacillation between choices and uncertainty over the best available options may have affected decision-making. Pate (2011) defined decision-making as "the act of generating a resolution, following the synthesis of probability outcomes, based on attitudes, beliefs, intentions, and perceived benefits" (p. 333). O'Connor (1995) described antecedent factors including verbalization of uncertainty, vacillation, knowledge deficits about alternatives and relevant consequences, emotional distress and others that hindered decision-making and may have fostered decisional conflict. Further, O'Connor defined decisional conflict as "a state of uncertainty about a course of action" (p. 25). These attributing factors may pose a hindrance on the ability by women veterans to make effective decisions that facilitated consistent healthcare access and utilization.

Previous research described specific barriers that affected access and/or utilization to healthcare by WVs in both VA and non-VA settings. However, a paucity of research exists that

described whether the previously reported antecedent factors actually affected the decision-making process to access and utilize healthcare.

Statement of the Problem

The presence of women who participate in military service continues to increase while the U.S. remains engaged in foreign and domestic conflict. Injury and illness related to military service will continue to proliferate among women veterans. The myriad of post-deployment healthcare issues will prevail while the presence of women veterans increases during ongoing military conflict.

Previous quantitative research has examined barriers and facilitators to accessing and utilizing healthcare and identified specific variables that may have affected the WVs decision-making processes. Existing studies inadequately address how and why WVs grapple with the decision to initiate and return for follow-up healthcare. Qualitative studies to explore the process of how and why a woman veteran sought and continued to use healthcare has not been explored in previous qualitative research. Recognizing the existence of barriers and facilitators, understanding the motivation and rationale of healthcare decision-making by women veterans become paramount. Unresolved issues include the absence of understanding about how a WV decides that she requires healthcare, and insufficient knowledge of the barriers that preclude the decision to seek healthcare and then return for follow-up healthcare.

These unresolved issues led to the development of a problem in which a knowledge deficit exists regarding the decision-making process of women veterans to access and continue to utilize healthcare in VA and/or non-VA healthcare settings.

The Statement of Purpose

The process of decision-making by women veterans to access and utilize healthcare is a concept not yet explored using qualitative methodology. An inadequate amount of information on this topic led to the proposal of a grounded theory (GT) research study. Straussian grounded theory (SGT) methodology (Corbin & Strauss, 1998) was proposed to collect and analyze data about the decision-making process by women veterans. The purpose of the proposed study was to explore the decision-making process WVs used to decide to access and utilize healthcare.

Research Question

The inconsistency in the access and utilization of healthcare by women veterans remains well documented in the literature. It is therefore essential to understand the decision-making process that guided their choice of healthcare when health issues developed. This research was guided by the question guiding, "What is the decision-making process used by women veterans to access and utilize healthcare?"

Theoretical Framework

Philosophical Underpinning

Pragmatism and symbolic interactionism (SI) provided the philosophical basis for this study. Pragmatism promotes the notion of reflective thinking as the way to problem recognition and resolution (Corbin et al., 1998). Through interactive dialogue and reflection with women veterans, the process of healthcare access and utilization by them may be revealed.

Symbolic interactionism (SI) utilizes a social psychology approach through analysis based on the actions and interactions of human experiences. SI focuses on shared portions of human acts and contact, meaning, and interpretation of meaning (Carter & Fuller, 2016). Personal meaning(s) that resonate with people often incite a response and meaning is often

derived through modification and interpretation of social interaction (Carter & Fuller, 2016). SGT, while rooted in SI, espouses that theory represents interpretations made from given perspectives (Kenny & Fourie, 2015).

Symbolic interactionism emerged from the pragmatist philosophy of Herbert Blumer (Kenny et al., 2015) who described three underlying principles. The first pertains to human beings acting in response to things or symbols. The second implies that meanings are not intrinsically present within entities, rather ascribed to objects, gestures, actions and ideas through social interaction, and lastly, these ascribed meanings become subject to modification as they are defined and redefined through the interpretive process (Kenny et al., 2015). This interpretive process consists of the interaction between oneself and other people, including the resultant actions. Thus the essence of this research intends to explore and understand the relationship between women veterans and the factors that affected their decision-making process to pursue and use healthcare.

Symbolic interactionism expounded on the meaning that WVs attach to healthcare access and utilization at both VA and non-VA healthcare practices. This philosophical perspective presented an opportunity to develop an understanding of WVs analysis and interpretation of symbols that lead to interpretations and subsequent behaviors that affected their decisions to access or not access and utilize health care services.

Description of Grounded Theory

Blumer (1969) described the phenomena of SI and pragmatism as best understood through face-to-face interaction with those who are involved in the event or experience. The aim of this experience becomes the focus of the interaction with the meaning of the event from those living the experience. Development of theory, analyzed from interactions between participant

and researcher, provides the foundation of GT methodology. Through these interactions, beliefs and meanings underlying actions surfaced the explanation of a person's response to particular events and life experiences (Strauss & Corbin,1998).

Strauss & Corbin (1998) suggested that openness and serendipity be present in the novice researcher when engaging in GT. Further flexibility in the approach to data collection and analysis ensures an effective process. Moreover, GT proves useful when "attempting to uncover beliefs and meanings that underlie action, to examine rational and irrational aspects of behavior, and to demonstrate how logic and emotion combine to influence how persons respond to events or handle problems through action and interaction" (Corbin & Strauss, 2015, p. 11). Strauss & Corbin (1998) argued that quantitative research methodology does not provide the necessary details about phenomena, such as thought processes and emotions, and qualitative methodology bridges that knowledge gap.

In an attempt to understand the decision-making process of healthcare access and utilization by WVs, the researcher heard about the experiences directly from the study participants. Interview questions relevant to the decision-making process addressed factors that may have affected the access and utilization of healthcare. The dearth of qualitative studies to explain the underlying process (i.e., decision-making) provided the impetus for use of Straussian grounded theory. An abundance of literature spanning many decades of research, consisted mostly of quantitative studies that measured factors affecting healthcare access and healthcare utilization by WVs wherein qualitative research explored the process and relevant factors.

Qualitative data provided abstract explanations through use of instrumentation such as an interview; an advantage to using quantitative data was its ability to generate data measuring specific variables. Integrating a quantitative instrument to gather additional information on one

potential construct of the decision-making process yielded important data not able to be collected during the interviews. The utility of a mixed method approach, embedding a quantitative measure with the qualitative interview data, provided greater breadth and depth to the research topic and enriched the theory under development (Creswell, 2013). The Decisional Conflict Scale (O'Connor, 1995) facilitated the mixed methods approach to explore decision making relevant to healthcare access and utilization in this population (Lee, 2016).

The following definitions represent the conceptual and operational measurement of terms used throughout this study.

Definition of Terms

Women Veterans

Conceptual definition: Defined as women who have served or continue to serve in the military, deployed to a combat zone as a National Guard or Reservist on active military service and discharged or released under conditions other than dishonorable status (USDVA, October 2012).

Operational definition: A woman veteran with experience in the decision-making process to access and utilize healthcare services.

Healthcare access

Conceptual definition: "The timely use of personal health services to achieve the best possible health outcomes" (IOM, 1993, p. 10). The availability, eligibility, amenability, and compatibility of healthcare (Norris & Aiken, 2006).

Operational definition: The pursuit, initiation, and action of seeking out healthcare services at either/or a VA or non-VA healthcare facility as a woman veteran.

Healthcare utilization

Conceptual definition: “The use of healthcare, qualified by the need for care; the interface between potential users and healthcare resources; the ability to seek and obtain care” (Levesque, Harris, & Russell, 2013, p. 2) and includes the outcome of the interaction between health professionals and patients (Da Silva, Contrandriopoulos, Pineault, & Tousignant, 2011).

Operational definition: The process of follow-up care or continuing use of healthcare services at either/or a VA or non-VA healthcare facility, or not returning and discontinuing healthcare.

Decision-making process

Conceptual definition: The process of making choices among competing courses of action. A process including the following steps: listing relevant choices, identifying potential consequences, determining the importance of such consequences, and combining this information to decide on the most appealing choice (O’Connor, 1995).

Operational definition: The decision-making process described the time during which a woman veteran considers her healthcare options which may be thwarted by existing barriers or motivated by facilitating factors.

Decisional Conflict

Conceptual definition: “Uncertainty about course of action to be taken when choice among competing actions involves risk, loss, or challenge to personal life values” (North America Nursing Diagnosis Association [NANDA], n.d.). Additionally, O’Connor (1995) described decisional conflict as a “state of uncertainty about a course of action” (p. 25).

Operational definition: A perceived sense of uncertainty and ambivalence in women veterans while considering their healthcare options.

Decisional Conflict Scale (DCS)

Conceptual definition: The DCS is a self-reported questionnaire with 16 items allocated to subscales that measure uncertainty, values clarity, perceived support, uncertainty, and effective decision-making (O'Connor, 2010). Responses are scored to generate a measure of each item and then a summative measure of overall decisional conflict based on a 5-point Likert-type scale.

Operational definition: A valid and reliable quantitative instrument for measuring decision-making factors thought to be relevant to WVs in accessing and utilizing healthcare services.

Operation Enduring Freedom (OEF)

Military efforts launched in response to the terror attacks by al-Qaeda on September 11, 2001. OEF commenced on October 7, 2001 and the combat mission ended on December 28, 2014. Troops remained deployed to complete a variety of post-conflict missions.

Operation Iraqi Freedom (OIF)

The objectives of OIF were to end the regime of Saddam Hussein while identifying and eradicating weapons of mass destruction. This campaign commenced on March 19, 2003 with the combat mission completed on August 31, 2010. Troops remained deployed to complete a variety of post-conflict missions.

Assumptions

The literature reviewed on women veterans relevant to the decision-making process of healthcare access and utilization led to the following assumptions significant to this study:

- WVs have unique healthcare needs based on gender and military culture.

- WVs may not return for follow-up healthcare provided at the VA given the presence of barriers that include accessibility and lack of gender- specific knowledge and gender-sensitivity.
- WVs may be dissatisfied with healthcare provided at non-VA facilities due to perceived inadequate knowledge of healthcare providers about veteran-centric issues.
- The decision-making process to access and utilize healthcare in both VA and non-VA settings depends on preconceived perceptions and assumptions.
- Decisional conflict may thwart the decision-making process.
- Active duty WVs and honorably discharged WVs perceive healthcare access issues and related decision-making in a similar fashion.

Limitations

- The sample of women veterans may be too broad and general without specifying a specific military era for the purpose of this study.
- The sample of participants could include WVs who do not recognize the importance of accessing and utilizing healthcare through either VA or non-VA healthcare providers.
- A focus on different combat eras may reveal factors affecting the decision-making process to access and utilize healthcare relevant to specific conflicts.
- Length of time post-deployment may pose a variation in the decision-making process.

- WVs who are interviewed by phone only may provide different information than women who allow observation of their body language in face-to-face interviews or video phone interviews.

Delimitations in this study include selection of Straussian grounded theory methodology to provide a conduit for explanation of the decision-making process. Other qualitative research approaches such as phenomenology might have explained the lived experience of a WV's decision-making process, but would not have provided an explanation of "how" and "why" they elect or elect not to access and utilize healthcare. Women veterans continue to be a marginalized subpopulation within the veteran community. An abundance of literature described less than optimal healthcare experiences and relevant barriers and facilitators in VA and non-VA healthcare settings for women veterans as compared to their male counterparts. Factors involved in the decision-making process rather than factors involved in accessing and utilizing healthcare remained a consistent focus in this study. A dearth of research existed that explained how and why WV decided to access and utilize healthcare despite the many available options.

Significance to Nursing

Closing the Knowledge Gap

Previous studies have reported statistical data on women veterans using non-VA healthcare services. A barrier linked to dissatisfaction with experiences at non-VA healthcare facilities is the perception of inadequate knowledge in healthcare providers, including nurses. This may thwart women veteran's decisions to access and then return for healthcare services. Nurses who provide healthcare services to women veterans in non-VA healthcare facilities require a culturally-informed practice and approach (Crompvoets, 2011; Fitzgerald, 2010; Swords to Plowshares, 2016) to meet their veteran-specific and unique healthcare issues. Further,

an understanding of the resources available, such as mental health services, employment, housing, and education in communities where WVs reside, is paramount to providing comprehensive healthcare for this population.

Knowledge related to military culture and its unique healthcare issues could facilitate an understanding of the factors that affect WVs decision-making. However, instruction on military culture is not commonly found in the curricula of nursing schools and thus may inhibit asking valuable and poignant questions during the assessment process. The American Academy of Nursing (2014) launched the campaign "Have you ever served?" to increase the awareness of the healthcare issues veterans experience. This question, asked during the assessment of women veterans, has the potential to begin dialogue about their experiences in the military and its impact on her current state of health. Nursing school faculty with an interest in and/or experience with veteran-centric healthcare are well positioned to develop course content through an interdisciplinary approach thereby providing the knowledge and evidence of best practices in healthcare delivery for veterans. Engaging the disciplines of social work, psychology, physical therapy, occupational therapy, nutritional science, and exercise science can facilitate the development of innovative educational and practice strategies. Nurses can provide direction and leadership on this initiative, fostering the creation of a comprehensive veteran-centric curricula.

Educating existing registered nurses, Advanced Practice Registered Nurses (APRNs), nursing students, and other healthcare providers only addresses one aspect of effective healthcare delivery to meet the needs of women veterans involved in the decision-making process of their healthcare choices. Contributing to the growing body of nursing science related to the care and experience of women veterans is necessary to improve their healthcare outcomes.

Contribution to Nursing Science

The existing body of knowledge on the qualitative experiences of women veterans remains limited in the nursing literature. Previous qualitative research on the decision-making process by WVs to access and utilize healthcare is also limited, but specific to utilization of mental healthcare services and decision-making by homeless Vietnam veterans (Lee, 2016). Strauss & Corbin (1998) described qualitative research as a method that provides researchers with the opportunity to understand the meaning or nature of human experiences and then offer an explanation of how and why experiences and processes occur. Straussian grounded theory (SGT) provides a conduit through which to understand a social process, such as decision-making, and through which a theory to explain concepts emerges from data collected. Effective nursing practice relies on interactive processes with patients. Through these experiences, nurses are well positioned to identify meaningful experiences and thought processes of the WVs seen in their healthcare settings.

The intention of this study was to provide nurses with a theory grounded in data that explained how and why women veterans decided to access and then return (the decision-making process) for follow-up healthcare. A theoretical explanation of the decision-making process by women veterans provides a link to practice. It is through the development of theory through which evidenced-based practice strategies may be derived and implemented at both VA and non-VA healthcare settings.

Assessing Decision-Making Potential

Nurses who see women veterans in their practice settings, including VA and non-VA facilities, recognized through their assessments and interactions, barriers that affected the WVs ability to decide on healthcare options. Earlier studies have explored barriers that affected decisions by WVs in selecting healthcare options. Some of the barriers included uncertainty of

veteran status and eligibility, geographical challenges, perception of inadequately prepared healthcare providers, at both VA and non-VA healthcare facilities. These barriers may impose a state of uncertainty about the best course of action to pursue. O'Connor (1995) described this state of uncertainty as decisional conflict in the presence of making choices that involve risk or uncertain outcomes, vacillating between choices, presence of emotional distress, perceived pressure from others who may impose their view of best options, delaying decision-making, and questioning personal values and beliefs while attempting decision-making. Earlier research (Fontana et al., 2010; Hamilton et al., 2013; Haskell et al., 2011; Kehle-Forbes et al., 2017; Kelly et al., 2008; Street et al., 2009; Washington et al., 2007; Washington et al., 2013; Vogt et al., 2006) described the aforementioned factors and other influencing factors related to the access and utilization of healthcare by WVs.

Nurses can reduce the level of decisional conflict that may be a factor in the decision-making process. This occurs through provision of knowledge, exploration of meaningful experiences, value clarification, collaborating with other healthcare providers such as social workers who can probe further into the aforementioned concerns. The Decisional Conflict Scale (DCS; O'Connor, 1995) is a reliable and valid instrument that measures the presence and level of decisional conflict. Use of this instrument as an assessment tool would be valuable to nurses working with WVs who may demonstrate difficulty with decision-making choices relevant to their healthcare options.

Patient decision aids (PtDA) are tools, such as pamphlets and brochures that assist patients in decision-making relevant to treatment options (Ottawa Hospital Research Institute, 2018). PtDAs involve patients in the decision-making process in collaboration with a healthcare provider. Many PtDAs exist for the decision-making required in the treatment of acute and

chronic disease conditions, and more recently end-of-life care. To date, a PtDA does not exist for veterans, specifically women veterans. Availability of a PtDA for nurses who provide care to WVs would assist the women veterans to make informed decisions that align with their military culture and personal values and preferences.

Change and Influence through Policy

Improving healthcare through policy changes predates contemporary nursing. Reflecting on the mid-19th century, Florence Nightingale transformed care for soldiers in the Crimean War with recommendations on environment and hygiene changes (Selanders & Crane, 2012). Ms. Nightingale's effort marked the beginning of policy change in nursing. To that end, nurses must remain politically active through involvement in the political process at the local, state, and national level.

In 2015, the American Academy of Nurse Practitioners (AANP) urged Congress to grant APRNs full practice authority at all VA facilities (AANP, 2016). Full-practice authority by APRNs will expedite provision of healthcare for veterans thereby decreasing healthcare disparities and improving healthcare access. A report from the Institute of Medicine (2010) supported the involvement of nurses practicing to their full extent of their education and recognizes the role that nurses have in transforming the U.S. healthcare system.

Nurses working with women veterans must identify and engage stakeholders at both the VA and non-VA facilities. Implementing any practice change related to veteran healthcare, specifically for women veterans, requires their interest and buy-in. Identifying key stakeholders will facilitate implementation of evidence-based practices derived from a growing body of scientific knowledge relevant to the healthcare of women veterans.

Conclusion

Previous quantitative studies described the many obstacles WVs experienced in accessing healthcare through both VA and non-VA facilities (Duggal et al., 2010; Haskell et al., 2011), yet an exploration of the decision-making process that may explain why and how WVs decide or decide not to receive healthcare remains limited in qualitative research studies. Most studies on women veterans have included observational/descriptive quantitative methodology. However, improvement in the provision of healthcare services for WVs requires an understanding of their needs and preferences. Information gleaned through qualitative studies will inform healthcare providers on factors that might impact the decision to access and utilize healthcare.

The number of women veterans who continue to serve our country in tours of duty will continue to increase while the dissension within the Middle East endures. WVs will return home with myriad physical, psychological, and emotional challenges in the post-deployment phase of their service. Previous research reported the impact that specific experiences had on women veterans' decisions to access and utilize healthcare.

An insufficient amount of qualitative research exists that might explain how and why WVs decide to access and/or utilize healthcare services in the presence of treatment options and existing barriers.

Chapter Two

Review of the Literature

Introduction

The literature review for this study expanded on the breadth and depth of contributing factors that may hinder the decision-making process by women veterans to access and utilize healthcare. A review of relevant studies provided the opportunity to critically assess, critique, analyze and synthesize existing studies relevant to this study. Sections addressed in this review include (a) healthcare issues in women veterans, (b) healthcare access, (c) barriers to healthcare access by women veterans, (d) healthcare utilization by women veterans, (e) decision-making, and (f) a summary of the aforementioned areas.

A search for literature relevant to this research study was conducted in nursing, medical, social work, and public health literature using the databases CINAHL, PROQUEST, and Google Scholar. Reviewing dissertations on topics including women veterans assisted in determining potential study focus redundancy as well as snowball retrieval of text using dissertations and relevant journal articles. The review of the literature began by using Google Scholar with the following search terms, "decision-making in women or female veterans," which retrieved 173,000 studies. Narrowing the search strategy in CINAHL with the search terms, "healthcare utilization OR healthcare use by female OR women veterans" identified 737 studies. Further search for studies included the following series, "Healthcare Access" AND "Women Veterans" OR "Female Veterans" returned 99 titles. Publication year parameters were restricted to 2000-2018. Abstracts were reviewed to determine relevance to the topic of interest and this proposed research. Snowball retrieval of texts using the reference list of dissertations and relevant journal

articles completed this search. Relevant articles emerged as exemplars were included in this literature review.

Healthcare Issues in Women Veterans

Previously described demographics contributed to an increased prevalence of healthcare challenges unique to women veterans that will continue to rise during post-deployment. Nearly 56% of women veterans have a service-connected disability, such as injury or illness, occurring or worsening during service (Womenshealth.VA.Gov, 2016) and is expected to increase while participation in service continues.

Women veterans have greater physical and mental health burdens compared to their non-Veteran counterparts (Crompvoets, 2011; Fitzgerald, 2010; Womenshealth.VA.Gov, 2016). A significant prevalence of chronic disease exists and includes PTSD, hypertension, depression, hyperlipidemia, chronic low back pain, gynecologic problems, substance abuse, alcoholism, and diabetes mellitus (Fitzgerald 2010; Fontana et al., 2010; Johnson et al., 2013). Table 1 depicts commonly occurring physical and mental healthcare issues associated with specific eras of service.

Table 1

Healthcare Issues by Military Service Era

Military Conflict	Commonly Associated Health Issues
WWII and Korean War	Injuries related to prolonged exposure to cold climate such as Raynaud's Phenomenon and other neurological changes (numbness and tingling, frostbite)
Vietnam Veterans	Malignancies related to exposure to Agent Orange; Gynecological cancers, fertility issues, and pregnancy difficulties; MST, PTSD, depression; ischemic heart disease
Gulf War	"Gulf War Syndrome"- chronic fatigue syndrome, unspecified neurological disorders, skin disorders, neuropsychological disorders and gynecological issues
OEF/OIF	Polytrauma, traumatic brain injury (TBI), musculoskeletal issues, joint disorders, MST, PTSD, reproductive health issues, depression, hearing disorders, skin disorders, transitional issues with civilian life

Note. Descriptions derived from USDVA (2017); Haskell et al., (2011); Vogt et al. (2005); and Washington et al. (2013).

Some of the challenges presented overlap within the conflicts. However, a consistent finding throughout the literature review revealed that the most significant healthcare issues unique to women veterans, from recent and past conflicts, included military sexual trauma (MST) and post-traumatic stress disorder (PTSD). A concern among WVs who did not receive healthcare services for MST and PTSD was the increased prevalence of homelessness within this population (Hamilton et al., 2011; Montgomery & Byrne, 2014; Pavao et al., 2013) which presented another potential healthcare issue for WVs. This section of the review focuses on these issues and provides further insight into how they may affect the

decision-making process to access and utilize healthcare specific to military sexual trauma, post-traumatic stress disorder, and homelessness.

Military Sexual Trauma (MST)

MST refers to trauma from both sexual harassment and sexual assault occurring in military settings. The VA adopted this term to describe repeated sexual assault experiences while in training or on active duty (USDVA, October 2012). In 2014, there were an estimated 28 sexual assaults every day (Swords to Plowshare Institute for Veteran Policy, 2015). Other studies reported that 40% of women were victims of MST (Haskell et al., 2011; Kimerling et al., 2008; Swords to Plowshares, 2015). According to Fitzgerald (2010), the majority of women veterans experienced some degree of MST and the incidence of sexual harassment was reported at 75-80% among women in the armed forces. Often these cases were unreported due to shame and fear of retaliation and a lack of faith that appropriate action would be taken following a reported incident (Fitzgerald, 2010). Sixty-two percent of women reported some level of retaliation, including 53% who reported social retaliation, 32% who reported professional retaliation, 35% who reported adverse administrative action, and 11% who were punished for an infraction in 2014 (Johnson et al., 2013).

MST is not limited to women veterans of recent military conflicts, including Iraq and Afghanistan. A cross-sectional descriptive mixed-methods approach study (Wolff & Mills, 2016) explored the MST experiences of WVs (n = 52) who served in conflicts from World War II to OEF and OIF. Further, the researchers explored the challenges faced by the WVs when seeking healthcare. Of the 52 participants, 90% experienced at least one form of MST, 15% attempted to report the incident, but the majority remained silent due to fear of retaliation by their perpetrators. Women veterans in this study expressed a sense of betrayal by government

organizations and a mistrust of healthcare providers. These factors were described as creating a barrier to seeking healthcare at both VA and non-VA healthcare settings. Qualitative research methodology provided WVs with the opportunity to share their insight on the process through which their decision-making may occur. Factors such as uncertainty about the repercussions of reporting MST may have contributed to the barrier for health care access. However, questions during the interview process explored behaviors beyond the "why" and extend to the "how" women veterans decided to report their experiences.

Wolff and Mills (2016) reported that MST experiences spanned decades of WVs military involvement. Exploring women veterans' experiences, such as MST, and their decision-making relative to those experiences can inform health care providers about the need for interventions and other strategies to assist their WV patients.

A qualitative study of Vietnam and post-Vietnam (1975-1998) women veterans with self-reported trauma histories was conducted to obtain a richer understanding of their challenges receiving VA healthcare (Kehle-Forbes et al., 2017). Grounded theory methodology guided this study through semi-structured interviews (n = 37) to explore factors affecting women veterans' access to healthcare at the VA. The authors cited previous literature that described WVs access to healthcare, but not returning for follow-up care. One reason for lack of follow-up included general dissatisfaction with the VA. However, exploration of how WVs decided on next steps for healthcare access and/or follow-up care was not included in the questionnaires; therefore this information was not available. Factors that impacted WVs access included dissatisfaction with perceived flaws in the VA healthcare system, which mirrored extant quantitative literature relevant to gaps in VA healthcare. However, more current literature failed to address qualitative

research methodology that explored how a woman veteran decided to not return for follow-up healthcare, at either a VA or non-VA healthcare setting. This researcher's study addressed the gap in research literature by exploring the decision-making process involved in accessing and/or utilizing healthcare services. Understanding this process before measuring any variables involved would be fundamental to improving healthcare for women Veterans.

Calhoun et al. (2016) examined the association between MST and use of VA and non-VA healthcare services among WVs who had served in Iraq or Afghanistan. The study authors reported that an insufficient amount of research exists that examines the association between MST and healthcare access and utilization among WVs, particularly among those who served in OEF and OIF. Utilizing a modified Dillman procedure, participants (n = 185) responded to a mailed survey that queried WVs for demographics, combat exposure, MST, PTSD, depression symptoms, and health service utilization. The authors hypothesized that experiencing MST would result in an increased use of healthcare services. More than half (52%) of the women who reported a history of MST were not using any VA healthcare. This study did not address healthcare utilization at non-VA facilities and therefore the findings cannot be generalized to that source of healthcare. The study authors suggested that continued outreach and education be made available to WVs through the VA. However, previously described statistical data (Washington, 2006; 2011) noted that many WVs are not accessing and utilizing healthcare at the VA and consequently will not receive the necessary resources.

The implications of this study underscore the importance of understanding why WVs decided or did not decide to access and utilize healthcare. Data collected and analyzed through interviews with WVs will inform healthcare providers, particularly nurses, on the factors involved in WVs decision-making processes.

Summary

Many healthcare challenges remain in the lives of WVs. The role of these challenges as barriers to accessing and utilizing healthcare have been examined in previous literature (Cohen et al., 2009; Haskell et al., 2011; Vogt, 2011). Post traumatic stress disorder (PTSD) often occurs as a result of MST. Burkart & Hogan (2015) described previous research that identified an association between MST and PTSD. Approximately 19% of women veterans were victims of sexual assault and or abuse prior to entering the military; they entered the military hoping to escape a potentially vulnerable situation (Cohen et al., 2009; Haskell, 2010, Vogt, 2011). Prior studies indicated that approximately 10% of the WV population had been diagnosed with PTSD (Maguen et al., 2012).

Post-Traumatic Stress Disorder in Women Veterans

The American Psychiatric Association (2013) described post-traumatic stress disorder as the presence of chronic symptoms that lasted more than one month and included specific recollections and re-experiencing of traumatic events, persistent avoidance of stimuli associated with such events, negative cognition and dysthymic mood, and persistent symptoms of increased arousal not present before the traumatic event. It is directly connected to a variety of negative mental and physical health outcomes for WVs that include suicidal ideation, suicidal attempts, and worsened overall physical health for WVs (Haskell et al., 2011; Katz, Huffman, & Cojucar, 2017; Levahot, Simpson, Der-Martirosian, Sadler, & Washington, 2013; Maguen et al., 2012). In addition to comorbid health conditions, additional consequences of PTSD exist.

PTSD in women Veterans is associated with negative reproductive outcomes, including sexually transmitted diseases (STDs,), dysmenorrhea, endometriosis, abnormal pap smears, and infertility (Cohen et al., 2009). The behaviors of increased risk-taking, increased substance use

and neglect of necessary gynecological services increased the prevalence of these outcomes (Cohen et al., 2009; Crompvoets, 2011; Feczer & Bjorklund, 2009).

Rivera and Johnson (2014) reviewed the historical and recent knowledge of the physical and mental health issues experienced by OEF and OIF women veterans. Through their search of the literature, two prevailing themes emerged, gynecological and psychological issues. They found the risk for PTSD among this cohort of WVs was twice that of their male counterparts. Additionally, untreated PTSD has been associated with other mental health problems, such as depression, anxiety, eating disorders, and suicidal ideations. The study authors reported that similar to screening and treatment programs for PTSD, programs to identity the aforementioned sequelae are also lacking.

A national, cross-sectional, observational study of WVs (n = 3,611) conducted by Levahot et al., (2013) sought to examine the unmet medical needs and barriers to healthcare among WVs who screened positive for PTSD, current depressive symptoms, or both. The study authors examined the prevalence of unmet medical needs, reasons for those unmet needs, and barriers to using VA care. The results indicated that 59% of WVs had unmet needs. Barriers and reasons for going without or delaying healthcare included lack of knowledge related to VA eligibility and affordability. A major limitation of this study involved the VA dataset used as it included only VA users. While an advantage to using this dataset exists, whereby access to many WVs provides a large sample of study participants, these WVs do not represent a large segment of the population of WVs who experienced similar health disparities. Therefore, these findings cannot be generalized to most of the WV population who may consider accessing and utilizing healthcare services in the presence of barriers.

Koblinsky et al. (2017) acknowledged that quantitative studies have identified barriers that affected a WVs access to healthcare and recognized the dearth of research in which women were asked to describe the factors that might improve the quality of healthcare and thus increase the likelihood of accessing and utilizing healthcare. Twenty-nine OEF and OIF WVs were interviewed through a grounded theory approach. Questions included, "What advice would you give mental health professionals who are treating women Veterans?" and "How could VA or civilian clinicians improve care for women veterans who experience depression, PTSD, or other mental health conditions?" Saturation of major themes was achieved after five groups. Trustworthiness and authenticity of the data were ensured through interviews with three additional women veterans of OEF and OIF, one of whom added detail to several emergent themes. The coding process resulted in three thematic categories: (a) Therapeutic Relationship, (b) Clinical Care Environment, and (c) Health Care System. Major recommendations suggested by the WVs included the importance of establishing therapeutic relationships with their healthcare providers, increasing non-VA healthcare provider's knowledge of military culture, and increasing the availability of community-based support programs and other.

Significance of the Koblinsky et al. (2017) study to this research includes the affirmation of the need to conduct qualitative research to understand the interpersonal dynamics that occur within the WV population and the context in which they occur. Exploring how and why WVs decided to access and return for follow-up care can occur when a therapeutic relationship exists. Understanding the factors that affected those decisions remains paramount to improving their access and utilization of healthcare, thereby improving their health outcomes and quality of life. Finally, the study authors recommended future studies to explore how and why unmet needs exist and the development of appropriate screening tools.

Summary

Previous studies have explored and described the antecedent factors involved with MST and PTSD. However, experiences with MST and PTSD are associated with numerous mental and physical consequences that include obesity, weight loss, substance abuse (Crompvoets, 2011; Burns, Grindlay, Holt, Manski, & Grossman, 2014; Fitzgerald, 2010; Johnson et al., 2013), PTSD from MST, depression, sexually transmitted diseases, and sexual dysfunction (Kimerling, Street, Pavao, & Smith, 2010; Swords to Plowshares Institute for Veteran Policy, 2015; Turchik, Pavao, Nazarian, & Iqbal, 2012). Fayne, as cited in Fitzgerald (2010), reported that older women veterans who experienced MST may experience a variety of seemingly unrelated diagnoses such as breast cancer, heart disease, obesity, and pulmonary disease, indicating that MST is not limited to women veterans of recent or current military experiences.

Consequences that accompany both MST and PTSD increase the chances of WVs experiencing unemployment, potential disability, substance abuse, and adjustment disorders, thus causing difficulty finding work after discharge from the military. This cascade of events contributes to the increased risk of homelessness in women veterans.

Homelessness

The fastest growing segment of the homeless veteran population today is women (Pavao et al., 2013; Perl, 2015; Washington et al, 2010; womenshealth.VA.Gov, 2016) who have been reported to be 2.1 times more likely to be homeless than their non-Veteran counterparts (Perl, 2015). Hamilton et al. (2011) reported that at the time of their research this number will continue to increase particularly among younger WVs from OEF and OIF. The U.S. Department of Housing & Urban Development (HUD; as cited in Montgomery, 2016) identified 4,338 women veterans who were experiencing homelessness, comprising 9.1% of the entire Veteran homeless

population. Further, it is estimated that 1–2% of all women veterans, and 13–15% of women veterans living in poverty, experienced homelessness over the course of a year. These statistics, combined with those describing WVs access to healthcare at non-VA facilities, validates the need to understand how all WVs, regardless of their residential situation, decided for or against accessing essential healthcare services. Early identification of factors that affect decision making through discussion with WVs may lessen these alarming homelessness statistics.

In a case-control study of non-institutionalized homeless women veterans (n = 33) and age-matched housed women veterans (n = 165), Washington et al. (2010) examined health, health care, and factors associated with homelessness. The results of the study indicated that MST, being unemployed, screening positive for an anxiety disorder and/or PTSD were significant ($p < .01$) and independent predictors of factors associated with homelessness. The researchers suggested that interventions aimed at alleviating homelessness may be accomplished through improved access to healthcare.

However, having access to healthcare may not prevent homelessness (Hamilton et al., 2011; Montgomery et al., 2014; Pavao et al., 2013; Washington, 2010). Understanding why WVs decided to access healthcare and discontinue or not return for follow-up healthcare has the ability to assist healthcare providers in developing interventions and services that support their preferences. Timing of this exploratory discussion between healthcare providers and WVs remains critical for intercepting the trajectory of potential homelessness.

Pavao et al. (2013) estimated the prevalence of MST by examining the association between MST and mental health conditions and describing health care utilization among homeless veteran men and women. Utilizing a national, cross-sectional study of 126,598 homeless veterans (women veterans, n = 8,915), 39.7% of women had experienced MST.

Further, WVs who experienced MST demonstrated a significantly higher likelihood of many other mental health issues including depression and PTSD. The authors concluded that the availability of VA programs for the homeless and access to mental health care for veterans with MST needed to remain a priority. Moreover, they suggested that future studies focus on mental health outcomes for veterans affected by MST. To date, quantitative research has been used to investigate the relationship between healthcare access/utilization and homelessness among WVs. A dearth of qualitative studies, particularly non-sponsored studies from non-government agencies presented a gap in the literature. Identifying risk factors for homelessness and measuring attendant variables remained critical to broadening an understanding of the potential hardships of the WV. However, exploring, hearing, and observing the experiences directly from a WV provides the healthcare community (particularly nursing) with knowledge that explains how WVs make healthcare decisions that inevitably impact their quality of life.

An observational study by Decker, Rosenheck, Tsai, Hoft, and Harpaz-Rotem (2013) compared clinical symptoms and treatment preferences among women veterans (n = 509), with and without MST, who enrolled in 11 VA homeless programs for WVs. Forty-one percent of WVs in this study reported MST. Using multivariate analyses, the authors found that homeless WVs who experienced MST had greater severity of PTSD and other psychiatric symptoms. Further, those who had experienced MST were more likely to report interest in treatment.

The results of Decker et al., (2013) described the prevalence of homelessness in WVs with MST and recommended the examination of treatment preferences for those seen at VA facilities. However, Washington, Farmer, Mor, Canning, and Yano (2015) described a

significant segment of WVs receiving healthcare in non-VA settings. Discussion of how and why WVs elected to access and return for follow-up healthcare (utilization) in the presence of treatment options at both VA and non-VA healthcare settings should inform healthcare providers on the development of best practices to satisfy the treatment preferences of WVs.

Statistics on the relationship between homelessness and MST, and MST and subsequent mental health sequelae, were well documented by the U.S. Department of Veteran Affairs and other Veterans Service Organizations (VSOs). Previous research described access to healthcare as the solution to ameliorate healthcare issues such as MST and potential consequences, including homelessness. However, current studies failed to demonstrate how women veterans make the decision to access healthcare and continue to utilize healthcare services, despite pathways to access. Barriers and facilitating factors to WVs accessing healthcare remained well documented, yet WVs continued to under-utilize healthcare services (Brooks et al., 2016; Koblinsky et al., 2017; Washington et al., 2006).

Healthcare Access

"Healthcare access" remains a broad and often ambiguous term. Often, the terms, "access and utilization" appear in study titles. Although, one might assume that accessing healthcare implies use, or "utilization", or that there is a subsequent relationship such that after "accessing" healthcare, "utilization" occurs. However, a distinction exists between the two actions, and one action may not necessarily precede the other. Utilization may imply follow-up care or continuing use of healthcare services at either/or a VA or non-VA healthcare facility, or not returning and discontinuing healthcare.

Further exploration of what "healthcare access" entails may provide some clarity on exactly what access to healthcare might mean to the woman veteran. Norris and Aiken (2006)

sought to develop a concept analysis of "personal access to healthcare" due to the lack of consensus on its definition. An operable definition would facilitate a common interpretation of "health care access" for those seeking, providing, and legislating health care policy, in addition to those attempting to study that broad concept. Their review of the literature revealed that "access to health care" had different meanings in each article reviewed, yet some common variables existed in each. Empirical referents included "access to the healthcare system," "structural barriers to the access," and "provider ability to address the needs of the patient." The common variables included demographic variables such as age, race, gender, and other health-related characteristics such as perceived health status, health insurance coverage, and place of residence (i.e., rural or urban). Additional underlying themes identified within their review included (a) perceived need of health care, (b) fit between the patient and the healthcare system, (c) knowledge of availability, (d) time, and (e) cost of services.

Attributes of access to healthcare identified within the Norris et al., (2006) review included availability, eligibility, amenability, and compatibility. Interestingly, the literature on access and utilization of healthcare by WVs consistently described the same underlying themes as either barriers or facilitators in the context of their unique factor that affected the decision-making processes. Finally, the authors described a single antecedent and several consequences for access to healthcare. The antecedent "perceived need for healthcare services," was usually derived from symptoms or illness and thus a desire for intervention. The positive consequences included appropriate utilization, decreased disparity, and improved quality of life. Negative consequences identified were over- or under-utilization of services. Norris and Aiken's concept analysis resulted in a description of access: "personal access to healthcare exists when all of the identified attributes are present: availability, eligibility, amenability, and compatibility" (p. 64).

Existing literature on WVs described these variables as potential barriers to accessing healthcare. Additional studies described WVs as utilizing healthcare as needed. However, the literature also described how WVs delayed their access to healthcare or underutilized it (Koblinsky et al., 2017; Washington et al., 2006; Washington et al., 2013). The description of common healthcare issues among WVs suggested that WVs were not accessing and utilizing healthcare enough to allay the potential development of the aforementioned sequelae.

Like Norris and Aiken (2006), Levesque, Harris, & Russell (2013) described the multiple interpretations of health care access across a variety of disciplines. The authors focused on the concept with a multilevel perspective whereby access to healthcare occured at the interface of health systems and populations. This approach was relevant to the study of women veterans and the health systems through which they access and/or utilize healthcare (i.e., VA, or non-VA healthcare settings). Levesque et al. provided an initial definition of patient - centered access to health care: “the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs” (p. 1). Following their review of the literature, Levesque et al. described themes within the context of access to care dimensions that included approachability, acceptability, availability and accommodation, affordability, and appropriateness. Levesque et al. identified the various elements that contributed to each of these themes, noting that they are not and cannot be independent constructs and may indeed influence each other differently depending on an episode of illness or wellness. Elements described included health literacy, personal health beliefs related to illness, and wellness to develop a “patient-centered” conceptual framework of access to health care.

Levesque et al. (2013) described this framework based on the experiences and resistances faced by individuals. These experiences may have represented barriers or facilitators to accessing health care at various stages of illness or wellness. After patients realized the healthcare required, the authors posit that this process occurred by starting at access and ending with utilization. They described a step-wise process: (a) identification and perceptions of healthcare needs, (b) seeking out healthcare services, (c) reaching the healthcare resources, and (d) obtaining or utilizing the health care service appropriate for their needs of care. Despite the title of this framework, "access to health care," included health care utilization and represented a dynamic and cyclical relationship that suggested that the healthcare seeking trajectory of WVs should reflect this framework. Levesque et al. proposed a slightly different definition of "access to healthcare": "The opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use healthcare services and to have a need for services fulfilled" (p. 8). This definition highlighted the relationship between access and utilization and that the two are distinct concepts with different dimensions.

Of particular interest, Levesque et al. (2013) suggested that access to care should not occur based on geographical and organizational availability or affordability, but that decisions to access healthcare should encompass perceived acceptable and effective services. Many women veterans will either use the VA due to the aforementioned factors and have a less than satisfactory experience or will use a non-VA healthcare provider with the assumption that the healthcare may be more acceptable or effective. Previous research (Koblinsky, 2017; Washington, 2010) described both positive and negative experiences, yet the process of deciding how and why to access in the first place remained unclear in the literature. Further, Levesque et al. noted that utilization of healthcare was strongly associated with the capacity and motivation of the individual to

participate and commit to a treatment plan. The authors posited that participation and motivation of the individual related to decision-making and treatment decisions. Interviews with women veterans through a grounded theory study by this researcher and such that decision-making factors can be explored, revealed the specific factors that hindered or facilitated the decision-making process to access and utilize healthcare.

Moreover, Levesque et al. (2013) elucidated how the concept of "access to care" is differentiated from "accessibility," whereby, access to care requires the individual to recognize and perceive the importance of obtaining healthcare. Accessibility described the nature of services that provide the opportunities to access healthcare. The differentiation provided by Levesque et al. pertained to the topic of women veteran's and healthcare access in which accessibility may be the single factor involved in the decision-making process, and the antecedent factors of recognizing and perceiving the needs for healthcare affected this process to a greater extent.

The strength of Levesque's et al. (2013) framework stemmed from their emphasis on the interaction of several determinants that affected healthcare access. The previously described dimensions of approachability, acceptability, availability and accommodation, affordability, and appropriateness supported the concept of patient-centered care. For women veterans who may have struggled with the decision to access and utilize healthcare, interactions occurring between these dimensions and healthcare providers at both VA and non-VA healthcare settings decreased existing barriers and thus facilitated patient-centered care to improve the quality of life for Veteran women (Levesque et al., 2013; Norris & Aiken, 2006).

Summary

The previous discussion presented an overview of both personal and multilevel perspectives to healthcare access. While the aforementioned authors represented the positions from both nursing and social sciences, respectively, a congruence of themes emerged from their reviews of the literature. The most common parallels between their findings included, (a) availability/availability, (b) eligibility/appropriateness, (c) amenability/accommodation, and (d) compatibility/acceptability.

A qualitative research approach using Straussian grounded theory increased the breadth and depth of understanding of the factors that contributed to a theoretical explanation of the decision-making process employed by women veterans to access and utilize healthcare.

Barriers to Healthcare Access by Women Veterans

Earlier studies described contributing factors that presented as barriers and affected a WVs decision to access and utilize healthcare. The most widely reported barriers discussed in the literature included (a) a lack of veteran identity, (b) perceived ineligibility, and (c) dissatisfaction with the quality of care provided.

Identity. Women veterans who struggled with identification as a veteran may not pursue healthcare services if they question their eligibility status for benefits. WVs struggle with veteran identify for several reasons including, lack of combat participation or witnessing physical combat, being in the National Guard or in the Reserves, experiencing traumas that are closely related to their military service and trigger negative associations with being a veteran, having a less than honorable discharge despite the likelihood of honorable service (Swords to Plowshares Institute for Veteran Policy. org, 2016), and a lack of knowledge about eligibility and

availability of healthcare (Crompvoets, 2011; Johnson et al., 2013). Street et al. (2009) described a study in which Vietnam veteran women reported an unsupportive homecoming reception that positively correlated with post-deployment PTSD. This particular cohort of women witnessed the bias towards male veterans who were considered to be "real veterans" due to gender differences, underlining the reality of their challenges. The lack of acceptance as a veteran, regardless of gender, continued to impact the identity of many women veterans, particularly from recent conflicts (Street et al., 2009).

A shortage of research addressing the sense of self and identity for women in the military exists. Johnson et al. (2013) described "veteran identity" as occurring from their personal military experience within a socioeconomic context. Factors influencing this identity and use of healthcare services, particularly those through the VA, included length of time served in the military, combat exposure, service-related disability, and overall perception of military service as positive or negative. Additional research indicated that women veterans struggled with the identity of being a veteran particularly when reintegrating to civilian life (Crompvoets, 2011). This phenomenon commonly occurred in response to the myriad roles and responsibilities outside of being a service member. The focus on roles often superseded their identity as a veteran and may have distracted from the reality of identifying as a veteran. Identification as a woman veteran provided eligibility to access and utilize healthcare services that could improve the woman veteran's quality of life.

Perceived role conflict existed within the role of service member and may thereby dissuade a woman veteran's recognition of veteran identity. Women with children did not consider a healthcare facility without childcare, or one that did not provide flexible hours for convenient appointments (Washington et al., 2011). The perception of the seriousness of need

also prevented access to necessary healthcare services (Crompvoets, 2011; Johnson et al., 2013; Washington et al., 2011).

Crompvoets (2011) conducted a systematic review of the literature to examine the health and wellbeing of women veterans. Specific foci included the nexus of roles that many WVs assume and the impact of those roles on accessing healthcare. The author (Crompvoets, 2011) described the literature reviewed and suggested that a clear relationship existed between identity and access to healthcare. One of several themes revealed throughout this review included "access to services." The author described how assuming a dual role of mother and warrior may affect a woman's decision to access healthcare. To address this conflict, Crompvoets suggested that improved attention be given to WVs in the post deployment phase as they reintegrate into civilian life.

This study (Crompvoets, 2011) highlighted the importance of addressing potential role ambiguity because WVs assume many different roles in their lives and described the reality of the impact of those roles on women veterans' accessing healthcare. However, this study contained some inconsistencies. One such inconsistency occurred within the introduction in which the author described the population as the newest generation of female veteran with unique experiences that pose threats to their health. This statement alluded to an examination of WVs from very recent conflicts, including OEF and OIF. Data on participants for this study pertained to military experiences of Australian military nurses in Vietnam. While one may assume that a nexus of roles occurs across the WV population, studies of WVs from more recent conflicts would have made this review more generalizable.

Understanding the challenge of the nexus of roles shared during the interview process assisted in better understanding how and why women veterans decided to or decided not to access healthcare services.

DiLeone, Wang, Kressin, and Vogt (2016) conducted a mail survey of women veterans who experienced a recent OEF or OIF deployment (n = 407). The authors hypothesized a positive correlation between identifying as a veteran and access to medical and mental healthcare services at the VA. Results from this study demonstrated that a positive association existed between veteran identity and healthcare access. This study reinforced the importance of women veterans recognition of their identity and communication by healthcare providers who can assist with clarification and identification of their role as women veterans. The positive association between recognition as a woman veteran and healthcare access was hypothesized to affect the decision-making process when considering to pursue healthcare. The current study emphasized the importance of considering this potential barrier and integrating it within the interview process during this researcher's study.

Previous literature has discussed the diverse roles of the woman veteran, particularly relevant to her veteran identity, or lack thereof. An understanding of the context of this issue may have contributed to the exploration of its role when deciding or deciding not to access healthcare. A grounded theory methodology revealed a contextual understanding of this factor within the decision-making process. Further, knowledge that WVs struggle with identity as a woman veteran may have deterred them from pursuing healthcare due to perceived ineligibility status.

Eligibility. Many WVs remained misinformed that service-related healthcare issues provided them with healthcare eligibility, yet this perceived ineligibility status remains a barrier to

to accessing healthcare (Johnson et al., 2013; Swords to Plowshares Institute for Veteran Policy.org, 2015, Washington et al., 2011; Vogt et al., 2006).

Washington, Yano, Simon, and Sun (2006) examined decision-making by women veterans to understand why WVs used or did not use VA healthcare in a cross-sectional survey of 2,174 women veteran VA users and VA-eligible non-users in southern California and southern Nevada. Data analysis revealed that women veterans who chose not to use VA healthcare had negative perceptions of the quality of care and expressed a knowledge deficit in terms of their eligibility for services. After adjustment for socio-demographics, health characteristics, and VA priority group, knowledge deficits about VA eligibility and services and perceived negative quality of care delivery at the VA predicted outside health care use. The limitations of this study included the age of the data and the limited geographical population for this study. However, more recent studies also reported that a lack of knowledge relevant to eligibility status continued to affect a WVs decision to access healthcare,

Studies included in this section of the review span the time frame 2006–2013. A recurrent theme described across the studies pertained to women veterans who continued to struggle with identity and eligibility status. This represented a concern such that the largest healthcare provider in the United States, which purports to deliver quality and effective healthcare to women veterans, continued to demonstrate an ineffective and inefficient process of communicating with women veterans. The aforementioned studies indicated the potential impact that identity and perceived ineligibility had on the decision-making process to access and utilize healthcare. This researcher intended to gather pertinent information from the WVs as study participants on the extent to which identity and eligibility affected their decision-making process. Data collected from this study has the potential to inform healthcare providers in both VA and

non-VA healthcare settings of the importance of conveying timely and accurate information to women veterans, particularly those returning home and reintegrating into civilian roles.

In addition to identity and eligibility issues, women veterans often assumed that they would receive less than satisfactory quality of care. This may surface as another factor affecting the decision-making process to access and utilize healthcare.

Perception of quality of care. A study entitled, "Give us respect, support, and understanding…" suggested strategies to improve quality of care that underpinned the existing chasm between women veterans and their experiences with healthcare access. Koblinsky et al. (2017) recruited 29 WVs from OEF or OIF conflicts to describe their recommended strategies to improve healthcare experiences. Focus groups were conducted and data analyzed through a grounded theory approach. The multistage coding process revealed three thematic categories of recommendations, the (a) Therapeutic Relationship, (b) Clinical Care Environment, and (c) Health Care System.

Koblinsky et al. (2017)'s qualitative study represented one of few studies that sought recommendations for improved healthcare experiences directly from women veterans. The significance of this approach and the emerging themes highlighted the need for continuing qualitative research that provides information on how and why women veterans approached their healthcare challenges. Asking questions related to the aforementioned themes during the interview process of this researcher's grounded theory study provided valuable information about additional factors affecting the decision-making process involved in accessing and utilizing healthcare.

The historical and current perceived bias towards the treatment of male veterans at the VA has discouraged many women veterans from accessing services. In response to this

perception of inequitable care, many WVs may decide to seek care from a non-VA healthcare provider (Johnson et al., 2013). Although this may allay the potential dissatisfaction with care received at a VA setting, most often, civilian healthcare providers tend to be unfamiliar with military culture and the unique healthcare challenges in women veterans. This knowledge deficit may affect their initial assessment of women veterans and may lead to a dissatisfied healthcare experience. Knowing more about the specific healthcare issues that affect WVs leads to accurate diagnoses and if necessary, referral to other healthcare providers who have the skills and proficiency to deliver effective and quality healthcare.

Similarly, Vogt et al. (2006) sought to document the perceived and/or actual barriers to care of WVs and examined associations with use of the VA for healthcare. They conducted a telephone survey of 1,472 women veterans who had used or had formerly used the VA. The majority of responses indicated that healthcare provider knowledge and sensitivity, the ease of accessing the VA, gender-specific services, and lack of healthcare continuity affected their decision to access healthcare at the VA (Vogt et al., 2006). Though data collected in this study did not include the perspectives of recent women veterans, this issue warrants further consideration when exploring factors involved in the decision-making process to access and utilize healthcare.

Studies conducted since the Vogt et al. (2006) study, indicated that women veterans continue to experience dissatisfaction with the quality of care provided by the VA (Bergman et al., 2015; DiLeone et al., 2016; Fitzgerald, 2010; Haskell et al., 2011; Washington et al., 2013). The VA responded to these inequities by developing mandatory guidelines to improve healthcare delivery. Provision of gender-specific healthcare across this institution occurred in response to the well-known health disparities among women veterans. These provisions outlined

in the VHA Handbook 1330.02 (USDVA, 2015) set forth guidelines to improve the healthcare experiences of WVs. Despite these recent mandatory changes, healthcare for women veterans at the VA remains fragmented and at times fails to meet their physical and mental healthcare needs (Bergman et al., 2015; Brooks et al., 2016).

When considering decision-making of this population to access and utilize healthcare, it remains necessary to explore where the access and utilization may occur. Women veterans have the option of pursuing healthcare at both VA and non-VA healthcare settings. Past experiences that may represent barriers to future use warrants exploration during the interview process for this researcher's study.

Ease and accessibility to healthcare access. Many barriers relevant to the convenience and accessibility of VA and non-VA healthcare facilities were described in the literature. The significance of these barriers increased when WVs considered seeking healthcare. Brooks et al. (2016) described how many WVs delay, underutilize, or bypass healthcare in the presence of barriers. The absence of child care, distance, hours of service, and inability to take time off from work presented barriers to accessing healthcare (Brooks et al., 2016; Washington et al., 2006; Womenshealth.VA, 2016). Previous research reported that WVs living in urban areas with non-VA healthcare providers may choose to access their care due to convenience (Burkhart & Hogan, 2011; Washington et al., 2013) and suggested that a perception existed that the VA facilities were inconveniently located. Earlier studies reported WVs who had accessed healthcare at non-VA healthcare facilities had a negative experience as a result of a perceived inadequate level of knowledge by non-VA healthcare providers.

Brooks et al. (2016) conducted focus groups with WVs (n = 35) to understand their perspectives on health care needs, access, and quality in rural areas. The results of this study

indicated that participants supported having local gender-specific healthcare options, dental, and mental health options and alternative modalities of healing. While this study focused on access to healthcare by WVs living in rural areas, it highlighted the importance of understanding their decision-making process to access healthcare in light of existing barriers. This study raised the question of geographical barriers. Specifically, if such barriers were eliminated, among other physical access barriers, what other factors would have influenced the decision-making process in WVs to access and utilize healthcare? Additional qualitative studies have provided healthcare providers who work with this population insight into the barriers and strategies to facilitate the decision-making process to access and utilize healthcare in settings that encourage continued utilization.

Summary

Understanding the reasons to access healthcare despite the presence of the aforementioned barriers facilitated a deeper understanding of the decision-making process employed by this population.

Previous studies have examined the variables and barriers of healthcare access and utilization by women veterans, yet issues relevant to WVs seeking and utilizing healthcare remained a challenge. Identifying factors that impeded a decision remains part of the solution. However, understanding how WVs mitigate these factors and ultimately decided to pursue healthcare remained paramount.

Healthcare Utilization by Women Veterans

Norris and Aiken (2006) described healthcare access as antecedent to healthcare utilization whereby accessing healthcare enabled people to take the steps necessary to obtain healthcare (Levesque et al. 2013; Norris & Aiken, 2006) and completion of this step during utilization may reduce health disparities (Norris & Aiken, 2006).

Utilization is defined by Da Silva et al. (2011) as the outcome of the interaction between health professionals and patients. This definition used in the context of a women veteran's decision-making process to utilize healthcare remains appropriate. Moreover, utilization following access, indicated that WVs return for follow-up care and continue utilizing healthcare services as necessary.

A review of study findings from relevant literature on healthcare access and utilization by women veterans illustrated the prevalence of the challenges experienced by the population. Understanding the decision-making process by healthcare providers, particularly nurses, will facilitate development of interventions to improve their healthcare experiences and outcomes.

Availability, amenability, compatibility, and eligibility were mentioned earlier as common themes in defining healthcare access. Additional studies examined these same variables from the perspective of healthcare utilization by women veterans. A search for literature on the decision to utilize healthcare by WVs produced many articles on utilization of healthcare within the VA, but a scarcity of literature on utilization outside of the VA. The aforementioned statistics noted that the majority of WVs sought care outside of the VA. Exploring the factors influencing their decision to access and utilize healthcare included representation from women utilizing healthcare services in VA and non-VA healthcare settings.

Once a woman veteran decided to access healthcare, continued utilization of services may become necessary. Previously discussed issues, such as MST and PTSD, may elicit chronic disease processes and other mental health sequelae whereby ongoing healthcare is required.

Hamilton et al. (2013) examined the factors that contributed to attrition from the VA by women veterans. Consistent with previous studies, geographically inconvenient locations, eligibility issues, difficulty with obtaining appointments, and lack of gender-specific services (Hamilton et al., 2013) affected attrition. Furthermore, the study authors reported a 30% attrition rate within the three years of initial healthcare utilization despite the recent improvements made by the VA to improve gender-specific healthcare. Swords to Plowshares Institute (2016) reported that attrition was also a concern among non-VA healthcare providers. Women veterans often begin their initial access to care, but due to the conflicting roles and responsibilities described earlier, they do not return to utilize services. Further, an element of dissatisfaction exists such that women veterans perceived inadequate understanding of the military culture by non-VA healthcare providers and did not return for follow-up care (Fitzgerald, 2010; Johnson et al., 2013).

A knowledge gap exists that explained how and why WVs decided to access and/or decided against pursuing follow-up healthcare. Previous quantitative studies reported specific barriers involved in access and utilization of healthcare. An insufficient amount of qualitative research literature existed that sought to explain the underlying process of decision-making in the presence of barriers.

Washington et al. (2013) examined the healthcare delivery preferences and healthcare utilization throughout military eras in a cross-sectional study of 3,611 WVs. The results of the study indicated that the era of military service may have affected WVs level of healthcare

utilization. OEF and OIF WVs had more frequent visits to the VA than did WVs from previous conflicts. Vietnam veterans described location and convenience of healthcare as very important in receiving healthcare. Gulf War and OEF and OIF WVs reported that affordability and amenability were most important.

The perceived limitation in this study, similar to previous studies published by these authors , included a lack of consideration for the WV population who may elect to access and utilize healthcare outside of the VA healthcare setting. Further, the same study authors have often cited statistics reflecting a large percentage of WVs seeking and utilizing healthcare outside of the VA. Women veterans are faced with the challenge of deciding how (i.e., considering the existing barriers), when (i.e., relevant to their healthcare issues), where (i.e., availability of VA and non-VA healthcare options, and why (i.e., status of current healthcare burdens) to access and utilize healthcare. It remains imperative that healthcare providers understand the factors involved in the decision-making process by WVs. Comprehension of these factors may be able to facilitate the removal of access and utilization barriers, improve conditions at the VA, and increase the knowledge of non-VA healthcare providers.

Summary

The physical, emotional, and psychosocial factors experienced by women veterans may affect their beliefs, attitudes, intentions, and perceived benefits of accessing and utilizing healthcare. Mitigation of these factors and an understanding of the WVs approach to the decision-making process may facilitate development of supportive intervention and best practices. Further, identifying contributing and causal factors associated with WVs decision-making may instill valuable process components and invite renewed provider engagement and encourage WVs to access and fully utilize available healthcare services.

Decision-Making

Pate (2011) discussed the decision-making process as the "utility of the chosen path" (p. 332). She posited that the potential consequences of the decisions apply to one's life purpose, generally as lessons learned that ultimately enhanced that purpose. A definition of decision-making by Pate was, "the process of making choices among competing courses of action" (p. 333). She included a discussion of models and theories relevant to the decision-making process, such as the "theory of planned behavior," and "theory of reasoned action," and lesser-known theories such as the "fuzzy trace model" and "willingness model." Through synthesis of these models and theories, Pate refined the definition of decision-making to be, "the act of generating a resolution, following the synthesis of probable outcomes, based on attitudes, beliefs, intentions and perceived benefits" (p. 333).

Healthcare access and utilization options exist in both VA and non-VA healthcare settings for women veterans. Pate's (2011) definition of decision-making, such that the process of making choices existed among competing courses of action, applied to WVs who view their options (i.e., care accessed and utilized in VA and/or non-VA healthcare settings) as competing courses of action.

The extant literature described similar barriers but did not provide indications of how and why women veterans decided or did not decide to access healthcare services. To facilitate a broader understanding of how the decision-making process affected healthcare access and utilization, studies that explored decision-making processes using different samples and settings were reviewed for potential similarities and relevance for application to this study.

Although this study reported older data, Washington, Kleinmann, Michelini, Kleinmann, and Canning (2007) utilized a grounded theory research approach to explore the perceptions

and decision-making processes of veterans' decision to use VA healthcare. The focus of decision-making by women veterans pertained specifically to this researcher's study and thus warranted review. The researchers partitioned VA eligible WVs into six focus groups. Data collection occurred through semi-structured interviews to query the WVs healthcare expectations, experiences, and insight into their decision-making process for use or non-use of the VA for healthcare, perceived barriers to VA healthcare, and specific VA and non-VA healthcare services they had. Key themes reported by the authors revealed within this group included: availability and accessibility of services and treatment, gender-specific resources, and overall quality of care (Washington et al., 2007). The authors acknowledged that their restriction to one geographic population may have limited the generalizability, yet, they concluded that the themes reflected the general attitudes of WVs toward accessing healthcare at the VA.

The relevance of Washington et al. (2007)'s findings, despite the older data provided, indicated that the presence of barriers affected the decision-making process with regard to WVs decisions to access and utilize healthcare. The historical precedence of similar recurring barriers that affected this decision-making process warranted additional and current research.

Shaw et al. (2013) conducted a grounded theory study that included a purposive sample of 30 patients. The study explored the decision-making process of patients who used emergency department (ED) services as opposed to primary care services for non-emergent needs. Findings from this study indicated that knowledge of healthcare service options and perceived benefits and barriers within each option affected WVs decision-making process. Further, the authors described the necessity of improving systemic factors, such as access and perceptions of patients' healthcare, when understanding how the decision was made to use the ED or other non-emergent healthcare facilities.

The significance of this study relevant to the proposed research study included its similarity in addressing the importance of being informed of healthcare options during the decision-making process. O'Connor (1995) described the difficulty of making choices that involved risk or that had uncertain outcomes, vacillating between choices, presence of emotional distress, perceived pressure from others who may impose their view of best options, delayed decision-making, and questioning personal values and beliefs while attempting decision-making. Previous literature (Brooks et al., 2016; Butler et al., 2015; DiLeone et al., 2016; Turchik et al., 2014) indicated that women veterans demonstrated delayed access to healthcare when they were uncertain about their options.

As part of a study that used a grounded-theory approach, 30 Chinese family caregivers were asked to describe their decision-making process when making a nursing home placement decision for their loved one with dementia (Chang et al., 2010). Results of this study indicated that vacillation and uncertainty about options negatively affected their decision-making. The authors (Chang et al.,) described the relevance of the nurse's role in helping patients identify factors that affected their decision-making process. Further, they suggested the importance of interventions that allayed any psychological stress during and after the decision-making process. This study lacked generalizability due to the exclusive focus of the Chinese culture.

Although this sample consisted of only Chinese caregivers, factors such as vacillation and uncertainty had been discussed in the literature regarding women veterans considering the decision to access healthcare. The study conducted by Chang et al., (2010) and the extant literature on WVs emphasized the importance of exploring factors that affected the decision-making process of WVs who elected to access healthcare.

Harada & Pourat (2004) examined the role that membership in veterans' service organizations (VSOs) had on the decision-making process of veterans selecting the VA as their regular source of healthcare. VSOs in the study included the American Legion, Veterans of Foreign Wars, Vietnam Veterans of America, and the Catholic War Veterans of the United States of America. Their mission involved improving the quality of life within the veteran population. The study authors utilized data from the 2001 Veteran Identity Program Survey. Results indicated that VSO membership influenced their decision-making of healthcare options.

Decision-making among veterans with pulmonary nodules was explored through a modified grounded theory approach consisting of 19 semi-structured interviews with veterans. (Slatore, Press, Wiener, Golden, & Ganzini, 2015). The authors focused on patient perceptions of shared decision-making with their primary care provider. Findings of this study noted dissatisfaction with the decision-making process among the study participants due to perceived inadequate communication and knowledge from their healthcare providers. A limitation of this study included an element of bias because the study authors were also primary care providers. However, this study underscored the importance of establishing effective communication between healthcare providers and patients. The extant literature on access to healthcare by WVs described the perception of inadequate healthcare-provider knowledge of gender-specific healthcare issues as a barrier.

The 2010 National Survey of Veterans, conducted by the Department of Veterans provided information on the future use of VA healthcare by select populations. Although the survey emphasized the quantitative aspect of service utilization, it did not provide any rationale for the decisions of the survey respondents not to use the VA for healthcare. However, 34% of women veterans reported that they have no plans to use the VA in the future (USDVA, 2011).

Information from this survey provided justification for conducting a qualitative study that explored factors that influenced the decision by WVs to access and utilize healthcare.

Prior research highlighted specific health issues in women veterans throughout military eras. However, healthcare delivery preferences have not been examined in studies to date. Washington et al. (2013) examined healthcare delivery preferences and use by military service era in a cross-sectional survey that included 3,611 WV participants. The authors sought to understand the features of healthcare that were important in healthcare decision-making by WVs across military eras. Features of care ranked very important in healthcare decision-making included: (a) cost of care (58.6%), (b) convenience of location (58.5%), (c) comprehensive healthcare services at one location (44.5%), (d) availability of after-hours care (35.3%), and (e) access to a women's health care provider or gender-specific clinic (21.8%). Findings from this study also indicated that healthcare delivery preferences were associated with age and military service era. The results of Washington et al.'s study underpinned the importance of understanding healthcare delivery preferences of WVs to improve their decision-making to access healthcare.

Summary

A review of the findings from relevant literature on healthcare access and utilization by women veterans illustrated the prevalence of this as a challenge for women veterans. However, knowledge of their decision-making process to utilize healthcare services may improve the lives of WVs. Understanding this decision-making process by healthcare providers, particularly nurses, will facilitate development of interventions to improve their healthcare experiences and outcomes.

Decision Making Theory

The application of theory to guide the development of interventions is represented broadly in nursing and health science literature. Lor, Backonja, and Lauver (2017) emphasized how the lack of application and explication of theory to research impedes the development of knowledge that guides nursing practice. Examination of a theory's concepts and propositions begins an iterative process wherein a researcher identifies the relationship between a practice issue and a parsimonious theory to support development of relevant interventions (Lor et al., 2012; McEwen & Wills, 2014).

Bekker et al. (as cited in Elwyn, Stiel, Durand, & Boivin, 2011) contended that many theories are prescriptive in nature and address how individuals should make decisions. Decision-making theories examine how individuals make decisions (Elwyn et al., 2011). Durand et al. (as cited in Elwyn et al., 2011) reported on their review of the Cochrane Collaboration's Systematic Review of Decision Aids and found that few interventions cited the relevance of theory. Further, Elwyn et al. (2011) described theory as a way to explain or describe how humans think rather than how tools could be designed that would facilitate effective decision-making. During their review of appropriate theories, the authors conducted a review of existing decision-making theories (DMTs) to assist them in the design of decision support interventions, inclusive of patient decision aids (PDAs). Eight theories were selected for review. Two theories, the Fuzzy Trace Theory (FTT) and the Rational-Emotional Model of Decisional Avoidance would provide an effective theoretical foundation in the development of a PDA to assist WVs with their decision-making process and are described in further detail.

Reyna (2008) described the FTT through an explanation of "gist" whereby individuals relied on the bottom-line meaning, and "verbatim" that provided information in greater detail.

During the development of a process model for vaccination decisions, Reyna (2012) explained that at times a vague gist or fuzzy representation of information may lead to more effective decision-making, although verbatim representations sometimes faded due to memory limitations and other cognitive issues resulting in a loss of information. According to the tenets of the FTT, gist is more useful than verbatim information in decision-making situations.

The FTT (Reyna, 2012) had relevance to the decision-making process among women veterans when healthcare providers assisted WVs with their decision-making process to access and utilize healthcare. Consideration of this theory underpinned the importance of how patient education is provided with women veterans challenged with making decisions relevant to their healthcare options.

The Rational-Emotional Model of Avoidance (Elwyn et al., 2011) proposed that decision avoidance is motivated by the need to regulate negative emotions differentiated as *anticipatory*, (e.g., being uncertain, afraid, or worried), or *anticipated* (e.g., guilt, regret, or remorse) that occurs once a decision was made,. Anticipatory emotions ensue when selecting the best option becomes difficult. Anticipated regret occurs by making a decision and feeling responsible for potentially negative outcomes. When the best option becomes apparent, individuals do not feel challenged with their decision-making. However, when options present with concurrent negative and positive attributes, decision avoidance is adopted while waiting for other potential solutions to emerge (Elwyn et al, 2011).

This theory has potential relevance to the decision-making process by WVs who contemplate if, when, and where to access healthcare. Highly negative attributes include the lack of gender-specific services at most Veteran Affairs hospitals often resulting in the foregoing of healthcare service. In contrast, knowledge of a community clinic that offers childcare during

appointments, APRNs with veteran-centric knowledge, particularly with WVs may reduce decisional avoidance. Elwyn et al., (2011) described this model as beneficial where avoidance is expected or if a situational is highly emotional. This is pertinent for WVs with MST and/or PTSD.

Consideration of the development of a patient decision aid (PDA) as an intervention to improve the decision-making process by women veterans warranted a theoretical foundation. Additional theories were explored to provide a theoretical foundation for the development of a decision-making PDA for healthcare access by WVs include, "Theory of Reasoned Action" (TRA) and the "Theory of Care-Seeking Behavior" (TCSB). The TRA explained the relationship among beliefs, attitudes, intentions, and behavior and assumed that people are rational and make decisions based on the information provided (McEwen & Wills, 2014.) The TCSB explained the probability of engaging in health behavior as a function of psychosocial variables and facilitating conditions regarding the behavior whereby sociodemographic and clinical variables influence decision-making (McEwen & Willis, 2014).

Conclusion

Women veterans are the fastest growing cohort of the military (Hamilton et al, 2011; Kehle-Forbes et al, 2017; Montgomery et al, 2014; USDVA, 2017). Past research has demonstrated the unique healthcare issues associated with WVs. An increase in the number of women serving in the military correlates with an increased incidence of physical, emotional, and psychosocial challenges that require healthcare. Recent experiences and current perceptions of healthcare service affect their decision-making process.

An abundance of quantitative literature, comprised of research studies and government reports, described the measurement of specific barriers relevant to the access and utilization of healthcare by women veterans. Understanding the context of the decision-making process to access and utilize healthcare cannot be measured through exclusive use of quantitative research methodologies. As previously described, qualitative research involving WVs provided a depiction of their experiences that were studied within their natural settings and elucidated the phenomena of interest through the meanings they ascribe to their experiences. Interviewing, observing, and comparing experiences of WVs experiencing the decision-making process to access and utilize healthcare can inform healthcare providers, particularly nurses, about strategies that might facilitate the most appropriate and effective decisions that will improve their quality of life. Consideration of a theoretical foundation to support the development of interventions that facilitated an effective decision-making process remains paramount. Buttressing this effort with a valid and reliable self-reported decisional conflict questionnaire strengthened overall findings and generated strong recommendations for both providers and WVs.

Chapter Three

Methodology

Introduction

The review of the literature surfaced the preponderance of quantitative studies that measured factors that were perceived to have affected healthcare access and utilization by woman veterans (WVs). However, a dearth of qualitative studies on the exploration of the "how" and "why" female veterans decided to access and utilize healthcare remained an understudied topic in healthcare research. An understanding of the context of the decision-making process provided nurses and healthcare providers with information to develop and implement best practices.

A description of the research methodology applied in this study includes the research question and study design, description of the sample, ethical considerations, and procedure for data collection and analysis.

Research Question

The overarching question, "What is the decision-making process used by women veterans to access and utilize healthcare?" provided the basis for this research.

Research Design

The identification of gaps in the literature that discussed what was and was not known about women veterans' decision-making process to access and utilize healthcare prompted the decision to select grounded theory as the choice of research methodology for this study. This decision was buttressed an embedded descriptive measure to describe a potential attribute of decision-making (e.g., decisional conflict). Integrating a quantitative instrument to gather additional information on one potential construct of the decision-making

process yielded important data not necessarily identified in the responses to the interview questions. The utility of a mixed method approach, through the embedding of a quantitative measure in addition to a qualitative semi-structured interview protocol, provided an in-depth understanding of the research topic and enriched the theory under development (Creswell, 2014; Glaser & Strauss, 1967 as cited in Walsh, 2015).

Grounded Theory

Grounded theory (GT) may generate the data that explains the phenomena on a topic or problem that has not been adequately described in previous studies (Creswell, 2014; Merriam 2009; Strauss et al., 1998). GT provides researchers with the opportunity to explore a topic of interest in-depth. Knowledge developed from in-depth exploration may contribute to theory development, thus making it appropriate for nursing theory research. Development of theory from data differentiates GT from other qualitative methodologies. Data collection occurs through interaction between the researcher and the participant. Through this interaction, beliefs and meanings that underlie actions and foster an explanation of a person's response to particular events and life experiences occurs (Strauss et al., 1998).

Grounded theory is an innovative methodology consisting of three prevailing traditions: Classic, Straussian, and Constructivist. While points of divergence exist among all three methodological approaches, the use of inductive logic as a foundation represents the most important commonality. Strauss et al., (1998) purported that the novice researcher engaging in GT must be "open to serendipity and flexibility in their approach to data collection and analysis" (p. 9). Moreover, GT proves useful when

> attempting to uncover beliefs and meanings that underlie action, to examine rational as well as irrational aspects of behavior, and to demonstrate how logic and emotion combine

> to influence how persons respond to events or handle problems through action and interaction. (Corbin & Strauss, 2015, p. 11)

Strauss et al., (1998) described the ways in which details about phenomena, such as feelings, through processes, and emotions, may be difficult to extract or learn through quantitative methodology, and therefore can be explicated through GT methodology.

Straussian grounded theory (SGT) was the methodology used in this research to explore and understand the research problem and to assist the researcher to explore influencing factors in this decision-making process. The emergence of categories identified through the constant comparison of data collected from these women revealed similarities and differences and barriers and facilitators of healthcare utilization. SGT served as the conduit for discovery of information and explanatory concepts that yielded a theoretical basis that enabled a better understanding of the decision-making process and related attributes.

This research study involved interviewing women veterans and (a) eliciting how each approached decision-making when deciding to access and utilize healthcare and (b) why they used the process that they described.

Philosophical underpinnings. Pragmatism and symbolic-interactionism (SI) provided the philosophical basis for grounded theory (Strauss et al., 1998). Pragmatism promotes the notion of reflective thinking as the way to problem recognition and resolution. It utilizes theoretical views to bring practical use of a theory to a person or situation. Development of knowledge through pragmatism must result in practical, not theoretical, outcomes. This study explored healthcare access and utilization and intended to produce a theory that explained concepts relevant to the decision-making process by women veterans. The core of SI is the process that attributed meaning to actions, events, and people relevant to the context in which

they were observed. Thus, this research intended to explore and understand the relationship between women veterans and the factors that influenced their decision-making process in healthcare access and utilization (Lee, 2016).

Embedded descriptive measurement. In order to capture embedded descriptive measures to depict decisional conflict, the researcher planned to administer the Decisional Conflict Scale (DCS; O'Connor, 1995) to study participants. This scale provided an integrated mixed methods approach to explore decision-making relevant to healthcare access and utilization in this population (Lee, 2016). Constructs of the DCS include uncertainty in choosing options, perceived level of support and information in decision-making, and perception of the influence of personal values on decision-making. Previous studies using the DCS provided researchers with additional data regarding barriers that might likely affect the decision-making process in healthcare-related situations.

Sample

The sampling approach for this study was purposive, which enabled the researcher to invite participants who facilitate the discovery and understanding of the phenomena under study (Creswell, 2014; Merriam, 2009; Strauss et al., 1998). In this research, purposive sampling of women veterans provided a basis for study participants.

Snowball sampling generated additional participants as needed, since the sampling and research processes involved querying participants about their knowledge of other women veterans who shared similar perspectives and who could contribute additional information. As knowledge accumulated, the snowball enlarged, resulting in a final pool of 26 participants. The use of both sampling methods assisted in identifying participants with relevant experiences.

While the initial sampling process of participants began with purposive selection, it was theoretical sampling that progressively and systematically shaped the data collection process, helping to foster the development of the emergent theory. Strauss et al., (1998) described this as the opportunity to "discover variations among concepts and to densify categories in terms of their properties and dimensions" (p. 201). Furthermore, theoretical sampling provided the researcher with an evolving process for jointly collecting, coding, and analyzing the data through which a theory gradually emerged. As themes began to emerge from the data analysis, theoretical sampling proceeded and contributed to the development of both open and axial coding for the emerging theory.

The researcher intended to employ the technique of *theoretical saturation* (Strauss & Corbin,1998) in this proposed research, whereby the need for additional information based on themes identified and emerging data determined a sufficient sample size (Creswell, 2014; Merriam, 2009; Strauss et al., 1998).

This researcher intended to interview a maximum of 20-25 female veterans for data collection. Data collection in this study stopped when themes or categories reached saturation or when the researcher began to hear redundant information from participants that resulted in no new themes or categories.

Participant Recruitment

Recruitment strategies for this study occurred primarily in-person. Online recruitment occurred to increase participation as needed. The in-person recruitment strategy included meeting key individuals in the veteran community. One example of potential study participants were to be drawn from participants in The Equus Effect, an organization that used the principles of horsemanship to facilitate emotional and psychological healing in veterans

from past conflict experiences.

Previously established contacts at the recruitment sites agreed to identify women veterans who might have been interested in participating in this study. Flyers describing the study (Appendix A) were provided to potential study participants. Additionally, this researcher visited each of the recruitment sites with additional flyers and to provide prospective participants with the opportunity to discuss the study. A recruitment script (Appendix B) served as a preliminary screening tool to ensure that volunteers met the recruitment criteria for participation.

In-person recruitment sites included, (a) Homes for the Brave (a transitional housing environment for women veterans who are homeless, and online methods included direct contact with (b) the Women Veterans Alliance (an online veteran service organization for women). Creation of a separate social media profile for the purposes of this study was a viable tactic to connect with veterans groups on Facebook. Obtaining permission from site administrators to post a recruitment flyer (Appendix A) facilitated meeting this tactic.

Inclusion Criteria

Selection criteria for potential participants included women veterans who were:

- verified as veterans according to the veteran status definition provided by the VA,
- between the ages of 18 and 65,
- eligible for healthcare through the Veterans Administration, and
- able to speak, read, and understand English,

Exclusion Criteria

Exclusion from participation in this study occurred only for WVs who did not meet the above criteria.

Protection of Human Subjects and Data Handling

This researcher sought permission from The Catholic University of America Office of Sponsored Programs and Research Services Committee for the Protection of Human Subjects to conduct this study. By obtaining Institutional Review Board (IRB) approval, all participant privacy, safety, health, and welfare concerns were ensured and protected. This researcher completed Collaborative Institutional Training Initiative (CITI) training in the use of human subjects in research prior to applying for IRB approval.

Women veterans invited to participate in this study acknowledged their veteran status by describing that they served in active military and had been discharged or released under conditions other than dishonorable.

Recruitment of participants began following IRB approval of the proposed research. In-person and online recruitment included a description of the study, including the provisions to protect human subjects and a participant consent form. After individuals agreed to participate, interviews were scheduled at a mutually-agreed upon time and setting that ensured the

particpant's comfort and confidentiality. Prior to the initial interview, participants received consent forms with verbal verification requested to ensure their understanding of the study's procedures, particularly the audio-recorded format, and purpose.

The researcher assigned pseudonyms to each participant to protect participant anonymity and confidentiality; participant pseudonyms accompanied all study documents. An explanation regarding pseudonym assignment was included in the description of the purpose of the study that was distributed to all participants.

An overview of the study and interview process provided each participant the opportunity to decline participation at any time. The use of existing healthcare services or eligibility for healthcare were not affected by participation in this study, which helped to insure their freedom from risk or harm.

Protection of privacy occurred through diligent electronic and hard copy data storage. A locked storage cabinet in a locked office contained any study document including those that associated a pseudonym with the actual identity of a participant. Upon completion of the study, all interviews were erased from the digital recorder and typed transcriptions will be destroyed upon successful completion of the researcher's dissertation defense.

Instrumentation

The Interview

Grounded theory does not use or assume a specific tool or instrument to measure the variables of interest. The instrument to elicit the information required to understand variables within a process includes the researcher; the interview provides the structure.

Strauss et al., (1998) described unstructured, semi-structured, and structured interviews as sources of rich data for theory-building. The semi-structured interview was the format used to

collect data in this study. Providing researchers with a format described as neither too rigid nor too open, allows researchers to maintain some consistency over concepts discussed during the interview (Strauss et al., 1998). In this format, topics are presented rather than structured and derived from a review of the literature. Despite the benefits of the semi-structured interview, Strauss et al., (1998) noted that the unstructured interview yielded a rich source of data since participants can talk more freely while providing the researcher with the opportunity to follow-up as needed in subsequent interviews, thereby generating additional data. The interview protocol developed for this study began with a grand-tour question (Strauss et al, 1998) to elicit informal conversation and provide participants with the opportunity to speak freely about their experiences. The semi-structured interview protocol served as a guide for the researcher while simultaneously relying on the energy within the interaction for further direction.

GT Instrumentation: The DCS

The DCS is a self-report questionnaire with 16 items in subscales that measured uncertainty, values clarity, perceived support, uncertainty, and effective decision-making (O'Connor, 2010). Approximately 5-10 minutes is required to complete this questionnaire.

Responses were scored to generate a measure of each item and then a total measure of overall decisional conflict based on a 5-point Likert-type scale. Psychometric analysis of the instrument was completed in other studies and the DCS continued to demonstrate validity and reliability in a variety of adult patient populations. Additional psychometric testing in studies (Katopdi et al., 2011; O'Connor, 1995; O'Connor & Jacobsen, 2006; O'Connor et al., 2006) reported the DCS to be internally consistent (Cronbach Alpha = 0.78 – 0.96) with a reported test–retest reliability correlation of 0.80.

The Interview

Demographic data. The individual interview process began following the recruitment of women veterans. Rather than having participants fill out a demographic survey, the researcher asked participants demographic questions at the beginning of each interview as an ice-breaking strategy (Appendix B). Participants were queried about their age, race, military service history (e.g., branch and number of years served), marital status, occupation, education, use of VHA or Non-VHA healthcare centers. Data were analyzed using frequency distributions and measures of central tendency. SPSS 23 was used to analyze the data to describe the characteristics of the sample.

Interview guide. A review of the consent process was provided prior to the start of the interview. The researcher provided a description of the dissertation study and an explanation of the r esearcher's int erest i n the pa rticipant's experiences. Participants were reminded that their participation was voluntary and withdrawal from the study could occur at any time without fear of repercussion. Each interview was expected to last approximately 60-90 minutes and were audio-recorded. Digital transcription occurred following each interview. The researcher took notes during interviews; such notes included important observations about body language, theoretical and methodological thoughts, and personal perceptions and thoughts. Data collection and analysis occurred simultaneously to maximize theoretical sensitivity.

Following the demographic data collection and when the researcher perceived a sense of readiness on the part of the participant, the researcher began the interview with a broad question, "What are some of the biggest challenges that have affected your well - being over the last few years?" Following this initial question, the remainder of the interview was guided by an interview protocol that included open-ended questions that provided structure to the interview (Appendix B). In cases in which additional prompts were needed to obtain a rich, thick narrative, the interview guide allowed the researcher to query the participant to expand on statements while remaining on the central topic.

Data Collection and Analysis

Development of a theory grounded in data differentiates this type of qualitative research from others. One of the foundational pillars of GT is the concurrent and cyclical process of data collection and data analysis. This study used the researcher-participant interview as the conduit for this cyclical process. For this research study, interviews to explore the factors involved in the decision-making process by women veterans to access and utilize healthcare provided the data of interest. Data analysis began after the first data were collected. Diagram 1 illustrates the cyclical process of data collection and analysis.

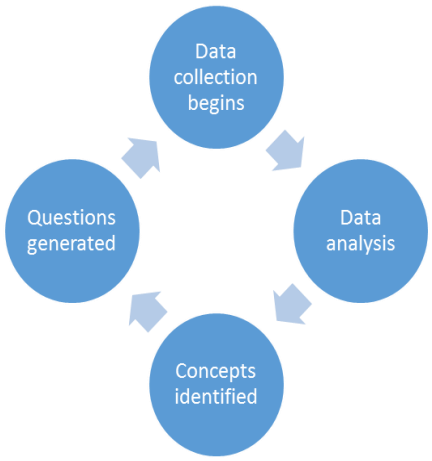

Figure 1. The cyclical process of data collection and analysis using Grounded Theory.

A descriptive level of measurement embedded in this study to enrich the understanding of the process of inquiry were participants' responses on the Decisional Conflict Scale (DCS; O'Connor, 1995). Descriptive statistics, such as frequency distribution and measures of central tendency, provided for the analysis of these quantitative data. Demographic data collected from participants included age, marital status, ethnicity, highest level of education completed, occupation, military service history, and type of health care facility used (VA, non-VA, or other).

Analysis of Interview Data

Constant comparative analysis (CCA). With the goal of generating a theory to conceptually explain a social process, such as the decision-making process to access and utilize healthcare, GT employs a system of inductive guidelines to collect and analyze each datum. It is during this analytical process that the researcher shifts between abstract and concrete thought processes to simultaneously look for relationships and identify patterns (Strauss et al., 1998). The authors underscored the importance of remaining flexible and responsive to the data so that discovery of an organized theoretical explanation transpired.

The foundational analytic approach in GT applies CCA. Making constant comparisons refers to comparing one piece of datum, in this study the interview responses, and examining it against another for conceptually similar or unique differences (Strauss et al., 1998). Conceptual labels were created and the development of codes and categories by reduction of the concepts occurred through the repetition of this process, thereby facilitating the development of coding and categories.

Coding structure. While conceding that their coding structure may be more complicated than that of Classic and Constructivist GT methodology, Strauss et al., (1998) explicated that their coding process provided structure for novice GT researchers. This coding structure provided the researcher with a systematic process through which to analyze the data whereby the interrelationships of the concepts facilitated the emergence of an explanatory theory that closely resembled the reality it represented. The authors posited that use of this coding paradigm ensured density and precision of theory development (Strauss et al., 1998).

Open coding. This initial phase of data analysis began by coding data segments with conceptual labels that denoted the concept they represented. Defining core categories occurred through analysis of the properties and dimensions . As categories become more dense, the use of sub-categories was employed. Constant comparison clarified the connections between categories and data. Transcripts from the interviews were reviewed line by line, sentence by sentence, and, word-by-word. Analyzing word phrases or sentences involved selecting one word that seemed significant, listing all of its possible meanings, and then validating the findings against the text (Strauss et al., 1998).

Axial coding. Forging of the links between category and its sub-categories occurred during this phase. Strauss et al., (1998) described a paradigm model that further demarcated sub-

categories within each category: (a) causal condition, (b) context, (c) intervening conditions, (d) action/interactional strategies and (e) consequences. Use of these subcategories seemed markedly relevant for exploration of the factors that affected the decision-making process by women veterans. Moreover, the use of this model provided additional structure for analysis.

***Selective coding*.** This process encapsulated the categorization of the data by encouraging the emergence of one dominant core category that was broad and abstract enough to integrate the other categories and to solidify the properties and dimensions of the phenomena of interest. The use of a visual diagram, depicting this model, assisted in understanding the analytic coding process.

Analytic Strategies

Corbin & Strauss (2015) outlined analytic strategies found valuable within their GT work. Some of these strategies considered for use within the analysis process of this study are described in Table 2.

Table 2.

Analytic Strategies (Corbin & Strauss , 2015)

Flip-Flop technique	Turning a concept inside out or upside down to obtain a different perspective.
Waving the Red Flag	Questioning or exploring issues that "stand-out" during the interview
Looking at language:	Use of "in vivo codes" indicates that a concept is a term used by the participant.
Looking for words that indicate time	The use of time-related words often denotes a shift in perceptions, thoughts, or events. Women veteran's involved in the process of deciding to access and utilize healthcare may describe their decision in the context of time. Words such as "if", "then", 'when", "since", "after"… may indicated specific conditions as factors that affect or have affected this process

Assessment of GT Rigor

Trustworthiness

Merriam (2009) explained that the researcher's selection of a study design determined the criteria for evaluation of trustworthiness. Trustworthiness of a study "refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study" (Connelly, 2016, p. 435) and contributed to the comprehensiveness and quality of the research product (Amankwaa, 2016). When referring to trustworthiness in both research paradigms, Merriam (2009) explained that different rhetoric was used to persuade readers of the study's rigor.

Variations in terminology for assessing the rigor of qualitative research are described throughout the literature, and the terminology is often specific to the qualitative approach used in the study (Creswell, 2013). The most common criteria are those proposed by Lincoln and Guba (1985). Their trustworthiness criteria remain well cited throughout the literature (Melnyk & Fineout-Overholt, 2015; Merriam, 2009; Streubert & Carpenter, 2011) and was useful for evaluating the rigor of this qualitative study. The four criteria (Lincoln & Guba, 1985) included credibility, dependability, transferability, and confirmability. Agazio (as cited in Streubert & Carpenter, 2011) stated that determination of methodological rigor should involve these four criteria. A fifth criterion, authenticity, was added in 1994 (Cope, 2014).

The issue of trustworthiness in qualitative research and a description of strategies for strengthening the rigor of qualitative studies relevant to the aforementioned criteria is addressed in the following discussion.

Trustworthiness Strengthening Strategies

Strategies for enhancing the rigor of qualitative studies is presented according to the trustworthiness criteria developed by Lincoln and Guba (1985, as cited in, Amankwaa, 2016; Connelly, 2016; Cope, 2014; Houghton, Casey, Shaw, & Murphy, 2013; Melnyk & Fineout-Overholt, 2015; Merriam, 2009; Streubert & Carpenter, 2011). Experience in the doctoral dissertation process led Amankwaa (2016) to develop a protocol for establishing trustworthiness, a priori, in a qualitative research process. The strategies described in the Amankwaa protocol provided the novice qualitative researcher and doctoral student with clear exemplars for establishing trustworthiness and rigor in both the qualitative research and the dissertation process. A specific protocol for each trustworthiness criterion is presented below.

Credibility. Analogous to the concept of internal validity in quantitative research, this concept refers to the confidence in the truth of the study and therefore the findings; the representation of them by the researcher (Amankwaa, 2016; Connelly, 2016). A study is considered credible if the "descriptions of the human experience are immediately recognized by individuals who share the same experience" (Cope, 2014, p. 89). Utilization of standard procedures in a qualitative approach should be consistent with other studies using the same approach (Connelly, 2016). This research study utilized peer-debriefing, triangulation, and member-checking as strategies to ensure credibility. Table 3 illustrates specific strategies used in this study to strengthen credibility.

Table 3

Credibility strategies

Strategy/Technique	**Sources**	**Example**
Prolonged engagement and persistent observation	Amankwaa (2016); Connelly (2016); Cope (2014); Houghton et al., (2013).	Establishing rapport with study participants to foster rich and detailed responses. Using demographic questionnaire and administration of DCS as an ice-breaking strategy to foster rapport.
Triangulation	Houghton et al. (2013); Melnyk & Fineout-Overholt (2015); Merriam (2009); Streubert & Carpenter (2011).	Verification/corroboration of multiple data sources. Participants from local Veteran Service Organizations and online as needed triangulated the sample.
Peer debriefing	Amankwaa (2016); Connelly (2016); Cope (2014); Houghton et al. (2013).	Consultation with colleagues during time of interviews and data collection. Consultation with female veterans who are actively engaged with research of female veterans.
Member checking	Amankwaa (2016); Connelly (2016); Cope (2014); Houghton et al. (2013).	Asking, "Does the interview transcript reflect your words during the interview?" As part of interview conclusion, researcher checked to clarify and or verify responses from participants.
Journaling	Amankwaa (2016).	Entries in journal after each interview
Protocol	Amankwaa (2016).	Development of a timeline with planned dates for each activity related to credibility before study begins

Dependability. Dependability refers to the stability of data throughout the duration and conditions of the study (Cope, 2014) and consistency of the findings such that they have

repeatability (Amankwaa, 2016; Connelly, 2016; Cope, 2014). Dependability is analogous to reliability in quantitative research (Cope, 2014; Melnyk & Fineout-Overholt, 2015; Merriam, 2009; Streubert & Carpenter, 2011). Streubert and Carpenter (2011) maintained that a study could not have dependability without credibility. Furthermore, Sharts-Hopko (as cited in Streubert & Carpenter, 2011) suggested that triangulation had the potential to strengthen the dependability of a study. Table 4 includes specific strategies used in this study for strengthening dependability. Triangulation, reflexivity, and an audit trail ensured dependability in this study.

Table 4

Dependability strategies

Strategy/Technique	**Source**	**Example**
Audit Trail	Amankwaa (2016); Connelly (2016); Melnyk & Fineout-Overholt (2015); Houghton et al. (2013).	Include a list of documents planned for audit (Amankwaa, 2016). Use of NVivo to maintain a 'trail' of decisions during data collection and analysis (Hougton et al., 2013).
Journaling	Amankwaa (2016).	Before and after interviews and/or major events in the study.
Reflexivity	Houghton et al., (2013).	Maintaining a diary of researcher thoughts and reflections
Triangulation	Streubert & Carpenter, (2011).	Time, space, and person triangulation methods includes different sources of participants

Transferability. Transferability implies the ability of the researcher to express the feelings and emotions of the participant's experiences in a faithful manner (Cope, 2014). Transferability also indicates that findings are useful and applicable (i.e., transferable) to other people in similar settings and is analogous to generalization in quantitative research (Connelly, 2016). It also suggests the "fittingness" of a study (Cope, 2014; Streubert & Carpenter, 2011).

Transferability is analogous to generalization in quantitative research (Connelly, 2016). Thick descriptions from each participant ensured transferability in this study. Table 5 illustrates specific strategies for strengthening the transferability of a study.

Table 5

Transferability strategies

Strategy/Technique	**Source**	**Example**
Thick description (field notes)	Amankwaa (2016); Connelly (2016); Houghton et al. (2013).	Direct quotes from the participant, field notes showing how themes were developed (Houghton et al., 2013). Asking open ended questions that solicit detailed responses (Amankwaa, 2016).
Journaling	Amankwaa (2016).	Same as above.

Confirmability. Similar to dependability (Houghton et al., 2013), confirmability in a study substantiates that the findings and interpretations were grounded in data (Melnyk & Fineout-Overholt, 2015) and that the data accurately represented the participants' responses and not researcher's biases or perspectives (Cope, 2014). It is analogous to objectivity in quantitative research (Connelly, 2016). Streubert and Carpenter (2011) described confirmability as a process criterion, similar to a fiscal audit in which the audit trail provided the findings that another researcher can follow. The importance of a clear description of the evidence and thought processes generating the conclusions is emphasized. Triangulation, reflexivity, peer debriefing and member checking provided confirmability of data collected in this study. Table 6 illustrates the strategies for ensuring a study's confirmability.

Table 6

Confirmability strategies

Strategy/Technique	**Source**	**Example**
Triangulation	Amankwaa (2016); Houghton et al. (2013).	Determine specific triangulation methods; multiple data sources.
Reflexivity	Hougton et al. (2013).	Reflective diary of thoughts and ideas throughout study.
Journaling	Amankwaa (2016)	See other journal examples.
Peer debriefing and member checking	Connelly (2016).	Discuss notes with a respected peer/colleague to eliminate bias.
Protocol	Amankwaa (2016).	Create a timeline with activities relevant to confirmability before beginning study.

Conclusion

This chapter described the methodology used in conducting this research. The theoretical approach of Straussian Grounded Theory, with an embedded quantitative element, assisted in understanding the phenomenon and in examining the data. The purpose of this study was to explore and understand the decision-making process of healthcare access and utilization by female veterans. The sample consisted of $n = 26$ participants. Ethical consideration was provided to ensure the protection of participants. Of the $n = 26$ women veterans who volunteered for the study, *26* participated in the semi-structured interview of open-ended questions and completed the items included in the Decisional Conflict Scale questionnaire (O'Connor, 1995). Data analysis followed the constant comparative method of Strauss et al., (1998) that resulted in a substantive theory describing the decision-making process to access and utilize healthcare by women veterans.

Chapter IV

PRESENTATION OF FINDINGS

This qualitative study utilized the Straussian grounded theory (SGT) process to explore the research question: What is the decision-making process by women veterans to access and utilize healthcare? This design provided an understanding and explanation of the phenomenon through the theoretical development process. The Decisional-Conflict Scale (DCS) was embedded as a quantitative instrument to measure the potential attribute of decisional conflict within the decision-making process. The purpose of this chapter is to describe the findings related to the question. Sections included in this chapter are (a) description of participants, (b) description of theoretical development process, and (c) presentation of the substantive theory, "The G.R.I.T. Theory of Decision-Making by Women Veterans".

Description of Participants

Recruitment of study participants began with contacting the veteran organizations described in chapter three. Purposive sampling and the snowball method assisted with identifying potential study participants. Women contacted this principal investigator (PI) through email, telephone, and text messaging. A total of 57 WVs responded to the recruitment efforts and met the inclusion criteria. The first 20 women were scheduled. Additional women were informed by the PI that they would be contacted if additional information was required for this study. The final study sample consisted of 26 participants who met the criteria for participation. Anonymity and confidentiality of study participants was maintained through the use of an initials/number format

as a pseudonym. Participants provided informed consent for the study upon agreeing to participate and again at the beginning of the data collection process.

Data collection occurred through the interview process. Interviews were conducted at a mutually convenient time between the participant and the PI with consideration of the time zones. Due to the geographical divide among study participants, all interviews occurred over the telephone. Individual semi-structured telephone interviews were conducted from November 2018 through January 2019. The interview process began with a collection of demographic data, followed by administration of the DCS. Demographic data including age, race, ethnicity, education level, marital status, military service, and healthcare preference are presented in Table I (See table 1: Study Participant Demographics). Analysis of the DCS results are presented in Table 2. This process provided established rapport before beginning the semi-structured interview. Interviews were scripted to elicit information about experiences that contributed to the decision-making process to access and utilize healthcare (See Appendix A). Additional probing questions were used to clarify or expand on responses. The open-ended questions generated a story that each participant was eager to share. Each interview lasted between 45 and 90 minutes and were audio-recorded and transcribed verbatim. Transcriptions were verified by listening to recordings to ensure accuracy. Field notes and memos were written during and after each interview and were included in the data analysis. Data collection and analysis took place concurrently to maximize theoretical sensitivity.

The study sample consisted of participants between the ages of 27 to 64, with a mean of 46.6 years. Ethnicity was divided among Caucasian participants (77%), African American (19%), and Hispanic (4%). Marital status among participants included married, (50 %), divorced, (46%), or other (4%). Education level ranged from high school graduation (4%), some college

(46%), a Bachelors degree (38%), Masters degree (8%), or PhD degree (4%). Participants served in the Army (58%), Navy (19%), Air Force (AF) (8%) or Marines (15%). Healthcare usage among participants included, VA (35%), VA clinic (15%), private (19%), and VA/other (27%). Study participants shared if they were victims of MST, PTSD, or both during the interview. More than half of the sample, 58%, described being victims of both MST and PTSD, 34% of the participants did not have exposure to either MST or PTSD, and 8% reported PTSD.

Table 1.
Demographic Data

Participant	**Age**	**Ethnicity**	**Marital**	**Service**	**Education**	**Healthcare**	**Trauma**
MS#1	32	White	Single	Marines	PhD	Private	None
SL#2	55	AA	Divorced	Army	College	VA clinic	MST/PTSD
AK#3	27	White	Married	Army	MBA	Tricare	None
TB#4	42	White	Divorced	Navy	College	Private	MST/PTSD
HW#5	32	White	Married	Army	College	Tricare	None
JT#6	46	AA	Married	Army	BA	VA	MST/PTSD
BH#7	37	White	Divorced	Marines	College	Private	None
AL#8	34	White	Divorced	Navy	College	VA clinic	MST/PTSD
JG#9	55	White	Divorced	Army	College	VA	MST/PTSD
RW#10	33	White	Married	Army	BS	VA/Private	None
KR#11	48	White	Married	Army	BS	Medicaid	PTSD
NS#12	32	White	Married	Navy	BA	Private	None

Table 1. (continued)
Demographic Data

Participant	**Age**	**Ethnicity**	**Marital**	**Service**	**Education**	**Healthcare**	**Trauma**
JS#13	30	White	Married	Army	BS	VA/Private	PTSD
TS#14	46	White	Divorced	Navy	BS	VA clinic	MST/PTSD
TR#15	54	White	Divorced	AF	College	VA	MST/PTSD
AW#16	32	White	Married	AF	College	VA	MST/PTSD
ASW#17	38	White	Divorced	Army	College	VA	MST/PTSD
JJ#18	46	White	Divorced	Marines	BS	VA/Private	MST/PTSD
BM#19	62	White	Married	Navy	College	VA	None
ASCBD#20	30	White	Married	Army	BA	Private	MST/PTSD
MH#21	49	Latina	Married	Army	Masters	VA/Private	None
GB#22	64	White	Divorced	Army	College	VA	MST/PTSD
UK#23	63	AA	Married	Army	BS	VA	None
CC#24	52	AA	Married	Army	BA	VA/private	MST/PTSD
EH#25	46	AA	Divorced	Marines	College	VA	MST/PTSD
AO#26	40	White	Divorced	Army	HS	VA clinic	MST/PTSD

The Decisional Conflict Scale

Quantitative Analysis

The DCS is a quantitative instrument that assesses decisional conflict. Chapter three includes a detailed description of this scale. It was used in this study following completion of the demographic questionnaire as a technique to build rapport with the study participants in additional to exploring if decisional conflict affects the decision-making process to access and utilize healthcare.

Basic descriptive statistics were first calculated on all 16 items of the scale. (See Table 2: DCS scale). The total DCS and the 5 subscales were analyzed separately for reliability (Table 3). Total scores were calculated to assess decisional conflict. According to the user manual, a score of 0 indicates no decisional conflict, whereas, a score of 100 indicates a high level of decisional conflict. The opinion of the PI was that this represented a broad range with potential for an arbitrary interpretation. Further exploration of how this scale has been used in previous studies revealed that previous researchers (Hecker, 2015) have established cut-off values; scores less than 25 indicate participants make sound decisions, whereas, scores greater than 37.5 indicate conflict or delay with making decisions. Of the 26 study participants, 15% had scores greater than 37.5 indicating conflict or delay with making a decision; 85% indicated that decisional conflict did not affect their decision-making process.

O'Connor (1995) who developed the DCS, found good internal consistency, with a Cronbach's a = .78 - .92. Reliability for the DCS scale and its subscales in this study indicated Cronbach's alpha coefficients ranging from a = .75 to .95 (see Table 3 for reliability data). Most items on both the full DCS and its subscales appeared to be worthy of retention, resulting in a decrease in the Cronbach's alpha if deleted. Exceptions to this include, item 6 on the values

clarity subscale, “I am clear about which is more important to me, the benefits or the risks and side-effects” where *a* = .85. Deleting this item from the scale would increase its reliability to *a* = .91. A slight increase in reliability would occur on the support subscale, *a* = .75, if item 9, “ I have enough advice to make a choice” was deleted resulting in an *a* = .79.

Table 2 *DCS Scale* *n* = 26	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree 94
1. I know which options are available to me.	34.6%	50%	11.5%	0	3.8%
2. I know the benefits of each option.	26.9%	38.5%	23.1%	7.7%	3.8%
3. I know the risks and side effects of each option.	19.2%	50%	15.4%	11.5%	3.8%
4. I am clear about which benefits matter most to me.	38.5%	30.8%	15.4%	7.7%	7.7%
5. I am clear about which risks and side effects matter most to me.	38.5%	38.5%	11.5%	7.7%	3.8%
6. I am clear about which is more important to me (the benefits or the risks and side effects)	50%	30.8%	11.5%	3.8%	3.8%
7. I have enough support from others to make a choice.	38.5%	46.2%	7.7%	7.7%	0
8. I am choosing ·without pressure from others.	53.8%	42.3%	3.8%	0	0
9. I have enough advice to make a choice.	42.3%	30.8%	19.2%	3.8%	3.8%
10. I am clear about the best choice for me.	34.6%	38.5%	11.5%	11.5%	3.8%
11. I feel sure about what to choose.	34.6%	30.8%	19.2%	11.5%	3.8%
12. This decision is easy for me to make.	30.8%	26.9%	26.9%	11.5%	3.8%
13. I feel I have made an informed choice.	38.5%	42.3%	11.5%	3.8%	3.8%
14. My decision shows what is important to me.	46.2%	30.8%	15.4%	3.8%	3.8%
15. I expect to stick with my decision.	34.6%	46.2%	11.5%	3.8%	3.8%
16 . I am satisfied with my decision.	34.6%	34.6%	19.2%	7.7%	3.8%

Table 3

DCS Reliability Analysis

	Cronbach's Alpha
Full DCS	*a* = .95
Uncertainty Subscale	*a* = .92
Informed Subscale	*a* = .94
Values Clarity Subscale	*a* = .85
Support Subscale	*a* = .75
Effective Decision-Making Subscale	*a* = .92

Results from the administration of the DCS within this study sample indicate that most women veterans do not experience decisional conflict relevant to accessing and utilizing healthcare. Results from the qualitative data analysis in this study clearly indicate that while other factors affect their decision-making process, study participants did not describe feeling conflicted on their decision to access and utilize healthcare.

The DCS is a valid and reliable instrument for assessing the presence of decisional conflict. Recommendations for future use is discussed in chapter 5.

The participants indicated they saw their study participation as a vehicle to communicate their positive and negative healthcare experiences.

Conversation throughout the interviews often resulted in divergence from the interview guide as study participants eagerly shared their story. With subtle redirection the conversation resumed. Many of the interviews took place in a location where the study participants would not be interrupted. One participant preferred to be interviewed while she was in her car and her

family was inside the home. She expressed that she had no privacy but that contributing to this study was so important to her. Another participant had returned home three weeks after service and acknowledged that she was "trying to find her groove" but she also did not want to miss an opportunity to share her experiences. The interviews could easily have continued longer- The camaraderie between the researcher and the participant demonstrated that a trustworthy rapport was established. These women wanted to be heard!

Participants were given a $20 Amazon electronic gift card at the conclusion of each interview. Some participants described how they planned to use this compensation. Some of the study participants shared with the PI how they were going to use the gift card, while others asked to have the card donated to other veterans in greater need than themselves. Most participants asked if they could hear about the study's findings. The researcher explained that following study completion and successfully defending the dissertation, a summary of findings and recommendation would be sent to each participant using the email provided for the study. The participants thanked the researcher profusely for the work of the dissertation and expressed gratitude that a civilian healthcare provider was interested in supporting their concerns relevant to accessing and utilizing healthcare. A common sentiment resonated throughout the interviewees' responses, "I hope that my story will help other women veterans." Validation of the importance of this dissertation topic was confirmed following reflection after each interview and reviewing the audio-recorded transcripts. This note received from one of the study participants corroborates the gratitude gained throughout the interview process:

> Dear Corinne, Thank you for letting me be part of your journey! In doing what you're doing, you have become an extension of Female Veterans...part of a large, mostly unheard, voice. It was very rewarding to talk to you and share my experiences, thoughts,

etc.! I wish you much love, luck, and happiness always. Please let me know if I can (ever) help further...I would be honored! Thank you for the Amazon.com Gift Card! -GB

P.S. I can't wait to read your summary of your dissertation!

Prelude to Data Analysis

The purpose of this study was to explore the decision-making process to access and utilize healthcare by women veterans. Following grounded theory methodology, the inductive process of exploring the phenomena of this study was implemented.

The interview process began with some trepidation that occurred after completing the first few interviews. Of these initial interviews, three of the study participants were highly educated and had professional careers, described effective decision-making processes whereby they were satisfied with how and where they received their healthcare. A concern of the researcher was perhaps the inclusion criteria was too broad, and should have excluded women veterans who had advanced degrees, or perhaps including only participants that used the VA for healthcare. A potential interviewer bias began to emerge as this researcher presumed that highly educated women veterans whom did not experience any hardship also did not experience challenges with decision-making relevant to healthcare choices. Through a process of reflection and reviewing study journal notes, it was determined that additional interviews may be needed to elicit more relevant concepts. Six more study participants were interviewed. The interviews did not reveal any new codes or concepts and it was determined that saturation was reached.

Theory Conceptualization Process

Theory conceptualization began with replaying the recordings of each interview. Notes were taken before looking at the transcriptions. To ensure accuracy, this PI, reviewed the transcriptions and compared them against the notes to identify similarities and differences. This

PI chose to analyze the data organically and be completely immersed in the data without the distraction of learning a software program and potentially skewing the process.

Constant comparative analysis. Constant comparative analysis was woven throughout the coding process for this study. As codes and categories emerged, similarities and differences in their properties and dimensions were analyzed. Comparison of the first six interviews against each other initiated this process. When participants were asked to describe the factors that either motivated them or prevented them from getting healthcare, a natural description of how study participants approached their decision to get (access) and return (utilize) for healthcare was offered. Following the organic flow of conversation, the interview was modified by adding the question, "So, we have talked about what motivates you and what gets in the way of your decision to get healthcare and then may or may not return for healthcare, can you tell me if there are specific steps you take to make this decision?" Most participants paused before responding and then shared 3- 4 statements about how they arrived at their decision. Including this question in the remaining interviews seemed to confirm that women veterans think and reflect about why and how they may or may not access and utilize healthcare. As a result of this modification, a greater understanding of the participant's perspectives led to the identification of common themes across the data.

The remaining interviews were examined multiple times to ensure properties and dimensions were accurately reflected in the codes. This process required a significant amount of time and led to the PI feeling overwhelmed by the volume and depth of data requiring analysis. Breaks during the analysis sessions enabled this PI to return to the data analysis with clarity and confidence that important concepts were identified. Moreover, Strauss & Corbin (1998) iterate

the importance of comparisons emerging fluidly and genuinely reflecting the participant's perspectives.

Open coding. Strauss & Corbin (1998) referred to the process of open coding occurring through opening the data to expose thoughts, meanings, and ideas contained therein. Statements and responses from participants that seemed to stand out were highlighted on the transcripts and/or captured as notes on the interview guide. A handwritten list of identified codes became the PI's working document with similar codes highlighted the same color for ease of categorizing during the coding process. Codes were extracted to create a coding inventory (See Table 3: Code Inventory). Line by line coding facilitated identification of "in vivo" codes. For example, "keep putting one foot in front of the other", "trust in my team", "I can get in the way of me", "need to unravel right now", "have to advocate for myself or I'll end up dead". These statements were added to the code inventory. Ongoing analysis of their words and phrases enriched the dimensions of each concept. In this study, the in vivo codes that emerged were unforeseen and thus validated the accuracy of category identification.

Table 4

Code Inventory

Lack of information	Untimely information	Trust vs mistrust
Very much a man's place	Jump through hoops	Red tape
Complicated	Convoluted	Inconsistent care and communication with HCPs
Lack of confidentiality	A hassle	Empowered
Feeling responsible	Too many processes	Not prepared to think about healthcare upon return
Someone who listens	Unfamiliar with process	Transportation issues
Unseen healthcare issues but had to maintain other roles as a woman	Some VA's better than others	Lack of autonomy and agency
Cost	Location & distance	Don't understand women veterans' issues
Difficulty articulating what is needed	Transition class very helpful	Fear of unknown
Difficult to get appointment there so will use ED or urgent care	Lose time in process	Remain silent for fear of backlash
Skeptical and guarded	Feels separate from civilian world	Feels proud
Lack of communication between DOD and VA	Reason for seeking healthcare is for QOL	No time to decompress
Easily dismissed	No warm fuzzies	Transition is difficult
Supported physically, mentally, and emotionally	Sense of loneliness	Women veterans misunderstood in community
Cookie cutter approach	No exam table in GYN office for women	Records are not automatically sent VA
Not thinking about it when deployed	Need for self-advocacy	Relief from the pain
Ashamed to ask for help	Being stuck	Knowledge deficit of women veterans' health issues among HCPs
Wanting to return home	Determined	

Through this process of open coding, 54 codes were extracted from the data and revealed a strong relationship among the concepts that provided the basis for category development (See Table 4: Code Inventory).

The strength and relevance of the codes was determined by the repetition of occurrence throughout the data analysis. Theoretical sampling allowed for saturation of categories, and the development of concepts illustrated through their properties and dimensions At this point in the coding process, concepts began to almost naturally fall into higher abstract groups. The next step was to organize the groups and identify a relevant name for each category.

Axial coding . This phase of the analytic process resulted in the process of reassembling the fractured data collected during the open coding phase. Codes were examined and delineated in terms of their properties and dimensions. Through an organic and inductive analysis, themes and categories emerged. Strauss & Corbin (1998) describe how the initial "hunches" often occur during this phase of analysis. Relationships among concepts were explicated and categories started to emerge.

The initial hunch for this PI was that women veterans are "unheard" and "misinformed". This led to the development of the first two categories. Comparison of the data continued to validate this category's presence. The process of looking for other relational properties among the concepts that would form additional categories continued. Returning to the transcripts and notes, the categories of, (1) navigating the system, (2) sense of being vulnerable, (3) inner resolve or digging deep, (4) being informed, (5) being heard, (6) identity, and (7) presence of barriers emerged. This process resulted in 54 first level codes and seven categories (See Table 5: Initial Codes and Categories).

Table 5

Initial Codes and Categories

Navigating the system	Jump through hoops, red tape, complicated, convoluted, a hassle, too many processes, unfamiliar with processes, lose time in the process, not thinking about HC when deployed,
Being vulnerable	Trust vs mistrust, very much a man's place, inconsistent care and communication with HCPs, lack of confidentiality, skeptical and guarded, fear of unknown, no time to decompress, sense of loneliness, ashamed to ask for help, being stuck
Relying on inner resolve	Empowered, responsible, supported physically, mentally, & emotionally, seeks healthcare for quality of life, feels proud, determined, relief from the pain, need for self-advocacy, wanting to just return to whatever normal is
Being informed	Lack of information, untimely information, transition class very helpful,
Being heard	Women veterans misunderstood, easily dismissed, keep it in due to fear of backlash (consequences), Knowledge deficit of women veterans' health issues among HCPs,
Identity	Not prepared to think about healthcare upon return, unseen healthcare issues while maintaining other life roles, lack of autonomy and agency. Feels separate from civilian world,
Encountering Barriers	Some VAs better than others, cost, location, distance, transportation, difficulty articulating needs, appointments difficult to get, lack of communication between DOD and VA, cookie-cutter approach, no warm fuzzies, no exam table at GYN office

One of the appealing qualities of grounded theory is its non-linear nature. Phases of data analysis are dynamic and cyclical. For example, open coding is not complete once all concepts are derived. Similarly, axial coding continues beyond the first round of categorization. Dimensions and relationships continue to evolve through the analysis and enrich the explanatory power of this methodology.

The process of explicating categories for this study involved creating a separate list for each identified category. Relevant concepts were sorted into the categories by asking the questions, why, how come, where, when, how, and with what results (Strauss et al., 1998). Answering these questions facilitated the contextualization of the phenomena and elucidated the process and structure of the data. Strauss & Corbin (1998) referred to this organizational scheme

as the “paradigm”. Looking for the conditions, actions-interactions, and consequences forms the basis of this paradigm. An example of how the paradigm facilitated the organization of categories for this study is as follows:

> ***Conditions-*** I wanted to die and I couldn’t die. I couldn’t find a non-messy way to kill myself. I didn’t do it because it was going to be messy and then my kids and family would have to pick up where I left off.
>
> ***Actions-Interactions***- This is what got me to the VA.
>
> ***Consequences*** -And there’s a lot of women veterans in my shoes. That is why I help. I don’t want other women to get to the point I was at. That is why I am working with DAV, running the fishing trips.

This process revealed redundancy among some of the categories with concepts being duplicated on lists. This required further analysis of the categories. Categories were being “folded-in” to other categories. For example, “being heard” was folded into “being vulnerable”; being informed was folded into “navigating the system”. This interplay between induction and deduction led to the process of refining categories. When no new properties, dimensions, relationships, conditions, actions/interactions, or consequences were identified in the data, categories were saturated. Refining the categories and looking for signs of the emerging core category would follow.

Selective coding. This phase of the analytic process results in selection of a core category that is linked to and relates all of the main categories of the study. However, at this point of the data analysis, it became clear to the PI that another break away from the data was necessary. Doubt about the categories and their relationships to the concepts and each other began to flood the mind of the PI. It was clear that continued immersion in the data for subsequent days would

result in the development of an inaccurately identified core category, and hence a theory that would not be substantiated.

Following this break and returning with a fresh perspective, categories were once again refined and integrated to form a larger theoretical scheme. This was the final phase of categorization. It felt right and the pieces (concepts>categories>interrelated concepts) fell into place almost seamlessly. The explanation between the linkages was logical and consistent.

The final major categories that emerged included (1) being vulnerable, (2) navigating the system, (3) digging deep, (4) managing my life as a veteran, and (5) encountering barriers.
Labels of categories were revised slightly with guidance from Dr. Janice Agazio, Dissertation Chair (See Table 6: Final Categories and Codes). Throughout the analytic process, the PI and the Chair discussed the findings, exchanged ideas, and brainstormed on the evolving theoretical orientation. The following memos illustrate the origin of theory development through the relational statements,

Memo 2/20/19:

> Having inner resolve also reflects a process in this study. First introspection occurred, then a response to self-preservation, and then through persevering (or tenacity) inner resolve became the factor that supports decision-making. Further, the potential core category, “having inner resolve” began to emerge.

This was reviewed with Dr. Agazio for confirmation that she saw this emerging category through her review of the data analysis.

Memo 2/21/19:

> Looking at the categories and how they emerged, having inner resolve seems to integrate each:

They [participants] could not navigate the system without resolve

Their resolve supports them through vulnerability

They use resolve to manage their lives as women veterans, and

Resolve enables them to overcome barriers [to access and utilize healthcare] they encounter

Table 6

Final Codes and Categories

	AGGREGATED AND FINAL	SECOND ROUND CONCEPTS
Being vulnerable	(1) ashamed to ask for help (2) not being heard, (3) lack of trust	Trust vs mistrust; quality of care from healthcare providers; ashamed to ask for help; Not being heard: Women veterans misunderstood, easily dismissed, keep it in due to fear of backlash (consequences), Knowledge deficit of women veterans' health issues among HCPs,
Navigating the system	(1) Information needs, (2) a fragmented process, and (3) a complex and convoluted experience.	Complex and convoluted experience; fragmented process; Being heard: Lack of information, untimely information, transition class very helpful,
Managing my life as a veteran	(1) From military to civilian life (2) Gender bias & stereotype	Not prepared to think about healthcare upon return, unseen healthcare issues while maintaining other life roles, lack of autonomy and agency. Feels separate from civilian world, very much a man's place, don't understand women's issues
Encountering Barriers	Personal Physical	**Structural:** Some VAs better than others, cost, location, distance, transportation, appointments difficult to get, **Interpersonal**: Gender bias continues, difficulty articulating needs, lack of communication between DOD and VA, cookie-cutter approach, no warm fuzzies, no exam table at GYN office

Emergence of the Core Category

Strauss & Corbin (1998) emphasize the necessity of checking the theoretical scheme for internal consistency and logic through verifying development and saturation of each category prior to choosing a core category. This was accomplished through ensuring that categories were well differentiated. For example, there was overlap in the concepts within the category being heard. This resulted in aggregating being heard and navigating the system. Similarly, concepts within the category "being informed" were not well differentiated from navigating the system and were aggregated within that category. Ascertaining that categories were clearly defined in terms of their properties and dimensions provided additional confirmation. Another important aspect for development of the core category is checking for density within existing major categories. The major category, "encountering barriers" was not as well developed with the sub-categories of "structural and interpersonal". Once the sub-categories were revised to reflect, "personal and physical" other codes were pulled in and included in the analysis resulting in a richer category.

The core category, "Having Inner Resolve" emerged as the overarching theoretical scheme. Inner resolve is central to the major categories identified, (1) being vulnerable, (2) navigating the system,

Through analysis of the words from the study participants, having inner resolve provides them with a strong foundation through which they can overcome their vulnerability, navigate a healthcare system, such as the VA, maintain the ability to reflect and introspect on their thoughts and emotions in response to their military experiences, and finally, conquer the personal and physical barriers they might encounter when accessing and utilizing healthcare.

Having inner resolve reflects a process through which the women in this study conveyed how reflection and introspection provided them with the gumption to seek out the type and level of care they required to function as a woman veteran in a civilian society. Inner resolve provided them with the impetus to respond to acts of self-preservation and become more resilient. Mistrust on many levels was expressed by every study participant. The ability to regain trust requires inner resolve. Seeking out healthcare in a system run by a government perceived as failing and abandoning them, is indicative of the rebuilding of trust- this too requires having inner resolve.

Having inner resolve explains the process of decision-making to access and utilize healthcare by women veterans. The five major categories providing the structure of having inner resolve are described through presentation of verbatim portions of interviews and the PI's analytical process.

Description of a Substantive Theory

Theoretical relational statements derived from the emergence of the core category, "having inner resolve" and other category linkages, formed the basis of, "The G.R.I.T. Theory of Decision-Making". When diagramming the model (Appendix B) to illustrate the theory and its relational components, the word grit came to mind. After speaking with the twenty-six study participants, grit surfaced as a commonly woven character trait. The Oxford dictionary defines grit as, "courage and resolve; strength of character". Aligning with the core category of "having inner resolve" and hearing their words, tone of their language, and their emotional expression, grit seemed to fit the model. Grit is used in this theory as an acronym: G- gumption (determined and full of courage); R- resilience (emerged as a concept during analysis and clearly reflected during interviews); I- insight (insight, introspection builds inner resolve), and T-trust (fluctuating levels of trust that do not inhibit these women from striving to overcome their challenges.

McEwen & Wills (2014) describe the components of a theory including theoretical statements, linkages, and assumptions.

Theoretical statements in the G.R.I.T. Theory of Decision-Making are as follows:

1. Inner resolve supports women veterans through periods of vulnerability that may impact their decision-making skills.
2. Women veterans rely on inner resolve to navigate a healthcare system where they may choose to access and utilize healthcare.
3. Women veterans use their inner resolve to manage their lives as veterans in a civilian community where deciding to access and utilize healthcare may be hindered.
4. Inner resolve assists in conquering barriers to accessing and utilizing healthcare they may encounter throughout their decision-making process.

Linkages:

1. Overcoming vulnerability may facilitate navigating a healthcare system.
2. Overcoming barriers improve the management of their lives as veterans in a civilian community.

Assumptions:

1. Women veterans require inner resolve to navigate a healthcare system.
2. A vulnerable state of being impedes decision-making.
3. Women veterans have the courage and inner resolve to manage their lives in civilian settings.
4. Having inner resolve will assist them when encountering barriers to access and utilize healthcare.

Theoretical Categories

The following presentation of theoretical categories with verbatim transcript excerpts authenticates the development of The G.R.I.T. Theory of Decision-Making.

Being vulnerable

The initial coding of this category included concepts such as trust vs mistrust, feeling skeptical and guarded, and other descriptors that support a theme of being vulnerable (See table 4 for categories and codes). Another category, 'not being heard" resonated throughout participant responses. However, through the constant comparison process, folding this latter category into "being vulnerable" made more sense since women described feeling vulnerable when they were unheard. Therefore, the refined category of "being vulnerable" includes the concepts, (1) ashamed to ask for help (2) not being heard, and (3) lack of trust

Ashamed to ask for help. After being exposed to a burn pit during the conflict in Iraq, JT described feeling as though her body was "shutting down". She remained quiet about the hallucinations she was having, the pain in her abdomen, visual issues, and how basic daily tasks became so arduous that she would not leave her home:

> Ya know what was happening to me had happened to a lot of women. Mine lasted about 15 months. I never felt so alone. It becomes like a shame issue for us, this depression that we go through to the point where we can't function. But, we don't say anything, we are alone in our suffering. We are ashamed because of our depression.

JT shared how her inability to "make it through the day" was the driving force to get help for her MST and PTSD at the VA. She described the shock when she realized that the Director of the MST program was male,

> "This is a trust issue…women do not want to go and talk about their rape by a male to a male… and there are no one to one appointments, so if you are not good with talking about your issues in a group setting, you will not get the help that you need".

For those women in the study who were victims of MST and PTSD, concerns about negative reactions from peers and superiors was often a deterrent in reporting their experiences for fear of retaliation and feeling more vulnerable. For JS, "asking for help was the hardest thing I have ever done,

> I have insomnia and I pace back and forth, almost like an OCD thing… they were going to prescribe me medication that would affect my deployability and if that happens, then your put on a list and that list is given to the higher-ups and I worked for the higher-ups and I know what happens when you're on that list. And so I decided to bite my lip and then I went in, I was like, okay please don't mention my name. I decided to try it again, two years later when I had my daughter cuz I knew I needed the help.

TS already had a "bad taste in her mouth" when thinking about going to the VA for treatment of Gulf War related symptoms since "they never provided us with any information on what we were feeling might possibly be related to what we were exposed to". She related these statements when describing her thought of seeking help for MST and PTSD:

> Now the big thing is military sexual trauma and I was raped while in the military, and I've had other sexual harassment situations. But like with my PTSD I wouldn't deal with it for a long time. I thought it was useless to say anything and I did not have the courage to look at it and see how it impacted my life and that kind of encouraged me to finally submit all the paperwork.

A commonly woven thread throughout the interviews was a focus on the lack of gender equality and the demeaning portrayal of female service-members by their male counterparts often occurring in their presence. One woman noted, “It is still very much a man’s place and they don’t feel they need to listen to us”. Acknowledgement of this truth led to feelings of isolation and shame. The following words illustrate this sentiment:

> I never said anything because I didn’t think there might be some solution or something. It is not uncommon to keep things hush-hush. And then it's not until you leave that environment, when you feel, like, you're actually safe enough to share your experience. It wasn’t until several years after active duty, things were coming up and then I was finally able to get the pieces together…
>
> I have had so many female issues- women need to know they are safe to get help- we are afraid. I’d go to the VA but when I feel judged it makes me not want to go back.
>
> …when you feel violated by the VA, you feel like it’s a violation by a family member

And finally, the most poignant response as related by CC:

> I was a young soldier in the Army, the Captain’s assistant touched me inappropriately, and he grabbed my breasts. I reported through the chain of command, and nothing happened to him. He simply shied away from me. I, on the other hand was shamed and ridiculed for months to come by other soldiers in my unit. I didn’t know how to seek help. No one helped. I felt alone for a very long time, but didn’t think I could do anything about my situation.

Feeling vulnerable is indeed affected by feelings of shamefulness and loneliness as illustrated in the transcripts. However, closely intertwined and perhaps preceding those feelings, is “not being heard”.

Not being heard. Having a voice, or lack thereof resonated throughout the interviews. The women recounted feeling easily dismissed or misunderstood. Many commented on feeling that healthcare providers in both VA and non-VA settings were not listening to their concerns. Some women indicated that it was difficult to articulate what they needed.

> Memo (1/9/2019) It feels like these women volunteered so quickly for this study because they saw me as a vehicle for their voice. I really sensed they thought whatever they were telling me, perhaps I would relay the information to the VA and be a conduit for change? Listening to their comments such as, this is why we need you" and "we really need someone who listens to us". I was thanked by every participant for listening to them. I found myself frequently jotting down notes on their transcripts such as, "wanting to be heard", "feels no one listened to her", and other similar thoughts.

One study participant illustrated an experience where a plan to report (and hope to be heard) was hindered due to potential loss of commission to the Officer Candidate School (OCS):

> I was sexually assaulted by the Chaplain two weeks prior to leaving for OCS. I reported it to the chain of command. The First Sergeant refused to address the incident because he told me I was no longer an enlisted soldier since I was going to OCS. I was told that if I pressed charges, I would never receive my commission since officers must stick together. I, of course went on to attend OCS.

Needing to be heard was the focus of my interview with AL. After describing the day that she was raped and diagnosed with a brain tumor, she said talking about her experience has helped her heal:

> I am happy to share my story. I did nothing wrong. There is no reason for me to not have other women hear my story…I have been on a few podcasts talking about my experience

> and so many women have shared with me that now they are able to tell about their experiences. If I can help other women it is so worth it…

AL described how her assault was from a fellow servicemen whom she was tutoring. She reported him, and the only consequence was that he was dismissed from the class.

> Women [veterans] are not heard -Whenever they get their symptoms and say something is wrong they're always being dismissed and told it's probably because you're a woman and that gets very frustrating …

AL reflected, "If I don't advocate for myself, I'll end up dead". This comment supports the concept of needing to be heard. She also described her experience with her nurse practitioner (NP),

> My NP really listens to me. She asks me questions and we work back and forth to solve a problem. She just gets it. I also prefer to be seen by docs who are or were in the military or work at the VA. Civilian healthcare providers just don't get it, "I trust my tribe".

AL clearly illustrated both the need to be heard by healthcare providers as well as the need to have a voice for other women:

> I'm running for Congress. Yeah, I'm running for Congress in April …that's because of everything that I've gone through. I see major issues with what's going on in our country and healthcare- we're talking veterans! We're talking about the military, industrial complex, like it has directly affected my life and shaped me…Like I'm relatable to a lot of people who can take one or two things that I've gone through and say, I know what she's talking about…

Several other participants referenced not bothering to make appointments at their VA because they were told by other women veterans that "nobody listens". One participant noted

that “empathy and presence is most important to me”, while another commented, “I need more care but I don’t want to rock the boat, so I won’t ask therefore I won’t get. The ability to advocate helps with getting healthcare…no voice, no help”.

Most of the women in this study indicated that despite the type of healthcare issues they experienced, their needs felt minimized. A few of the participants expressed that non-VA healthcare providers lacked knowledge of the unique and specific healthcare issues experienced by women veterans. Further they described being referred to other providers when the physician was unable to provide appropriate guidance and direction. One study participant commented, “I feel like I get the run around by these doctors”. Receiving care at the VA did not always provide a solution. The participants in the study describe a fragmented system with a lack of resources resulting in high levels of frustration. Others explained feeling as though their concerns were unheard by employees at the VA. Responses from the study participants suggested that not being heard contributed to their sense of vulnerability.

Lack of trust. Participants commented on feeling uncertain of the attention and care they would receive [at the VA]. “Fear of the unknown is enough to keep me from going there [local VA] said one participant, while another shared, “I had an anthrax series before I deployed and I really don’t trust that the government has tested the effects of Anthrax on humans with ovaries” .The women who were interviewed confided in this PI about their MST explaining that it’s difficult to trust when a lack of sensitivity is conveyed by their healthcare providers and how that contributes to being vulnerable. One of the interview questions pertained to factors that affect the decision to access [get] and utilize [return] healthcare. SL responded, “trust in my team is what motivates me”:

> Because they've been so faithful and so helpful and everything that I need help with. You know, their level of communications within the agency, all of them, you know- I can't say enough good things about them. I need to be one of those people that has a commercial that says. You know, I'm [local politician] and I approve this message… [Laughter]

SL's description suggests that having trust in the system [VA] helps with her decision to continue to access and utilize healthcare through her local VA. However, the majority of the study participants provided statements that suggest otherwise. RW's healthcare issues began during her tour in Afghanistan. She related this experience:

> I feel like they keep you coming in the door just because they want to take money from you. They're like, "oh, you want to be tested for that, ok if it will make you happy and just keep throwing birth control at you for any female issue, as opposed to actually trying to treat and help their patients... there's no connection… doesn't matter where it is…I probably would still be pursuing somebody else who wasn't part of the VA system… I don't believe women get treated very fairly. Like I said any anytime on active duty, I mentioned having any type of female problems…that's all they do is throw birth control at you and they don't even try anything else…There is just this stigma. I usually just stay away from all military on that end…

A study participant who had multiple deployments including the Gulf War illustrated a few reasons for her mistrust:

> I was deployed multiple times originally with the Gulf war and then was no longer able to deploy because I was just sick. I had gynecological issues here and there…then I was raped in combat [by a serviceman] and it resulted in a pregnancy that ended in a

> miscarriage. I only told my fiancé [also in military] but he didn't believe that I was raped He was the only person I did tell and thought would believe me…

The following experience corroborated this participant's lack of trust:

> … And I was just diagnosed with a brain tumor. Apparently almost six years ago they caught a portion of it on an MRI [for another issue] and the radiology report said [possible brain tumor] refer to neurology surgery. But nobody told me that, nobody told me anything. And I was never referred to anybody. So now I'm supposed to have surgery, because now it's at the size where my only option is surgery. The VA was supposed to have done surgery on November, 1st, but that day came, past, went, whatever…you know, I was calling all the time, when's my surgery going to be? What do I need to do? I heard, 'somebody'll call you' it was weeks before anyone called me…

This statement confirms how mistrust contributes to feeling vulnerable,

> You don't want to walk two to five minutes in the dark because there were rapes that went on around there. I mean soldiers raping soldiers-it's horrible…Women war veterans sometimes endure abuse and mistreatment because it is so prevalent in the military and when we seek help, people call us liars or no action is taken against the assailants…

Further, many participants in this study described encounters with VA staff members whose preoccupation with other issues and lack of responsiveness to their requests for information resulted in feeling devalued and more vulnerable. Women noted how they felt "caught off guard" by the lapses in communication from their healthcare provider. AS commented, "My distrust and skepticism motivates me to seek healthcare outside of the VA…but before going anywhere I need

to “fact-check”. Other participants noted that it was common to be uninformed of changes in their provider or treatment plan during their appointment. Moreover, TB said,

> I don't feel like my stuff would be kept confidential and I feel like it can't just be, so I won’t go there- I’ll stick with my therapist who helped me through my divorce-I speak my mind and when I do it, it’s with my therapist

Despite the majority of experiences that instigated the lack of trust among the study participants, MH provided a different perspective:

> There's women [in the military] that may not be strong enough and may not be able to get support from the folks around them-they’re very vulnerable. There's people out there, not just in the military that want to take advantage of you… I was fortunate enough to be able to recognize the signs and be able to see where I shouldn't be, what to stay away from… I tried to show them and let them know, “Hey, you know, you might want to do something else and not be around them or something like that” on the side. So yes, if you are vulnerable and not strong enough to overcome, then yes you will get into those situations

Another participant’s description confirmed that a lack of trust may be established early in their military career,

> Okay, so for the mistreatment, when you're in the military, it can start even at the recruiting station, you know, some recruiters try to have sex. Then you get to basic training and you hear the stories or have seen yourself, preferential treatment, by the drill sergeant to the ladies recruits that they, like, you know, the sexual kind of story. So you’re kind of groomed, if you will to accept, or to deal with this male-dominated way of either of oppression or harassment.

Navigating the system

Following analysis of the participant's interviews, the decision to access and utilize healthcare was affected by available resources to navigate a healthcare system. The majority of the women in this study used the VA at some level for healthcare. Their decision to access and/or continue to utilize healthcare within the VA system was largely affected by available information regarding their eligibility and process to receive care, the process itself, and the experience while navigating the system. Therefore, concepts supporting the development of this category include, (1) information needs, (2) a fragmented process, and (3) a complex and convoluted experience.

Information needs. Study participants described either a lack of information, untimely information, or information received at a transition class, as affecting their ability to navigate the system. Some women reported an insufficient amount or no information about VA benefits or services, while others received the information too late in their process of deciding to get health care. Often, this resulted in not applying for VA benefits. Military service by women in this study included the Army, Navy, Marines, and Air Force branches of the military. UK described how the availability of information depends on the branch of military, "The Air Force and Army run parallel whereas the Navy and Coast Guard do not provide any information. The Marine Corp mandates attendance at their transitional assistance program (TAPs)". This description was corroborated by responses to the question, "Where do you receive healthcare", followed by the probe, "Since you receive healthcare through 'X', if and where did you learn of your eligibility?"

BH, a retired marine who served in Afghanistan from 2005-2011 described her experience of being informed,

> but I will say that Marines who separate, I think have a little bit of an advantage over other branches, and that may not be the same now, but when I got out of the Marine Corps, it was the only branch at that time that required every separating service member

> to go to a class called TAPs It's a week-long class where you learn about what's available to you and how to file your disability claim, how to make a resume…

BH then emphasized the importance of women veterans being proactive about their healthcare so that they can "live a longer and better quality of life",

> If the women, don't know how to get into the office, because they don't have health insurance or because they're scared that the VA is going to take too long or because they're afraid the next ED three blocks away is going to turn them away. And they don't know how and where to find that special service that is going to meet their needs- they need the information, I feel like there's a huge lack of understanding of health insurance… Each branch should offer this week long information session.

SL described how the "regular flow of information" from her local clinic is the reason that she has "trust in her team" and that motivates her to return for appointments,

> That case manager sure does keep me on my toes, from the beginning of my diagnosis up until now. The whole team would never let me miss an appointment. They make it very difficult to break an appointment, they're happy when you come back, but they would never give up on you. They send me reminders, they connect me to other resources, ya know if they can't help me there-

Responding to the lack of available and useful information, one study participant, MH described that some women veterans receive their information from veteran service organizations. She emphasized that women veterans return home being totally misinformed about their healthcare options,

> Access to information is a big problem. Some, they end up separating within a month maybe 30 days, 60 days, so they're not really paying attention as to what benefits are out there. So, you know, them being able to know what their benefits are and how they can access it… needs to be accurate information. That's what Boot to Heels does, we provide information to our female veterans as well as the spouses. And they say, like that, what they can, and cannot do we actually bring the experts over from, you know, Texas Commission, the VA, whatever apply and I have them show them, you know, what's available for them.

Regarding the timing of information, TB reported that many women are not thinking about their healthcare when they are deployed. Upon return home, they are uncertain of their eligibility status,

> When you're deployed you don't think about how much premiums are, you don't think about how much co-payments are, you just go there, it's taken care of and, you know it seems like such a struggle for some people, who may not know what a copay is and people don't know what a premium is- I know I didn't when I got out the first time. You know, on top of it, say I do go to the VA and there is no help to guide me. So, I think that not knowing, you know, what's covered, who's going to take your insurance those would be obstacles to getting help…

Further, she [TB] suggested that it would be helpful for someone to "help break down the information" when they return home. She reported that there is "a lot of information to process on top of everything else when you return home". Similarly, JG described how women veterans "get lost in the transition" whereas, UK attributes the lack of information due to the male decision-making influence within the military.

Listening to the women describe their information needs reinforced that deciding to access and utilize healthcare can be hindered when the availability and timeliness of information is insufficient.

A fragmented process. The process of navigating the system becomes further complicated when women veterans are unfamiliar with the process of obtaining eligibility through the VA, there are too many processes to understand, and/or they have lost time in the process. The experience with the process of navigating the system was often described as fragmented. Study participants shared their experience with accessing and utilizing healthcare within (and outside of the VA) as being a very difficult process to navigate. While deployed, they did not consider how and where to get healthcare because it was all done at the base. Upon return home, uncertainty of how to proceed impacted their decision-making relevant to accessing and utilizing healthcare.

A contributing factor to the fragmented process occurs due to ineffective or lack of communication. This is exemplified by JG's description of how the DOD and the VA function like two very different systems, "they need to work more seamlessly". She suggested that "since you're getting out of the military, why not automatically send your records to the VA, there is no automatic transfer". Following her deployment, NS did not know how to facilitate her transition from being in the military to civilian life. She "felt very alone" in the process of exploring her healthcare eligibility. JT's experiences clearly describe the origin of the fragmented process,

> Beginning with the return to civilian life, most states don't know when servicemen are coming back from the DOD, there is a break in communication. They are not ready for us. There is so much to do in the process after leaving the DOD that a lot becomes lost. [In this part of the interview, JT is referring to the loss of time.] She stated, "I was

> unfamiliar with the process. I didn't even know how to file a claim, so I had no healthcare"

Many of the women noted that making appointments was very difficult and often required a long wait to receive an appointment. JS describes the Army's response to most women veteran's healthcare complaints as, "lose weight". This was a poignant statement during our interview as JS described her experience of hip pain following the birth of her child. She lost seventy pounds and continued to have debilitating pain. She describes her experience of receiving healthcare through the VA,

> So, then I had to go to physical therapy and then the whole entire process took a year and a half before I was told that I had torn cartilage in both hip joints. Oh, and I remember going when I found out that, that's what it was and the entire time that's what I was dealing with. I went to the patient advocate to be like, okay, they took a year and a half and I feel like, you know, like, someone drops the ball in my healthcare and I guess that the advocate had talked to the doctors and they all said that, like, this type of injury is kind of hard to diagnose and so it took that long for me to get diagnosed.

The following statements from TS clearly illustrate how a fragmented process contributes to difficulty navigating the system. Additionally, the negative VA experiences described by other women veterans on Facebook pages deterred her from pursuing care at a VA. TS was fearful that a VA visit would trigger her PTSD. Despite her intuition, she decided to inquire about her eligibility for military specific treatment for MST/PTSD. Her visit resulted in a major depressive episode.

> (It) really didn't encourage me to go back and have my stuff looked at again, because it is quite an emotional thing to revisit what happened to me and to be able to look at the long-term effects like, PTSD type symptoms that I just learned to manage through my whole life, and so then I finally did that, you know, turn me into a major depression. It seems like everything. I'm experiencing right now with the Iowa VA. Well, I still don't know everything. I can be doing. I get called, you know, like every day with people like, oh, we're gonna set you up for this appointment or that appointment. So, like, we're still in the gathering information phase.

A complex and convoluted experience. For those participants whom used the VA as their primary source of healthcare, common responses included, “I had to jump through hoops”, “It was a hassle so I didn’t go unless I absolutely need to”, “there are too many processes”, and “I am unfamiliar with the process”. For those who sought care outside of the VA, some participants shared that they were never asked by the community healthcare providers if their military associated issues were possibly related to an experience in the military. This often led to dissatisfaction and not returning for healthcare. JG reflects on the complex experience with navigating the system,

> It’s so easy to get lost in the transition- we are in such a hurry to get home and not necessarily interested about our healthcare options because we are not thinking about what we need at that time. We are thinking about our housing, jobs… and then all of a sudden we realize that we need help but we forget who to call, how to begin. We call the VA and realize that our records were not automatically sent from the DOD to the VA; there is no automatic transfer. Some of us are not savvy enough to know who and when

> to call, how to get into the system. It seems like there are two different systems (the DOD and VA) that don't speak. Many of us move around, multiple transitions and we don't know how to make the connections.

This description illustrates how the decision to access healthcare is clearly affected by a convoluted and complicated experience within the VA, and in some cases with non-VA healthcare experiences. Most of the participants described similar process issues. It was either complicated, or they were unfamiliar with how to proceed. Further, some women described the process as being cumbersome and attributed their healthcare issues to a delay in accessing healthcare due to a loss of time within the decision-making process.

KR describes how the lapse in time to get coverage through the VA forced her to try private therapy, but when she couldn't afford it, she went to the VA and "had to fight for it". She describes learning that she needed to be determined 'disabled' and would then be entitled to receive therapy through the VA. Next, KR was informed that she was denied due to not having exactly six months of active duty.

> I didn't recognize that I had PTSD so I didn't get the help. I came home pregnant and the army wouldn't pay for my pregnancy because I was no longer active duty- once they released me, they were done with me. They told me that I could go to the nearest emergency room and that I would get immediate care there. I ended up having to go on Medicaid which was extremely humiliating and depressing, but I had no other choice. Eventually, I ended up getting disability for my PTSD, actually at a 100 percent but it took a long time to get 100 percent.

Participants identified the length of time it takes to get an appointment at the VA as one reason for deciding to not access healthcare. Women in this study related their decision to forgo

accessing any type of healthcare unless they perceived their issues as requiring immediate attention. Many specified the use of an urgent care facility or emergency department when necessary. BH reported that many women simply don't know how or where to get the care that they need upon entering the VA. She describes that when a VA worker does not know the answer to your question, they are quick to send you "down the line" and it becomes this tedious process that prevents you from wanting to return. Regarding care at the VA, JT said that the 'VA is good for either the really sick, like if you have a physical wound, or if you're suicidal- there is no middle port. You can't be in-between and get the care you need. You literally have to jump through hoops to get seen by the right person.

Illustrating further complexity within the system, AL received an "other than honorable" discharge. She describes being raped and diagnosed with a brain tumor on the same day. The rape resulted in a head injury and during an MRI they saw the brain mass. AL describes losing her VA benefit and is still waiting to be evaluated while she receives her healthcare through Medicaid,

> I'm still waiting for some paper pusher to say, oh she was raped, oh she had a breakdown, but I can't even get my claim through the VA for my MST. It is ridiculous. [She says] this adds another layer of complexity and they are asking me to prove that I was raped, but it is the biggest catch-22. How do you prove something if they will not evaluate you?

Study participants attributed their ability to navigate the system, particularly the VA healthcare system being largely affected by the availability and timeliness of information provided, the process through which healthcare access and utilization occurs, and their experience once they have decided to access and utilize healthcare.

Digging Deep

Throughout the interviews, study participants provided statements that conveyed their ability to "dig deep". Their descriptions of experiences indicated that a process was involved in developing this quality. The category of digging deep is comprised of the attributes of the process, 1) being introspective (having insight), (2) responsive to self-preservation (3) perseverance

Being introspective. Most of the study participants described that reflecting on their military experiences assisted them with recognizing what was required to get the help they needed. Being introspective and having this insight provided them with guidance and direction. CC's Army Reserve unit was unexpectedly activated to Saudi Arabia. Our time together included in-depth discussion on how the effects of Operation Desert Storm changed her life forever:

> It was hard for me to sleep, my family was irritating me, and my desire to have fun was diminished…when I drove across bridges, I wanted to drive off the bridge…my soul and moral compass was injured. I desired to seek the needed help…I have had a relationship with God since I was a child and this has assisted me with navigating life. As I reflect on how the years at seminary helped me to heal…I am a woman, I am a mother, I am a child of God, and I am a veteran.

JT reflected on days that were so difficult, "I wanted to die and I couldn't find a way that was not messy- I didn't want it to backfire on my children, my family…" She described how her experiences as a Chaplain Assistant while in Iraq helped to shape her perspective on life,

> Because, I think people look at death as the final step, but, like, for me, you look at service members like, I remember burying twins, a year apart from each other that were killed on the …I wanted to make sure that their family knew what they did for their country and our world and I did…to be able to be a part of that input and shining light on

> the productiveness of what we are all called to do in the military… I told them that they created these lives that were part of a team, we train together, we fight together and we serve and I could go on and on and on and talk about that. It's just amazing. It is amazing.

ASCBD commented on how her skepticism and distrust in the VA led to her motivation:

> I may not have been so motivated to look into the research for myself …I really kind of credit my distrust and skepticism for getting me this far, because there's so many opportunities to just accept the way things are at the VA…My whole life changed when I started to really explore different methodologies of healthcare on my own and I've, I mean, I've lost a hundred pounds, because I started eating healthy. Like, so many problems. I thought that was the way that I had to live for the rest of my life or just ignore my experiences…this self-care, health care thing is my purpose in life…to learn how to get better at it because it is the most important tool that I have

Study participants conveyed their ability to "dig deep" and figure out what they needed- as their next steps towards getting and/or returning for healthcare. TB conveyed how she ponders what her new normal should be since returning home:

> I'm usually a social butterfly, Type A personality and since being home I have no tolerance for people's s***. I have no filter, no tolerance for nonsense. I haven't had time to decompress and figure out s*** but I know that there is something getting in the way. I'm trying to figure it out, but I think it is just going to be time.

Responses to the interview question pertaining to how they felt after the decision to get healthcare was made indicated an element of introspection in that decision-making process. One comment was, "I feel relieved when getting healthcare because this feeling of uncertainty is lifted". Another participant reflected on asking a series of questions to herself, "How bad is it?

am I going to die from this, maybe I should wait it out unless it begins to interfere with my daily functioning?, No, I think I will 'Google' it first"...

Response to self-preservation. The women in this study related different examples of how they have and continue to protect themselves from additional emotional, physical (dealing from conflict related injuries), and psychological harm. One participant commented, "I am a warrior and although my time in conflict is over, I need to keep fighting for myself…I can't go back, I can only go forward now".

Another participant explained,

> I'm honoring myself…I'm taking care of myself, sometimes it's just too much, ya know going from one doctor to another, it does make me weary, but this is what I need to do

Despite the hardship that CC experienced and continues to be affected by, she describes how helping others helps herself,

> So, I just have a passion to educate society about who women veterans are and what we endure and ways that society can help us and our families…also the issues that families of military, veterans, as well as active duty soldiers are dealing with, which is abandonment, poverty, and on and on. The Veterans Ministry helps combat the 22 veterans that commit suicide daily. And I think that was also a driving force of why I want to educate society.

Another example of this participant's response to self-preservation,

> I think my seminary journey has really helped to understand the academics of God in how God has just created a space for me to really talk about the things that bothered me that were suppressed.

TR an airplane mechanic who served in the Air Force during the Gulf War explained her situation after reporting MST to the VA that happened years earlier yet developed PTSD and fibromyalgia,

> They only gave me 10 percent for disability and told me what I was feeling was all in my head. I continued to go to my job every day, because my way of doing things was just to work harder and harder and harder until my body gave out and my career was falling apart…I don't want anything better than anybody else. I just want what I deserve and what I was promised when I gave up my health to be in combat…Now I'm fighting to get on Medicare but it is such a hassle. I'm willing to do anything at this point to get the care I need…I want to be older than fifty-six like my mother was when she died, and I want to be at least sixty-three like my Dad was when he died. I want to be around for my daughter.

Contrary to the previously described experiences, AK was one of the first few study participants who presented with a different orientation to the concept of self-preservation. Clearly eager to share her experience about how her [female] veteran status earned her leverage in the workplace,

> I think the main thing is, is it gives me an edge in a business environment. I think it's one of the main things that got me into as good of a business school as I did. There are a lot of male veterans in my school, but there's only three female veterans including me. So, I think when people think of a veteran, they generally think of this strong infantry marine ranger…its just giving me a stronger background than most of my peers-that help me be successful.

For AK, and a few other women in this study, self-preservation through their career success strengthens their inner resolve. KR presented with different circumstances,

> I was going to a marriage counselor and she diagnosed me with PTSD. She asked me if I ever had treatment through the VA and I said 'no', and then she said I should…I didn't have the money to continue seeing her, so, I went to the VA to get counseling for PTSD. They initially denied me, because I hadn't been on active duty for six months. And I said, "All, I really wanted was PTSD counseling". And so then I started fighting for it, because I needed counseling. And couldn't afford it. I then applied for disability-it was a long fight but they ended up giving me some kind of title and I got it on a temporary basis…and so now I have 100%- it took me a long time to get to a hundred percent, but I have a hundred percent…

Perseverance. Study participants conveyed experiences that at one point resulted in feelings of hopelessness and loss of pride. Cultural, spiritual, and circumstantial differences were present among the women interviewed. The ability to "put one foot in front of the other" as SL described her approach indicated their desire to persevere beyond their tumultuous experiences. Similarly, while the adage, "put one foot in front of the other" was not expressed by this participant, she related a situation where moving forward is what keeps her going,

> I am unable to work right now. I am 100% disabled for my MST and PTSD, oh, I have severe depression and anxiety too. I was in Iraq for 6 months. I'm doing real good right now. I moved from Michigan to Cape Coral. The weather is warm and sunny and that feels good. I am a volunteer at the military museum here. My biggest issue right now is not being able to go to my groups. They help me. We are a group of women who have had sexual trauma by our superiors, so we understand. Because I don't have a car, I have

> to take a bus, actually 2 bus's, and it takes me 2 hours to get there and 2 hours to get home, but I ain't gonna miss my group, someday I will get a car and that will get me there faster.

BH returned home from the Marine's fully informed of her healthcare benefits. Soon after, she faced an unexpected challenge, being evicted from her apartment while caring for her toddler son:

> I would do anything for my son. He is my life. For a while I was couch surfing at friends apartments and I felt embarrassed, so we started to ride the buses. At least he got to sleep and we were in a warm place. I would only do that at night, during the day I kept us busy…my benefits didn't kick in right away and so when my son needed healthcare, I would take him to this guy, to this day I don't even know if he was a real doctor, but he got him antibiotics for his ear infections…

All of the study participants conveyed experiences that illustrated their ability to persevere. JT's description of the horrific trauma she experienced and the work that she is doing for women veterans today, truly embodies a woman with perseverance. While at her "deepest darkest moments", JT explained how she wanted to die in a way that would not backfire on her children and family. It was at this point that she sought help from the VA.

> When I went to the VA, I said either, I'm going to give it one last chance to find some way to relieve myself from the pain or I'm going to screw myself and my family… I started working with Dr X at the VA and she tried CBT on me, and it kept bringing up bad memories and I could not do it anymore. I said, Help me unravel now… right now, not 6 months from now- I don't need a car, a house, a permanent place to stay… I didn't have any motivation, I knew I just couldn't die

JT is now completing an Associate's Degree in sociology and is very active with the Walter Reed Hospital where she visits with veterans each month. She is the ambassador for the Disabled Veterans of America and takes groups of male and female veterans on fishing trips.

SL is a participant currently residing in a transitional housing setting for women veterans. She describes a lengthy history with a chronic disease that developed during her deployment. There are many days when she does not want to keep her appointment,

> Whether I'm feeling lousy or whatever, I am still going to go. When I am feeling better about myself, I want to keep doing better and I'll keep that up. It makes me feel empowered.

Persevering to build inner resolve occurs differently among women veterans,

> …I do feel my anxiety is really bad, I'm so, emotional, but just everything is just too much. I know when to seek help, whatever…but in the meantime, I'm just like, okay, 'T' you haven't even gone through all your laundry in your sea bag., I don't even have a routine of my day-to-day and that's not normal. I'm normally up in the gym at 0. 4 or 4 in the morning. I go to the gym and be there by 430. Hey, but you know I'm not ready to deal yet… I got to figure stuff out on my own before I can, you know, start dealing with other people.

Managing my life as a veteran

This category emerged as the study participants spoke about issues they experienced upon return from service and while considering to access healthcare. Initially, "identity" was the main concept that came to mind as statements such as, "there is total lack of autonomy and agency", you feel "separate from the civilian world", "being misunderstood in the community" and "the transition is difficult". Discussion with the dissertation committee chair resulted in a

refinement of “identity” to “managing my life as a veteran”. This category better explicates the issues that women have to manage during the decision-making process to access and utilize healthcare when either returning home or when the need to get healthcare is recognized. Specific concepts that support the development of this category include, (1) from military to civilian life, and (2) gender bias and stereotype.

From military to civilian life. Women in this study reported that one reason for managing their role as women veterans in a civilian environment is so difficult is due to the “one-size fits all” approach when they are being assessed. Most commented on how their gender-specific needs were negated and/or dismissed. One participant, JT suggested that they have a gender-specific assessment for them when they are preparing to transition.

JT spoke about her experiences when transitioning to civilian life from service in the Army:

> It’s so frustrating when you leave active duty, there are so many forms to complete, so many notifications and you lose a paycheck because you’re not retiring, say if you got hurt or injured or raped, and there’s also dealing with the emotional aspect of it. We have volunteer groups, like, DAV or AMVETS or, you know, other service groups, to help segue to the VA, but if there's nothing there, it's like a blank slate. You gotta figure it out and start writing all over again. It’s so difficult when you come back- we feel separate from civilian life, almost like we are not in the same world. When you live on base, all is paid for you, food, housing, transportation, there’s no opportunity to build credit then when you return home, you have nothing and you have to start all over again.

Another participant explained how she ran a “tight ship” at home before she activated to go to Iraq. She had a routine for each of her children, knew what groceries to buy based on what

they liked. When she returned home, all of that changed and she felt like she was starting all over again.

Reflecting on her experience after serving, JG described how common it was for civilians to ask her if she was a veteran:

> When I told people who are not veterans that I am a veteran they ask, "Why would you do that? Why would you join the army? Were you sexually assaulted?" I'm always amazed that people feel like that's the automatic question to ask. Like, that's what they think that we're either sexually, sexually assaulted, or lesbians. It's the assumptions that get made, I'm not saying there is anything wrong with any of that. But when you say yes, I'm a female veteran, and yes it was a great experience, they look at me in shock and start to look for justifying factors, "oh you were a social worker there though…"

The following statements (by JG) within our conversation continued to support the concept of misunderstanding the identity of women veterans. JG explained, "My friends that have been in the military that are females say that we definitely have our own little sub-culture. It's the military female culture and is often overlooked.

A few study participants explained the difficulty of returning home and not having the time to process what they really need. KR said, "I didn't recognize that I even had PTSD so I didn't get help". Similarly, TB noted, "there's been no time to decompress". Still others talked about adjusting to a new identity after service clearly impacted their information needs. NS explained how no one was available to help facilitate her transition from the military to civilian life and this left her without any information on her healthcare options.

Another participant explained, "We don't get the time or help needed to adjust and assimilate back into society because we have to go back to female roles like being a mother and

wife". Similarly, TB's description related to this when she described returning home and "walking on eggshells because you're not sure what's going to happen, meaning, 'how am I going to react to them'?

Perhaps CC's experience illustrates the profound struggle that some women veteran such as herself have endured:

> When we returned, I was seen at a military hospital. My father picked me up and mentioned to me that I wasn't the same daughter he knew before I left for war. He noticed I changed mentally and physically. I didn't feel like the same person either. Being back in society no longer felt normal and I struggled with being home…my relationships were different because people misunderstood who I was a female veteran. I wasn't the same person they formerly knew. I didn't understand myself… I was getting sick, having mental breakdowns and flashbacks. My job performance was affected due [to my illnesses]. The military did not offer any mental health counseling. Finally, I came to terms that I couldn't work as a UPS driver anymore and my personal life was in an upheaval.

Many of the study participants shared details of their approach to manage life similar to CC's although not as ruinous. AL provided an example of how experiences within the military affect the management of life as a woman veteran after transitioning to civilian life:

> While on active duty I was hospitalized for mental illness issues three times- they diagnosed me as bi-polar, but I wasn't bi-polar, I had PTSD, even the military didn't understand what the military did…I was showing signs of PTSD and doing everything to avoid a full-fledged mental breakdown and then I ended up getting a UA and because of my drinking, they decided it was a pattern of misconduct and I then I got a less than honorable discharge. Now I am fighting for Medicaid.

Adjusting to civilian life is clearly illustrated by this description:

> After resigning from the Army, it was difficult to adjust to civilian life. I felt alone and alienated, as if I had settled in another country with different values. It was truly a cultural shock! I didn't stay in contact with my friends in the military, and it was difficult making new friends.

The transition from military to civilian life was portrayed by all study participants as difficult. However, the presence of a stereotype towards women veterans compounded this transition.

Gender bias and stereotype. Despite the VA's promise to ensure that all enrolled women veterans have access to appropriate services, regardless of the VA location, most study participants describe the unavailability of women's health primary care providers and clinics Women veterans in this study corroborated this assumption during the interview when they described the predominance of a male-centric aura at their local VA. Consistent responses by participants indicated unmet gender-specific healthcare needs. Privacy, safety, and dignity felt violated. A lack of sensitivity existed. Most participants described their experiences as "feels very much like a man's place",

Study participants consistently created a common visual for this PI, when describing their arrival at the VA (in particular) for healthcare: they receive stares and glares, they are asked, "Are you here for your husband or is this for you?" RW noted that it was mostly the older veterans that assumed she was there for her husband.

Study participants were asked what it is like to be a woman veteran. Some responded, feeling alone. KR described,

> being discriminated, treated poorly, lesser than, mocked. I didn't tell people (that I was a veteran) for the longest time- when I flew home from Saudi Arabia I was on a C1W and in uniform, but the second half of the flight I was not in uniform and everyone was being thanked and bought drinks for and ya know, I felt like we didn't fight the war that the Vietnam Vets fought and here you are getting praised for fighting on Saudi dust and I could not accept it. I was glad I was not in uniform and kind of just hid. I was the only woman on that flight-

The experience by MS's illustrated an omnipresent sense of gender-bias for women veterans who attempt to manage their lives as civilians after a period of military service:

> I was organizing a relay run across the country to honor fallen service members and went to the American Legion for support. There was an old man who called me sweetheart and told me I need to get the VFW involved- I explained to them well, I'm a member of the VFW, and he repeated, the VFW sweetheart not the auxiliary…It's very frustrating to kind of break that initial kind of stereotype- they ask you where your husband and things like that. And that was something, I didn't expect when I transitioned off active duty- I know they don't mean anything by it, but it's frustrating when you meet someone in the older generations and they say with surprise, "you were in the marine corps?" but you weren't in combat.

JJ explained that it is awkward being in the waiting room of a VA,

> A lot of times you are the only one and people will look at you and stare at you just like in the service, like what are you doing here? Is she a veteran? Is she here with somebody else? The older male vets like to sit and talk to you about their war stories and I just sit and listen, look at the window, they love to throw out the women's stuff, 'Oh we

> wouldn't allow women to do those things back then, and we were stronger core and you just want to choke the s*&^ out of them- and you do just like you did in the service- you sit and listen- I have MST and PTSD and I don't want to listen to them, the younger ones aren't so bad but the older men…

Conversely, BM was the only participant to share an experience that is atypical of the woman veteran stereotype:

> I had a male civilian nurse who was not military, was not a veteran, but had been working with veterans for 30 years as a civilian registered nurse. He said, I know that as a veteran woman you do not receive the treatment that you deserve. And, you know, I recognize you. I just want to tell you I think that you women veterans are getting a bad deal because people don't recognize you as being veterans. He said all the men come in here, and everybody sees them and assumes that they're the veteran and they're all wearing their hat. But you women don't have a way of recognition. You don't have a 'I'm a veteran woman hat' and he said I'm sorry for that. Many people here will think that you are the wife of a veteran and I'm sorry for that. That's not what you deserve. But he said, let me tell you that this nurse appreciate what you've done.

Additional evidence of a negative stereotype towards women veterans was provided through comments from UK:

> The problem is of course, men don't experience what we experience in the same way-it's [the healthcare needs] are looked at as less important than if a man came in with gas. You know, and it's hard to explain to a male doctor who has that mentality that there's something actually wrong. And had they did the tests that they were supposed to they would have discovered that most of my disability that I'm receiving compensation for is

> due to the lack of I don't know if it was knowledge or just the lack of patient care yes, yes.

UK continued to explain what it is like to be a woman veteran,

> It’s a wonderful experience when I’m recognized as a veteran. The majority of the time even at the VA, unless I wear my hat people assume that I'm the dependent and not the veteran-when you when you’re in one of the admin offices they automatically would ask me for my dependent ID card to remind them that no, I'm not the active duty member and then of course I am the veterans Yes. When they have veterans today, and all of the places have, you know, the free meals or whatever discounts for the veterans and basically have to wear my hat because nobody believes me.

In addition to the difficulty managing their lives as women veterans in civilian environments, study participants shared the specific personal and physical barriers that affected their decision to access and utilize healthcare.

Encountering barriers

A few questions asked during the interview pertained to factors that motivate and those that contribute to the delay in accessing and/or utilizing healthcare. Responses from these questions generated the information relevant to the barriers encountered by the study participant’s decision-making process. The barriers occurred irrespective of their time in service or time since serving. This category emerged based on the concepts heard from the women during the interview. Concepts comprising this category are, (1) personal, and (2) physical.

Personal. Study participants eagerly shared their personal barriers within the realm of accessing and utilizing healthcare. Negative experiences at VA’s resonated throughout the responses. Similarly, some experiences with non-VA healthcare providers also indicated

frustration and dissatisfaction. Most of the women in the study utilized social media such as the various women veteran Facebook pages for information. Negative information shared on these pages contributed to some of the personal barriers that affected their healthcare decisions.

TS shared that participating in this study was important to her so that she could share her experience and through the publication of this study, perhaps things would change for other women veterans:

> I never know who my appointments will be with- the uncertainty is a deterrent-
>
> I got seen by this female doctor, she wasn't really hearing me or listening to me when I'm telling her about things. I'm struggling with the pain due to my fibromyalgia, my anxiety is flaring up, and I am constantly tired. So I asked her, “can you check my vitamin D level and stuff like that? And she said, “I can't do anything about that, you're going to have to go to a functional medicine doctor”. I said, “I'm okay, but can you at least test me to give me an idea?” Like, I'm feeling this way and you know, I take a vitamin D supplement, but if my vitamin D is really, really low… I thought I shouldn’t have to tell her what to do, nor should I have pleaded for it.

Similarly, NS illustrated having a “bedside manner” as being “super important:

> I walk in and the doctor is like, ok, so what is going on this time? And I’m like, can’t you read my chart, it’s right in front of you- and then he says, well this is what was did last time, but I think I’m going to send you to a specialist for that…I have never had the same person twice. I feel like there is absolutely no connection, nobody to establish a rapport with-

RW related an experience that reflected the ongoing gender-bias issue that is pervasive at the VA,

> I feel like there is a lot of like judgmental stigma out there and especially when I go into the VA An older gentleman in an Army veteran hat questioned why I was there and he was like, so what did your husband do when he was in the military? I was like, well, *I* did…And so I've been getting these migraines for months, so bad to the point where it affects my daily functioning. I ask them where my treatment is. What are we doing here? It's been months and I'm still going through the evaluation process. They've got me going to an endocrinologist. They've also got me going to neurologist, but it's just medical evaluations and their taking their time and nothing is improving.

JG describing the lack of gender specific assistive devices. For example,

> …I remember, they gave me shoe lifts that were made for men's shoes. I was like ok, what I am going to do with these, you can see these are not made for women's shoes. Another time, they gave me glasses but that were clearly designed for a man. They were big with black frames. And then, I needed dental work and I have a really small mouth so they couldn't do the procedure because the equipment didn't come in like a pediatric size.

TB commented,

> There's no sense of urgency, I feel like the VA treats you like a cookie cutter, ya know unless you're standing there doing something drastic, you're not taken as seriously as the person who's standing in front of you. It would be that way if it was a guy. I've been at the VA for a long time because of my husband, and it is so not welcoming

An experience related to the misunderstanding of women veterans by civilians was clearly illustrated by CC:

> The misunderstanding part comes in, you know, we'll hear things like, you don't look like you served or if there's a veteran designated parking spot, and some of us women veterans park there, you know there's been stories of nasty letters being sent or people looking at you awkward as if, you know, you didn't serve. And just understanding that women for the most part, have the same training as men except for some combat roles, but even that's changing. Society has these misconceptions that maybe we were secretaries or cooks, that we really didn't see combat, but we did.

Physical. The most common physical barriers described by study participants were location and trouble getting appointments.

AO described the process she uses to get to a VA appointment as requiring two buses to get to there- a two hour trip each way. By the time her appointment is finished, it has become an eight hour ordeal. The bigger issue is getting an appointment:

> I have to call the VA and then I have to wait for an operator. And this is what I don't like. I don't like having to wait for an operator …then I never know who's going to answer the phone. So I have to tell them and sometimes they put me on hold for even longer… but if they're busy, they just transfer you to wherever in the hospital. It could be radiology it could be the front desk…. It's just a big waiting process. Okay. And you tell them, and then you have to wait. I just wish it was easier to schedule an appointment.

When asked what she would do if an appointment was needed sooner, AO responded, "I guess, if I really needed to see somebody, I'd have to use the emergency room and just have to wait.

HW is a single mother of two young children and finds that distance to the closest VA hinders her from seeking healthcare,

> I would say, location, something that is not too far away to travel, for instance like, because I'm in the reserves I have to go through these LHI appointments…I put my location in and there are no providers close to my house. I'd have to go downtown Chicago and I'm not driving, because it's over an hour for me. You know, I'm in school, I'm a mom…it's like wasting my time. I'm just not going to like, drive over an hour and a half down there, because you have to deal with traffic.

Another interesting perspective was presented by RW relevant to the physical barriers involved in pursuing healthcare. Her comments depict elements of dissatisfaction with both non-VA and VA healthcare:

> As opposed to like civilian doctors. I feel like they have you come in the door just because they want to take money from you. So then they'll want you to be tested for this and tested for that just to make you happy as opposed to actually trying to treat and help. At least at the VA, even though I'm going for all these different tests and evaluations, at least they are kind of ruling stuff out for me. Even if they haven't diagnosed you with anything, they are still trying.

Similarly, JG shared her experience with the difficult in getting an appointment:

> I don't know that it's any different for the men and women, but yeah getting an appointment that has to be scheduled two to three months out like right now I'm needing a hip replacement surgery. So we've been at this process now for at least 3-4 months. I've seen the orthopedist twice, but you have to, you know, usually like you get an appointment and they send you for X-rays. Then you have to get another appointment to get the results reviewed. And then like another six weeks go by. And now they approve

me to go outside of the VA for a specialized surgery. But nobody knows what the process is.

KR's description of the physical barriers that she experiences include both distance and the lack of comfortable examination space,

I feel like the VA tries really hard to give women health as an option. For example, my primary care physician is a small satellite office in Reno and don't ask me why but it's in Northern California and closer to my home. My satellite office has an OBGYN come in once a month so you can be seen, but it's really uncomfortable. They don't have those chairs that you recline in, they just make do. So to prevent driving 2 hours to Reno I just go there. My satellite office has no testing abilities either. So let's say, I am having pelvic pain. I called my doctor to be seen. He says don't bother just go to the ED .I have to drive an hour and 15 minutes and wait all day long, it takes forever and it's uncomfortable. You have to sit there for hours on end in a hard chair with poor WIFI service.

TS uses a combination of VA and non-VA healthcare providers. She will often choose to use the VA for healthcare for its proximity to her workplace. TS relayed the cumbersome process as being a physical barrier:

The process to get an appointment in the right dept. with the right people is really cumbersome. A lot of time I'm in appointments, all day, I can't answer my phone, so I play phone tag so they call and leave a message… I call back and get a voicemail and then we play phone tag for a week. I can't get a person and then I get this letter in the mail saying they're trying to get in touch to schedule an appointment…it's a really frustrating process for me to even get any of these appointments scheduled. It just seems like an outdated process.

Receiving mixed messages from the women's clinic and the emergency room has resulted in a very frustrating situation for TR,

> I go to the women's clinic, and they're understaffed and overbooked, they can't see you. So, then I go back and forth to the ER [at the VA] and eventually I get sent home. Then I went to the ER in the civilian community, because I had gallstones for the second time. I mean, how can this happen to me? Probably four times now within the last six months, and I went to the emergency and I ended up in the hospital …but I'm telling you if a civilian man walks in off of the street, he'll get seen right? But I'm a female veteran I want to be seen right now.

One of the last interviews for this study occurred with AW. This conversation in particular confirmed how the presence of both physical and personal barriers to accessing and utilizing healthcare puts women veterans at risk for potentially deleterious consequences.

The interview with AW involved a lot of divergence and often required redirecting to the interview questions. She was eager to share her experiences with attempting to get healthcare. When asked to describe the factors that got in the way of seeking healthcare, she described this situation:

> I'm on a waiting list to see a therapist at the VA for my issues right now. I really need to be seen. So, I physically went to the VA, and I was told, 'we don't have anywhere to put female veterans right now you have to go home and come back'. I was like really? 'You can go to the nearest emergency room'. The VA here doesn't have an emergency room and the nearest emergency room is nowhere near here.

Having inner resolve to find strength while vulnerable, navigate the web of healthcare at both VA and non-VA's settings, continuing to dig deep while managing their lives as women

veterans in a civilian world, and mitigating the barriers to accessing and utilizing healthcare was clearly illustrated through the voices of the women veterans who participated in this study.

Assessment of Study Rigor

Trustworthiness in this study was determined through the four criteria developed by Lincoln and Guba (1985, as cited in, Amankwaa, 2016). Presentation of the strategies used to maintain the credibility, dependability, transferability, and confirmability is displayed in Table 7.

Table 7
Evaluation of Study Rigor

Credibility technique	**Credibility evaluation**
Prolonged engagement and persistent observation	Establishing rapport with study participants to foster rich and detailed responses; Use of demographic questionnaire and administration of DCS as an ice-breaking strategy to foster rapport
Triangulation	Use of DCS and interviews
Peer debriefing	Checking in with Dr Agazio with transcripts
Member checking	Confirming with study participants if I accurately captured what they were describing; used the verbiage, “May I clarify…?”
Dependability technique	**Dependability evaluation**
Audit trail	Voicea® provided the transcription of each interview. Each transcriptions was printed for review and used for data analysis.
Reflexivity	Interview thoughts and reflections were used during data analysis to verify accuracy of recordings and meanings.
Triangulation	Participants were recruited through different veteran services organizations and snowball sampling.
Transferability technique	**Transferability evaluation**
Thick description	Direct quotes from each study participant. Field notes and memos used to augment some interviews. Open ended questions during semi-structured interviews facilitated genuine and congenial conversation resulting in sharing of experiences and perspectives.
Confirmability technique	**Confirmability evaluation**
Triangulation	Participants were recruited through different veteran services organizations and snowball sampling.
Reflexivity	Interview thoughts and reflections were used during data analysis to verify accuracy of recordings and meanings.
Peer debriefing and member checking	Dr. Janice Agazio, Committee Chair consulted with to verify and confirm accuracy of codes and category development.

Summary

The research question, “What is the decision-making process by women veterans to access and utilize healthcare” was investigated using a grounded theory approach. The G.R.I.T. Model of Decision-Making presents the relational and overlapping components of a theory that explains how inner resolve underpins the decision-making process by the 26 women veterans who participated in this study.

Chapter V

Summary, Discussion of Findings, Conclusions and Recommendations

The purpose of this qualitative grounded theory study was to gain new insights into and an understanding of the decision-making process women veterans (WVs) used to access and utilize healthcare. This chapter includes a discussion of the findings from this research study related to the literature. Connections between the substantive theory generated by this study and other theories are presented. The chapter concludes with a discussion of the study's limitations, nursing implications, and finally, a summary and conclusion.

An explanation of how and why WVs decided or decide not to access and utilize healthcare is illustrated through five themes: (a) being vulnerable, (b) navigating the system, (c) digging deep, (d) managing life as a veteran, and (e) encountering barriers. These themes reflect the concepts that described what WVs considered during their decision-making process. Findings from analysis of the data (a) provided an explanation that advanced the understanding of factors involved in the decision-making process, and (b) explained the relationship among the categories that led to the identification of the core concept, "having inner resolve".

The key findings of this study revealed that having inner resolve underscored and traversed the dimensions involved in the decision-making process of WVs. The linkages between the dimensions as concepts suggested that possessing G.R.I.T. was aligned with having inner resolve. Therefore, The G.R.I.T. (G.R.I.T., resolve, introspection or insight, and trust) Theory of Decision-Making by WVs was identified as the substantive theory.

Methodology

As discussed in Chapter 2, there was an abundance of quantitative studies available on decision-making and relevant variables but a dearth of qualitative studies. Listening to the WVs in this study provided descriptions and explanations grounded in data that was captured through their voices. Grounded theory was an appropriate methodology to explore WVs' decision-making process to access and utilize healthcare. Corbin and Strauss (2015) offered a set of criteria for evaluating the applicability of a theory: fit, understanding, generality, and control. This study generated a theory that met these criteria.

Fit

The theory of this study fits the substantive area of healthcare access and utilization issues within the population of WVs. Study participants shared their perspectives and experiences on what influenced their decision to access and utilize healthcare

Understanding

The concepts and theoretical linkages within this theory were purposefully grounded in the language used by the participants and therefore would be readily understandable by laymen.

Generality

This theory is general enough to be applicable with further testing for fit to a multitude of situations within the substantive area and can be applied to other patient populations/conditions, for example, those living with chronic illness. The G.R.I.T. Theory of Decision-Making, although developed in this study for use by WVs, could easily be applied to patients with chronic illness who may need to decide on potential disease modifying treatment.

Control

This researcher followed the methodological process of grounded theory throughout this study. Interviews were recorded, transcribed, and reviewed several times to ensure the accuracy of the data and the appropriateness of the emerging themes. The constant comparison analysis method resulted in the identification of concepts and categories that were summarized into a core category and subsequently used to generate the G.R.I.T. Theory.

Summary of the Study Findings

While the experiences relevant to accessing and utilizing healthcare varied among the study participants, each of the five themes that emerged were integral to the decision-making process of all of the participants. These themes have a dynamic dimension to them with an overlapping and cyclical presence. Each theme is described in detail in the following sections.

The core category, "Having Inner Resolve" emerged as the overarching theoretical concept. Inner resolve is central to the major categories identified through the data analysis, (a) navigating the system, (b) being vulnerable, (c) digging deep, (d) managing life as a veteran, and (e) encountering barriers. Having inner resolve reflected the described processes through which the women in this study conveyed how reflection and introspection provided them with the strength to seek out the type and level of care they required to function as a woman veteran in a civilian society. Inner resolve provided them with the impetus to respond to acts of self-preservation and become more resilient. Study participants expressed their mistrust in the military. The ability to regain trust may depend on their inner resolve. Seeking out healthcare in a system run by a government, often perceived as failing and abandoning them, was indicative of the rebuilding of trust–this too required having inner resolve.

Findings Related to the Literature

Having Inner Resolve

Findings from this study indicated that having inner resolve was at the core of a woman veteran's decision-making process to access and utilize healthcare. Inner resolve is defined as having determination, tenacity, G.R.I.T., preservation, strength of will (Oxford Dictionary, n.d.). This inner resolve underpins and overlaps each of the previously described sub-categories. A search for this core concept in quantitative and qualitative research did not result in any article or evidence-based study on inner resolve in WVs. Databases were then searched for these qualities or similar phenomena in WVs. Qualitative and quantitative studies including WVs and related phenomena including spouses of WVs, military men, working women veterans, PTSD survivors and military sexual trauma survivors were not found. Mia Brancu, PhD, a psychologist who works for the VA and does research on post-deployment mental health of women veterans while overseeing the operations of a VA mental health research center discussed the qualities of having high tolerance and high resiliency in the face of risk, needing a certain level of courage, persistence, grit, and resourcefulness as being required for effective leadership particularly in a male-dominated environment such as the military. Although the article targeted effective leadership, Brancu (2018) discussed how having these qualities might facilitate accessing necessary healthcare and asserted that a paucity of research exists on WVs who share these qualities.

While not directly related to the concept of inner resolve, a search for studies on resilience in women veterans returned few articles, all in non-scientific publications, blogs, or on veteran-related websites. Some researchers have attempted to understand resilience in WVs

within different contexts. Resilience as a mitigating factor for suicide risk among African-American WVs was studied by Dorsey-Holliman, Monteith, Spitzer, and Brenner (2018) in a qualitative study with 16 African-American women veterans as study participants. Three themes emerged in this study as protection against suicide, (a) resilience, (b) social support, and (c) religion. A few of the women who participated in this study shared how religion and support through their church provided them with resilience to access and or utilize healthcare. Leigh and Koblinsky (2017) explored resilience in WVs of OEF/OIF returning to civilian life. In an effort to better understand the experiences of women veterans as they return to their families and civilian life, five focus groups were conducted with 29 veterans. Analysis of focus group transcripts revealed seven common challenges, ranging from adjustments to the civilian pace of life and developmental changes in children's behavior to managing anger and difficult emotional interactions with family members. The findings from their study illustrated the ways in which WVs were resilient in the presence of adversity. Though not specifically described as inner resolve, parallels exist between the study samples of both studies.

The substantive theory of the current research, the G.R.I.T. Theory of Decision-Making by WVs, supports the assumption that inner resolve is at the core of decision-making to access and utilize healthcare. Findings from previous studies that described concepts similar to those that emerged in the current study will be discussed in the context of the ways in which those findings were similar and different than the findings of the current study. The supporting concepts of having inner resolve, (a) being vulnerable, (b) navigating the system, (c) digging deep, (d) managing life as a veteran, and (e) encountering barriers that influence the decision-making process by WVs are compared in the following discussion.

Being vulnerable

The concept of vulnerability was clearly evident throughout the interviews with all 26 study participants. Feeling misunderstood and disregarded by individuals in the military, including VA and non-VA healthcare settings, led to feelings of abandonment and mistrust. WVs in this study described how their awareness of the need to report situations of military sexual trauma (MST) or other women's health issues often resulted in feeling more vulnerable. They described a cycle consisting of wanting to be heard, fearing backlash, and then experiencing heightened levels of vulnerability when the issues were not resolved. This deep-rooted vulnerability seemed to function as a tool to cultivate strength from their experiences and a determination to seek resolution.

One of the earliest studies reviewed in the literature for this study was conducted by Hamilton, Poza, and Washington (2011). This group of VA researchers typically conduct quantitative studies, however this qualitative study explored pathways to homelessness among WVs. Lack of access and utilization to healthcare was a risk factor for homelessness among WVs (Hamilton et al., 2011). Study results from Hamilton et al. depicted a "web of vulnerability" that generated pathways to homelessness for WVs. The concepts that supported the sub-categories of this study are closely aligned with the "roots" of the web of vulnerability described by Hamilton et al. For example, the description of MST by 58% of this study's sample, in which many of these women were ashamed to ask for help, suggested that trauma and lack of support were associated with feeling vulnerable. A comment from one participant in Hamilton et al.'s study clarifies the connection to the findings of the present study: "you don't seek out that help that other women would seek out because they're lost. We don't feel like we're lost. We can do it" (p.813). This subtle expression of inner resolve is similar to what a

study participant shared in the present study, “I just put one foot in front of the other.” It became clear from the analysis of the data collected for this study that many WVs have inner resolve that fostered the strength to rise above their vulnerability and perhaps access and utilize healthcare.

Brownstone, Holliman, Gerber, and Monteith (2018) conducted a phenomenological study of MST among WVs (n = 32). Their approach sought to describe the experience, context, and perceived effects of MST on WVs. Several themes emerged from Brownstone et al. that indicated feelings of vulnerability among the WVs. For example, Brownstone et al.’s theme of “sexual harassment: expected, constant, and normal,” emerged from their study in that study participants described feeling objectified and sexualized while struggling to find connection and support in their environment. Findings from the current study aligned with those of Brownstone et al.’s findings in which vulnerability was inferred by participants describing being ashamed to ask for help. Moreover, study participants shared comments that acknowledged their sexual trauma but reported being afraid to report out of a fear of being ostracized and alone.

Women veterans in this study described feeling vulnerable for reasons other than sexual trauma and believed that reporting their pain and suffering might be interpreted as a sign of weakness, so they remained “alone in their suffering.” This is similar to the theme of mistrust. Women in this study related the difficulty of trusting others when insensitivity was conveyed by their healthcare providers. For example, some study participants reported that they had received the Anthrax vaccine without being informed of potential long-term effects. Although the study by Brownstone et al. (2018) focused specifically on MST, another emerging theme from that study was the loss of relational trust in a system that they thought could be trusted. In light of the expressed feelings of vulnerability and deciding to access and/or utilize healthcare, Wolff and Mills (2016) reported that WVs felt challenged to seek healthcare for MST due to fear of

retaliation and a general mistrust of healthcare providers. Similarly, in the current study, one participant described how she had been shamed and ridiculed for reporting her MST incidents through the proper chain of command. She reported that it took years before she sought help for her trauma.

A descriptive qualitative grounded theory study (Fredericks, 2013) of women's (*n* = 9) decisions not to have a hysterectomy sought to understand the decision-making process of women to have this procedure. Although the women in this study were not veterans, themes of "constructing a female illness identity," "deciding what to believe and who to trust," and making "informed treatment choices" emerged as contributing factors in the women's decision about their treatment selection process (Fredericks, 2013). Findings from this study corroborated themes identified in this PI's study in which vulnerability is seen as being comprised of mistrust, being unheard, and feeling ashamed to report of trauma to their bodies by servicemen, resulting in a delay or decision to not seek healthcare.

Koblinsky, Schoreder, and Leslie (2017) conducted a qualitative study to explore the strategies to improve mental health care in WVs (*n* = 29) through the voices of WVs. The title itself, "Give us respect, support and understanding" suggested that WVs felt vulnerable when not heard and understood and that they valued being respected. Thematic categories that emerged from this study included, (a) therapeutic relationships, (b) clinical care environments, and (c) the health care system. Concepts identified within these categories illustrated that trust in a healthcare provider fostered a therapeutic relationship, a gender-sensitive environment that is desired where they receive healthcare, and feeling safe within the health care system decreases feeling vulnerable. In the current study, participants reported feeling that their needs were

minimized and preferential treatment was provided to servicewomen who accepted “this male-dominated way of oppression and treatment”.

Similar to this study, Turchik, Bucossi, and Kimberling (2014) focused on developing an understanding of barriers to accessing healthcare through the perspectives of WVs in a qualitative analysis WVs (*n* = 9). Dissimilar to this study, Turchik et al. focused specifically on barriers to MST-related care; this study sought an exploration of the actual decision-making process used by WVs to access and utilize healthcare in general. Similarities between the studies included the findings from Turchik et al (2014) that identified four types of potential barriers: psychological avoidance, stigma related, gender related, and lack of knowledge. Most women reported a gender preference for a female clinical provider. MST was experienced by participants in both studies and influenced the decision to seek healthcare. Further, Turchik et al. acknowledged that qualitative studies aimed at understanding the experiences of WVs have been minimal and underscored the need for additional research.

Dardis, Reinhardt, Foynes, Medoff, and Street (2018) illustrated the concept of vulnerability most clearly in their study, “Who are you going to tell? Who’s going to believe you?: Women’s experiences disclosing military sexual trauma”. This study used qualitative methodology and semi-structured interviews to understand the process through which WV MST survivors (*n* = 23) choose to disclose their experience with MST. Themes identified as barriers to reporting included: potential negative effects on career, fear of judgement/being treated differently, fear for personal safety, shame, and breach of privacy. Responses by participants in the present study aligned with Dardis et al. as evidenced by statements such as: “I was told if I pressed charges, I would never receive my commission since officers must stick together” and “I thought it was useless to say anything and I did not have the courage”.

Finally, when considering the decision to access and utilize healthcare, Levesque, Harris, and Russell (2013) described the results of their study within the context of access to care dimensions and identified approachability and acceptability as facilitators to accessing healthcare. WVs in the current study described how being misunderstood, not heard, and feeling distrustful influenced their decision to seek healthcare. These concepts seem to fit with the dimensions of approachability and acceptability identified in Levesque et al. (2013).

Both the studies reviewed herein and the current study identified factors that contributed to a WV feeling vulnerable. The most significant difference between the findings from the studies described previously and the current study arise from participants' descriptions that were summarized as the quality of having inner resolve that functions as a strategy for overcoming the vulnerability that they feel in response to their military experiences. Previous studies did not provide an explanation of how WVs who described being vulnerable remained perseverant. Qualitative research, specifically this grounded theory study, provided the vehicle for revelation of this concept, inner resolve.

Navigating the System

The decision to access and utilize healthcare at either a VA or non-VA healthcare setting by the WVs in this study was hindered by difficulties they encountered while navigating the healthcare systems. The WVs described their decision to (or not to) access as having been influenced by the unavailability of accurate and timely information and an inability to navigate through a convoluted and fragmented process, specifically at the VA. The study participants often described inconsistency in communication or a complete lack of communication that they believed was necessary to guide them through the system.

Analyzing the responses of the WVs in this study suggested multiple threads woven throughout their responses, (a) information needs, (b) a fragmented process, and (c) a complex and convoluted experience, all of which were attributed by the participants as emanating from lack of knowledge about their healthcare eligibility. Being unaware of their eligibility for benefits or disability mired the process from the start of their attempt to access healthcare.

The "health care system" was identified as a theme in Koblinsky et al. (2017). This theme pertained to messaging about mental health services for WVs. One of their study participants said,

> The idea that there's women's health is completely new, so if you didn't have it on active duty, why would you have it now? Do you necessarily know that there's a women's health program in the VA? . . . but it's only as useful as it can be if you know about it (p.133).

Similarly, a study participant in the current study said,

> Access to information is a big problem. Some they end up separating within a month, maybe 30 or 60 days, so they're not really paying attention as to what benefits are out there . . . you know, them being able to know what their benefits are and how they can access it.

Further, a participant in the Koblinsky et al. (2017) study suggested a solution for improving the communication. Likewise, a participant in this study described a website idea that WVs could use to learn about how to determine their eligibility and apply for benefits. Despite the negative experiences the women in both studies had endured, the ability to rise above an issue and suggest a solution exemplifies the concept of having inner resolve.

Norris and Aiken (2006) developed a concept analysis of "personal access to health care". They described availability, eligibility, amenability, and compatibility as attributes of access to healthcare; similarly, Levesque et al. (2013) used a multilevel perspective whereby access to healthcare occurred at the interface of health systems and populations. Relevant themes in their study included accommodation and availability. The WVs who participated in this study described navigating the VA health system as requiring so many processes that are difficult to follow and with services that are not accommodating, misinformation, and ineffective communication. Responses from participants in this study included, "I had to jump through hoops", "so much red tape", and "there are too many processes". These statements indicated that the health system at the VA is perceived by this sample of WVs as not being accommodative to their needs and presented challenges to accessing and utilizing healthcare (Dardis et al., 2018; Washington, Kleimann, Michelini, Kleimann, & Canning, 2007).

Success in navigating the system by the WVs who participated in this study was dependent on whether or not their information needs were met. One participant shared how

> It's so easy to get lost in the transition . . . we just want to get home . . . then we call the VA and realize that our records were not automatically sent from the DOD to the VA.

This experience was similar to that reported by a study participant in Butler, Linn, Meeker, McClain-Meeder, & Nochajski (2018). The "lack of follow-through" was exemplified by not receiving necessary medication due to the lack of a paper prescription. This apparent oversight left the participant needlessly in pain and feeling frustrated and angry. Findings from both of these studies were also similar to what Norris and Aiken (2006) and Levesque et al. (2013) identified as barriers to accessing healthcare.

Despite the majority of negative experiences, a few women in the current study described a positive experience navigating the system. Participation in the transition assistance program (TAPs) required by the Marines Corps was beneficial for receiving information on how to access healthcare at the VA. Butler et al. (2018) noted that although the majority of their study participants described the VA as an overburdened system inflexible system, a few participants recounted positive experiences while navigating the system and accessing healthcare.

Knowledge of eligibility status may contribute to the difficulty of navigating the system for healthcare. Participants in this study described being unaware of the level of care they were entitled to receive, specifically the WVs who felt they required disability benefits. Previous studies confirmed that perceived ineligibility or misinformation of the level of care to which WVs are entitled was a barrier to accessing healthcare (Johnson et al., 2013; Vogt 2006; Washington et al., 2011).

Shaw et al. (2013) conducted a grounded theory study that explored the decision-making process of patients who used emergency department (ED) services versus primary care services for non-emergency needs. Study findings indicated that knowledge of healthcare options and the perceived benefits and barriers within each option affected the decision-making process. Further, the study authors described the necessity of improving systemic factors. Likewise, other studies (Levesque et al., 2013; Norris & Aiken, 2006), examined access and perceptions of patients' healthcare, when understanding how a decision was made to use the ED or other non-emergency healthcare facilities. Similarly, in this study, WVs reported using their local ED often due to their lack of proximity to a VA or VA clinic and/or being uninformed about their healthcare eligibility.

Other studies (Fredericks, 2013; Hershberger et al., 2013) explored the decision-making process in non-veteran women and found that a critical component of that process was whether the patient was informed about treatment options. In the current study, participants shared that their lack of information, or inaccurate information, impeded their ability to decide where to access and utilize healthcare.

In summary, participants in this study reported that navigating a healthcare system as a woman veteran became challenging when information needs went unmet and the experience, after deciding to access healthcare, was fragmented, complex, and convoluted. Results from previous studies (Butler et al., 2018; Dardis et al., 2018; Fredericks, 2013; Hershberger et al., 2013; Johnson et al., 2013; Koblinsky et al., 2017; Levesque et al., 2013; Norris & Aiken, 2006; Shaw et al. , 2013; Washington et al, 2007; Vogt 2006; and Washington et al., 2011) confirmed regardless of the type of healthcare system that was used for healthcare, both veteran and non-veteran women described how making healthcare decisions would be more effective when the barriers to navigation are removed and suggestions for improving the system are implemented.

Digging Deep

Although this was not a term used by any of the study participants, the participants' stories reflected a process of introspection. Comments captured from participants suggested a process whereby they first look inward, almost as a check-in step, then began to respond to acts of self-preservation, and continued to persevere. Perhaps it is due to their military ethos, but an uncanny ability to "dig deep" and figure out how and what they needed to get and continue the pursuit of healthcare was expressed by each study participant.

Previous studies have examined conditions or experiences that might lead a woman veteran to be introspective, persevere, and feel proud and responsible, characteristics that were

found in the responses of some of the participants in this study. For example, Burkhart and Hogan (2014) conducted a grounded theory study on WVs coping with the transition from military life to civilian life. Although the focus of their study was the transition experience, one theme, "having pride in being a veteran-civilian" indicated that study participants dug deep to develop this positive perspective. The study authors described how participants found meaning and purpose in their military career; specifically, participants expressed a sense of belonging to the military and found value in living a life of service. Similarly, participants in this study conveyed their determination and will relevant to improving their current situation and their desire to assist other WVs in similar situations.

Studies on healthcare decision-making in non-veteran women provided additional data against which to compare the responses of the participants in the current study. A qualitative, grounded theory study that explored mammography decision-making in older women with a family history of breast cancer resulted in a core category of "guarding against cancer" (Greco, Nail, Kendall, Cartwright, & Messecar, 2009, p. 353). The authors explored the conditions associated with the decision-making process, including triggering events and awareness of risk, and beliefs. Despite the differences between the study populations in the Greco et al. (2009) study and the current study, the commonalties (e.g., women as study participants who are in the process of deciding on treatment options and potentially feeling vulnerable) made the Greco et al. study germane to this research. The participants (Greco et al., 2009) who decided to have a mammography screening described feeling that they were "taking charge of health". This statement reflected the notion of being responsible, feeling empowered, and may also suggest responsiveness to self-preservation. Similar findings from this study were illustrated by comments from participants. One participant noted, "Whether I'm feeling lousy or whatever, I

am stilling going to go. When I'm feeling better about myself, I want to keep doing better and I'll keep that up. It makes me feel empowered." Another participant shared, "I seek healthcare for quality of life reasons." Women in both the Greco et al. study and the present study described an introspective approach when considering the risks and benefits of their decisions, and then responded to their insight by deciding to pursue healthcare. This also exemplified responding to self-preservation. This finding was corroborated in the DCS results reported in Chapter Four in which participants considered the risks and benefits of each option.

Fredericks (2013) explored women's decisions against undergoing a hysterectomy. Like the participants in the Greco et al. (2009) study, the participants in this study were not veterans, but were in the process of deciding on a procedure that clearly had both risks and benefits. The theme, "constructing a female illness identity" emerged. Fredericks explained that participants were motivated to examine and articulate how their identities as women were connected to their physical bodies, particularly their reproductive organs. These responses suggested that they were being introspective about their sense of female identity. One participant in the study expressed views regarding the oppression of women in the medical system as compared to men. This perception was similar to the findings of this study in which WVs articulated their connection to their female identity in the context of feeling vulnerable around servicemen, experiences with a lack of women-specific services at a gynecologist's office, and further, experiencing MST involving rape and in some cases pregnancy. Although not explicitly stated, the responses of the WVs in this study suggested that they constructed a female identity, perhaps in response to self-preservation, while in a male-dominated environment. The decision to access and utilize healthcare, regardless of the nature of the healthcare needs, was clearly influenced by a thought process that involved introspection followed by a response to the particular situation.

Concepts such as perseverance and tenacity, resilience, introspection and empowerment in WVs was not well represented in qualitative and quantitative literature. However, there was no shortage of studies that examined and explored the physical, emotional, and psychological trauma that WVs experience. The comments from the women who participated in this study conveyed grit.–their inner resolve in response to negative experiences (i.e., traumas) which had cultivated within them a motivation to overcome their negative experiences. Their decision to access and utilize healthcare seemed to rely on their perception of the situation, availability of resources, and a determination to improve their quality of life. The women who participated in this study "dug deep" to reflect on what would be required to have positive experiences that would result in an improved quality of life.

Managing my Life as a Veteran

The women who participated in this study consistently described feeling disconnected from civilian life. Roles that were once almost innately performed became blurred and difficult to maintain. Some participants described feeling unprepared to think about healthcare when they returned since their priorities were only to return home. A lack of autonomy and agency in the participants while serving was described as impeding the process to access needed healthcare in the civilian environment. The women in this study related that many civilians would often question their veteran status, implying that perhaps they were the spouse of a veteran. And still, the presence of gender bias continued to resonate throughout the communities and organizations where assistance may have been available. Role ambiguity presented obstacles to the women in this study, yet these women continued to forge ahead with their plans.

A qualitative study conducted by Ahern et al. (2015) explored the challenges of Afghanistan and Iraq veterans' transition from military to civilian life. Themes that emerged

from this study included, “military as family,” “normal is alien,” and “searching for a new normal.” Participants in the current study described the challenges of lacking structure, feeling disconnected from others in their community, and searching for a new purpose. Further, one of the study participant’s described a situation that mirrored that of a participant from the Ahern et al. study when she described attendance at a community event where unwarranted assumptions were made and insensitive questions were asked. Feeling challenged while managing their lives as veterans in a civilian environment was a common refrain in both studies.

Through a grounded theory approach, Burkhart et al., (2014) collected data from 20 women veterans who served post–Gulf War and generated a substantive theory of the process followed by women who entered, served in, and transitioned out of the military. “Coping with transitions” emerged as the basic psychosocial process used by women veterans; this finding was also discovered in the current study. A number of themes emerged from the Burkhart and Hogan study; the theme of “experiencing stressors of being a civilian” was also conveyed by participants in the current study. Challenges with meeting the necessities of life, such as figuring out the eligibility for healthcare and how to apply, finding employment, and in some cases, finding a home. Participants in the Burkhart et al., study reported similar negative experiences: becoming reacquainted with civilian friends, explaining to others that you can be both a veteran and a civilian, and managing different life roles. For example, one of the women who participated in the current study shared how she ran a “tight ship” prior to being activated for an Iraq tour. Upon return home, routines and schedules that she had created and implemented felt foreign. Crompvoets (2011) conducted a systematic review of the literature to examine the health and wellbeing of WVs. Specific foci included the nexus of roles that many WVs assume and their impact on accessing healthcare. The author (Crompvoets, 2011) summarized the literature

reviewed and suggested that a clear relationship existed between identity and access to healthcare. One of several themes identified by Crompvoets included “access to services.” The author described how assuming a dual role of mother and warrior affected her decision to access healthcare.

The presence of gender bias posed challenges to the women in this study during their period of transition. A participant in this study shared a story about the planning of a fundraiser for WVs. While soliciting donations at veteran service organizations in her community, she was encouraged to go to the auxiliary; her role as a woman-veteran was negated. Another participant spoke of her arrival at the VA and being asked by those in the waiting room, “Are you here for you or your husband?” Street et al. (2009) described a study in which Vietnam veteran women reported an unsupportive homecoming reception that positively correlated with post-deployment PTSD. This particular cohort of women witnessed the bias towards male veterans who were considered to be “real veterans” thus undermining the reality of their challenges. Similar to the reports of women in this study, the lack of recognition as veterans, regardless of gender, continues to impact the identity of many WVs, particularly from recent conflicts.

Despite feeling disconnected from civilian life, some study participants acknowledged that becoming involved with veteran service organizations, where other WVs shared similar experiences, was beneficial. Another positive commonality shared among a few of the participants in both studies was the sense of pride experienced while in their civilian communities. For example, women in the current study shared their experience of attending a Veterans Day parade in their community and having the opportunity to demonstrate their military identity in a positive manner.

Findings from previous research supported the findings of this current study. The participants described that managing their lives as veterans in a civilian environment presented challenges to their access and utilization of healthcare. Insufficient support and understanding from family and other civilians further complicated their experiences. In the extant literature, women who experienced support through social and healthcare experiences described less difficulty managing their roles as WVs in a civilian environment.

Encountering Barriers

Physical and personal barriers presented challenges to the women in this study. Location, appointment availability, and transportation presented logistical challenges to the use of VA healthcare facilities. The lack of gender-specific services and an omnipresent sense of a male-dominated environment resulted in most of the women questioning the necessity of seeking healthcare in that particular setting. However, the women in this study conveyed a relentless spirit that fueled their will to receive the care they perceived as necessary.

Previous studies examined the barriers to accessing and utilizing healthcare by WVs (Hamilton et al. 2013; Haskell, 2011& Washington et al. 2011). In the current study, the women openly shared the specific personal and physical barriers that influenced their decision-making process to access and utilize healthcare. The findings from this study were consistent with the literature reviewed; a variety of studies were included to underscore the persistent existence of these barriers.

Washington et al. (2007) explored the perceptions and decision-making of WVs (n = 51) through an ethnographic approach with six focus groups about VA healthcare. Four groups were conducted with women who had used VA healthcare within the past 5 years and two groups were conducted with women who had never used the VA for healthcare. Barriers, represented as

themes included, information needs, access, gender appropriateness, and quality of care. The women who participated in this study indicated that information needs were unmet due to inconsistent communication, receipt of inaccurate information, or unavailability of information. The majority of study participants who described their information needs related it to their experience with VA healthcare. Participants in the Washington et al. (2007) study noted, "Don't know what's available. Don't know what we're eligible for. And what is involved to be eligible. And the cost. I mean, it's all sort of run together" (p 813). Another participant in the same study shared, "Well, I have never received any information since I've been out of the Army. I mean maybe it's because . . . and I moved, but I've never received information about benefits or what's available for me" (p. 814

Participants in the Washington et al. (2007) viewed availability and accessibility in terms of location, distance, and ease of making appointments as barriers to accessing care. Similarly, in this study, participants shared the difficulty of getting appointments and having to travel great distances to a VA clinic, finding out she needed a gynecologist and that particular clinic did not provide those services. These barriers were communicated by almost every study participant in both the current study and that of Washington et al. With consideration to gender appropriateness and quality of care, the women who participated in this study shared how the presence of stigma and gender bias presented as barriers.

Grounded theory methodology guided a study by Kehle-Forbes et al. (2017) to explore factors affecting WVs with self-reported trauma histories to access healthcare at the VA. The majority of women who participated in this study reported experiencing MST. A commonality between the current study and that of Kehle-Forbes et al. was the fact that many WVs with a history of MST initially accessed healthcare at the VA but did not return due to negative

experiences. Additionally, participants in the current study described their efforts to receive therapy for MST and PTSD; they were told they did not meet the eligibility criteria. Another participant shared that the director of the MST program at the VA where she receives her care was a male. Her experiences with having males as perpetrators precluded her from returning to that site. Reports of gender bias as a barrier to access to healthcare for WVs were found in the extant literature (Fitzgerald, 2010; Haskell et al., 2011; Johnson et al., 2013; Vogt et al., 2006) discovered before the commencement of this study. Findings from these studies align with the findings from the current study.

Butler et al. (2018) conducted a qualitative study using a focus group approach to examine views on healthcare gaps and needs. Like the findings from the current research, some participants in Butler et al. (2018) reported feeling that their healthcare concerns were negated and minimized, and others described a lack of follow-through caused by an overburdened system that was unresponsive and inflexible. Navigating the system emerged as a category in this study; it was also reported as a healthcare gap by Butler et al. Participants in both the current study and that by Butler et al. reported having accessed healthcare from non-VA healthcare providers and described the lack of military culture sensitivity and competence. Additional studies (Bean-Mayberry et al., 2011; Butler et al., 2018 Rank & Heroux, 2018) found that when women participants felt that their military service was not valued or respected they would often decide not to return for healthcare.

As previously noted, personal barriers to accessing and utilizing healthcare by WVs has been well established in the literature. Issues with gender bias, ineffective communication, and unsatisfactory interpersonal experiences continue to plague the population of WVs. This ongoing widespread healthcare system issue is well supported as evidenced by the publication dates (i.e.,

2007-2018) of studies reviewed for this current research. Moreover, the study findings from this research were consistent with the findings reported in the previous review of the literature (reported in Chapter Two).

In addition to the personal barriers that WVs encounter during the decision-making process, physical barriers are of equal concern. For instance, WVs in this study reported that the distance to the nearest VA and/or VA clinic often resulted in the use of an emergency department at a local hospital for veteran-specific healthcare needs.

Brooks et al. (2016) explored WV's decisions to access healthcare for those who lived in a rural area. Their findings supported this research and described how WVs delay, underutilize, or bypass healthcare in the presence of barriers such as proximity to healthcare providers. Additional studies reported the absence of child care, hours of service, and the inability to take time off from work also presented barriers to accessing healthcare by WVs (Burkhart et al, 2015 Washington et al., 2013). Removing logistical barriers and addressing work-life challenges, so that appointment delays, long wait times, parking challenges, and access to specialists, would facilitate access to healthcare, specifically mental healthcare.

In summary, the findings of the studies reviewed for this dissertation illustrated a longstanding presence of personal and physical barriers that have influenced the decision-making process by WVs to access and utilize healthcare.

Relationship of the Substantive Theory to other Theories

The substantive theory of the current research, The G.R.I.T. Theory of Decision-Making by WVs, as seen in Figure 4-1, describes how the core concept of "having inner resolve" facilitated decision-making by WVs to access and utilize healthcare. Theories that described or explained the same concepts as those within the G.R.I.T. Theory were not found, despite an

exhaustive literature search. McEwen and Wills (2014) suggested that theory generated from research should be derived from replicated and confirmed research findings. Further, this approach "assumes that there is truth in real life, and that the truth can be captured through the senses, and that the truth can be verified" (p. 85). The research question guiding this study, "What is the decision-making process used by WVs to access and utilize healthcare?" was clarified by listening to the voices of 26 study participants and subsequent analysis of the interviews data. The shared experiences of the participants was surfaced through the interview.

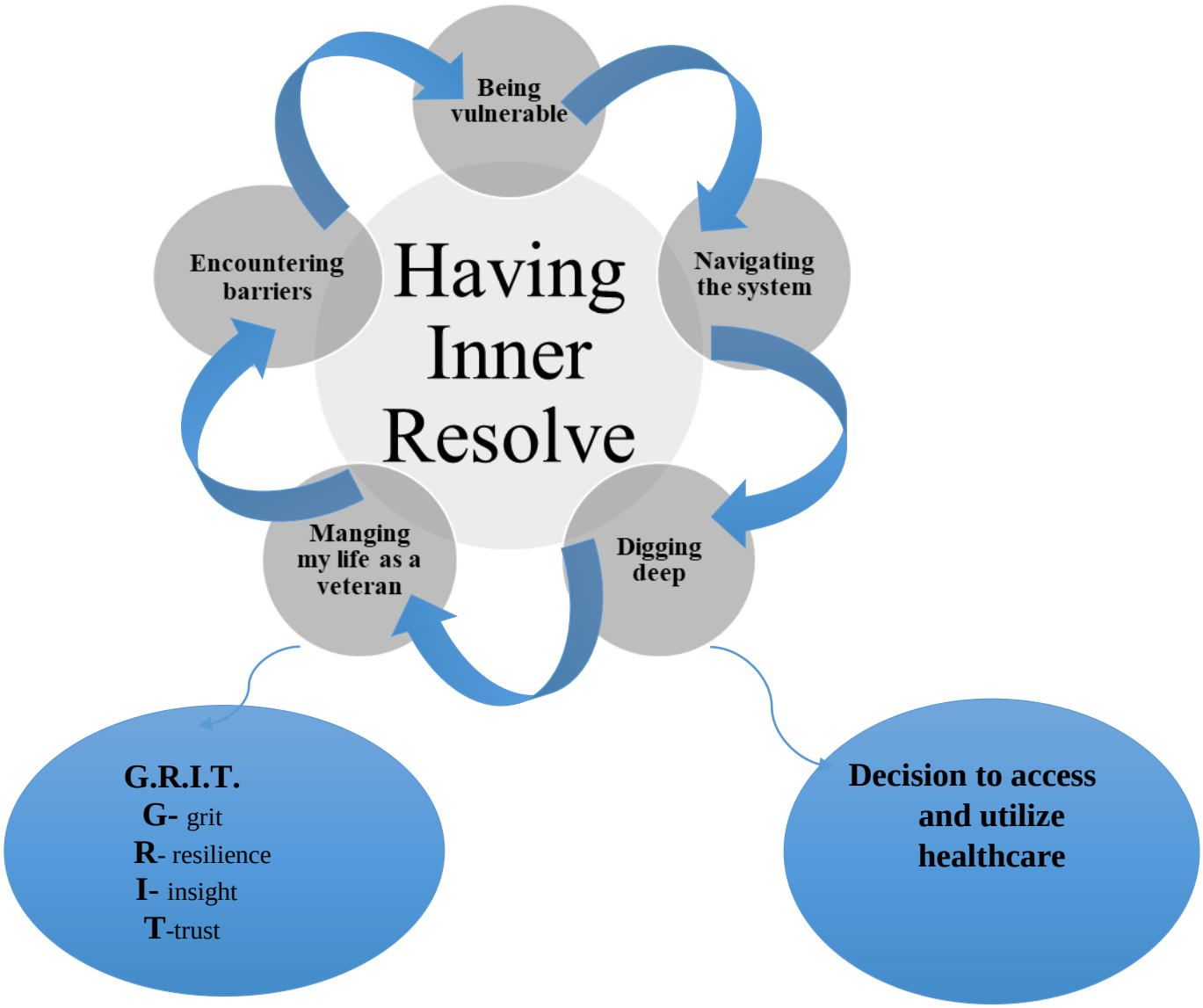

Figure 4-1: The G. R. I. T. Theory of Decision Making by Women Veterans

Reflecting on the philosophical underpinnings discussed in Chapter One, symbolic interactionism espouses the belief that theory represents interpretations made from a given perspectives. In this grounded theory study, the categories that emerged from the analysis, (a) being vulnerable, (b) navigating the system, (c) digging deep, (d) managing my life as a veteran, and (e) encountering barriers, represented the interpretations derived from the meaning as described by the participants and ultimately led to the identification of the core concept.

Although decision-making is a process, the concepts specific to this study involved in that process did not represent a process or a phase, rather they depicted a cyclical nature in the lives of the women who participated in this study. Searching for ways to position this theory within current nursing science uncovered several existing theories that were reviewed; specifically theories constructed from concepts such as resilience, decision-making, and inner resolve were explored. Yet, no suitable theory was found, and focusing on the big idea, having inner resolve, led to the development of The G.R.I.T. Theory of Decision-Making by Women Veterans.

Similarities and differences between the G.R.I.T. Theory and the Theory of Resilience will be discussed. The decisions to access and utilize healthcare by the WVs in this study relied on having inner resolve. However, the process thorough which decisions were made, may be explained by other theories. Thus, several existing theories were critically examined to determine the uniqueness of the G.R.I.T. Theory. For instance, Elwyn, Stiel, Durand, and Boivin (2010) acknowledged that most decision-making theories may not address the needs of those making decisions, particularly patients who require collaboration from others, which would well describe the WVs who participated in this study. The Fuzzy Trace Theory (FTT; Elwyn et al., 2010) was

identified in Chapter Two as potentially relevant to decision-making by WVs. Following the analysis of the interview transcripts, the FTT remained an appropriate fit for the G.R.I.T. Theory.

According to one study participant's description, WVs see themselves as a sub-culture within the military culture. Madeleine Leininger's Theory of Culture Care Diversity and Universality (i.e., Theory of Culture Care) focuses on the discovery of human care diversities and universalities and ways to provide culturally congruent care (de Chesnay & Anderson, 2016). Nurses are positioned to nurture the inner resolve of WVs by recognizing their cultural differences within the context of the concepts identified in the G.R.I.T. Theory, which is discussed within the context of the Theory of Culture Care and how nurses can cultivate the inner resolve of WVs through their culturally competent and culturally sensitive practice at both VA and non-VA healthcare settings.

The Theory of Resilience

The Theory of Resilience (Polk, 1997) is a middle-range nursing theory that was derived as a result of a lack of a theoretical delineation of an important concept, resilience. Previous understanding of resilience was based on the ability to transform disaster into a growth experience and move forward (Polk, 1997). The nursing profession supports individuals through the process of moving through adversity towards healing.

The core concept for the G.R.I.T. Theory, having inner resolve, emerged from a recognition that it formed a common thread woven between the previously identified categories. Having inner resolve requires resilience and the G.R.I.T. Theory was developed, using the data collected in the current study, to include the concept of resilience. According to the G.R.I.T. theory, having inner resolve facilitates the decision to access and utilize healthcare. Theoretical clarity of the concept of resilience provides nurses with a framework to assist in cultivating the

inner resolve of WVs. Though similarities and differences exist between the theories, consideration of the construct of resilience and how to cultivate it aligned with the constructs of the G.R.I.T. Theory.

Like this study, in which the concepts supported the description of having inner resolve, Polk (1997) identified clusters of phenomena related to resilience. Polk aggregated the concepts into patterns, (a) dispositional, (b) relational, (c) situational, and (d) philosophical, that underlie a pattern of resilience. The dispositional pattern referred to physical and ego-related psychosocial attributes. Examples of physical attributes include intelligence, health, and temperament. Ego-related psychosocial attributes include a positive self-esteem, sense of self-confidence, belief in self-efficacy, and autonomy. The similarities in physical attributes in this study were a consequence of (a) more than half of the participants having at least some college education, (b) all participants being concerned with a health-related issue or improving their health, and (c) demonstrated resilience.

Similarities also existed among the ego-related attributes. Having inner resolve was recognized as the women described their ability to introspect, respond to self-preservation, and persevere. Despite these similarities, many of the study participants who experienced MST, described a negative self-esteem.

The relational pattern refers to characteristics of roles and relationships that influence resilience. Examples include turning to someone for comfort, having the willingness to seek out a confidant, and identifying with positive role models. It is also manifest in having interests and hobbies. The willingness to seek community support and having positive social interactions with family, friends, and others is evident in resilient individuals (Polk, 1997). Relational patterns of resilience in the participants in this study differed from those described by Polk (1997). Many

of the interpersonal relationships and/or situations experienced by women in this study were negative and resulted in mistrust and shame. For example, one participant described an experience in which she reported an MST experience to a senior officer whose initial confidence and guidance was presumed to be longstanding later resulted in betrayal. Many of the participants were ashamed to share their negative experiences, so finding comfort in others proved difficult. However, some study participants described being involved with their communities and/or veteran service organizations that provided them with a community.

The third contributing pattern is situational. Attributes in this pattern pertain to how one responds or copes to situations and stressors (Polk, 1997). This is reflected by having the capacity for action in a situation and the ability to assess one's capacity for action. Flexibility, perseverance, and resourcefulness contribute to this aspect of the pattern of resilience (Polk, 1997). This pattern is clearly explicated in the G.R.I.T. theory. Perseverance and resourcefulness were exemplified by all of the women in this study through descriptions of their vulnerability, their processes for navigating the system, the ways in which they dug deep, the ways in which they managed their lives as veterans in a civilian environment, and how they responded when encountering barriers.

Lastly, the philosophical pattern is manifested by personal beliefs. The belief that self-knowledge is valuable and reflection about oneself and events contribute to this pattern (Polk, 1997). Resilient individuals have a conviction that "good times lie ahead" and hold a belief in finding positive meanings in experiences. Here again, women in this study demonstrated these attributes. One study participant described resilience by noting, "I put one foot in front of the other." Other study participants described becoming involved politically, organizing events

through veteran service organizations, and leading support groups for other WVs. Some of the women in this study admitted to struggling with depression and lacked a positive perspective on their future. Despite this position, their ability to reflect on the changes that were needed indicated their resilience. Polk (1997) postulated that these patterns share an energy field that has a transformative nature, whereby phases of order and disorder fluctuate and ultimately determine the presence of resilience. Resilience allows one to transform disaster into a growth experience and move forward (Polk, 1997). Listening to the WVs in this study describe how they recovered, or were in the process of recovering, from personal disasters related to military-related experiences, exemplified their resolve and resilience. In summary, the G.R.I.T. Theory of Decision-Making by WVs and the Theory of Resilience share many similarities. Resilience is one concept within The G.R.I.T Theory of Decision-Making and provides additional insight on how this quality may affect healthcare decision-making by women veterans.

Theory of Culture Care Diversity and Universality

The women in this study described belonging to a military sub-culture comprised of WVs**.** The description of a "sub-culture" by the study participants piqued the curiosity of this researcher, who wondered whether there was an element of cultural dissonance that has an effect on the development of their inner resolve. Recalling that manyof the study participants were not satisfied with the quality of care received, perhaps receiving culturally sensitive care might deepen their inner resolve and thus facilitate their decision-making process. The construct "having inner resolve" was identified as so important to the individually identified concepts that it led to the development of the substantive theory, the G.R.I.T. theory. In this inquiry, deciding to access and utilize healthcare by WVs was facilitated by participants' inner resolve. Concepts

that formed the G.R.I.T. theory will be discussed in relation to the Theory of Culture Care Diversity and Universality (Theory of Culture Care) (de Chesnay, 2014).

Leininger's theory is rooted in the assumption that humans exist within a culture, and culture is viewed as a universal phenomenon. The seven cultural and social structure dimensions that were depicted in Leininger's "sunrise model" were (a) technological, (b) religious and philosophical, (c) kinship and social, (d) political and legal, (e) economic, (f) educational, and (g) cultural beliefs, values, and lifeways. Concepts that support the categories and led to the development of the core concept, having inner resolve, reflected each of these dimensions. Caring (in the Theory of Culture Care; 2014) occurs through three modes of care action, (a) cultural care preservation, (b) cultural accommodation/negotiation, and (c) cultural care repatterning/restructuring. The fit of the theoretical linkages to the G.R.I.T. theory, as they pertain to the modes of care action are shown in Table 1. Additionally, examples of how nursing practice could facilitate culturally congruent care for WVs relevant to the G.R.I.T. theory is described in italics.

Cultural care preservation is described as the assistive, supportive, and facilitative actions that assist individuals and groups within a culture to retain and preserve their values for the maintenance or recovery from illness.

Cultural care accommodation/negotiation involves the actions and decisions that assist individuals and groups within a culture to adapt to or negotiate with others for the purpose of satisfying healthcare outcomes.

Cultural care repatterning/restructuring promotes actions and decisions that help those in a specific culture change or modify their behaviors to achieve a new and healthy pattern.

Table 1

Fit of theories

Theory of Culture Care	**G.R.I.T. Theory of Decision-Making Theoretical Statements**
Cultural care preservation	WVs using inner resolve to manage their lives as veterans in a civilian community in which deciding to access and utilize healthcare may be hindered. Inner resolve supports WVs through periods of vulnerability that may impact their decision-making skills *Actions required by healthcare providers include: (a) knowledge of this subculture and recognition of the importance of WVs striving to preserve their identity in a civilian culture, and (b) development of specific interventions and/or programs that lead to strengthening the inner resolve of WVs.*
Cultural care accommodation/negotiation	WVs rely on inner resolve to navigate a healthcare system where they may choose to access and utilize healthcare. *Actions required by healthcare providers include working with the system leaders to advocate and demonstrate the need for improved processes and flow of care, particularly at VA hospitals.*
Cultural care repatterning/restructuring	Inner resolve assists in overcoming barriers to accessing and utilizing healthcare WVs may encounter throughout their decision-making process. *Actions required by healthcare providers might include development of educational programs and services to minimize the physical and personal barriers that impact the decision to access and utilize healthcare.*

The Fuzzy Trace Theory of Decision-Making

Reyna (2008) described the Fuzzy Trace Theory (FTT) through an explanation of "gist" and "verbatim," whereby individuals rely on the bottom-line meaning (i.e., gist), and information in greater detail (i.e., verbatim). The gist includes the emotional meaning, or affective interpretation, of the information. During the development of a process model for vaccination decisions, the author posited that at times a vague gist or fuzzy representation of information may lead to more effective decision-making because verbatim representations sometimes fade due to memory limitations and other cognitive issues, resulting in a loss of information. According to the tenets of the FTT, gist is more useful than verbatim information in decision-making situations.

In the current study, participants who used insight and introspection when assessing their emotional, psychological, physical, and spiritual needs as they considered the decision to access and utilize healthcare, relied on the gist of what they felt would lead them to achieve the best outcomes. The G.R.I.T. theory includes the concept of insight and trust under the assumption that relying on one's insight and trust leads to getting the gist of the situation that requires decision-making. Consideration of this theory underpins the importance of how patient education is provided to women veterans challenged with making decisions relevant to their healthcare options.

Study Limitations

Interviews were scheduled following the order of responses to the recruitment advertisement. Some initial responders did not follow through on their initial inquiry and commitment to be interviewed. Limitations in this study included the potential for self-selection bias. Information provided in emails in response to the recruitment ad may have skewed this

researcher. Study participants who served in the National Guard or Reserve and were never deployed did not describe any barriers to accessing and utilizing healthcare and perhaps decision-making did not present a challenge. Participants who served in the Marine Corps described attending a transition assistance program (TAP) that provided them with information on how to determine their eligibility and access healthcare and were well informed of their healthcare options. Study participants who served in earlier conflicts such as Vietnam and Korea have been civilians for much longer than most of the study sample and did not experience any challenges with managing their lives as veterans in a civilian environment. The sample breadth in this study represented a broad population of women veterans. Limiting the sample to specific conflicts such as women who had served in OEF/OIF may have identified more resonant issues affecting their decision-making process relevant to this time of conflict. Lastly, although the study sample was adequate for a grounded theory study, the findings relative to the decision-making process may not be generalizable to the entire population of WVs.

Implications of the Findings

Implications for Nursing Education

A knowledge gap of veteran-centered care exists within nursing programs throughout the United States (Elliott and Patterson, 2017). Nurses are often the first line of contact with patients and commonly conduct the initial health assessment. Knowledge of the unique and specific healthcare issues of the veteran population will enable nurses to respond more effectively and efficiently in this growing population, particularly among WVs. Integrating culturally competent veteran-centered content in a few core courses, particularly the psychiatric-mental health courses, at all programmatic levels (on ground and online) will ameliorate this gap in knowledge. Creating women veteran simulation experiences to educate students through realistic experiences

with MST, PTSD, depression, anxiety, women's health, and homelessness will enhance the teaching and learning experience. Forming partnerships with local VA systems and clinics for clinical experiences, and with veteran service organizations for community health experiences would round out the learning experience.

The categories, navigating the system and being vulnerable, in this study reflected experiences among the study participants with healthcare providers who misunderstood the healthcare issues specific to WVs. Additionally, the quality of care received was less than satisfactory from healthcare providers who lacked veteran-centered healthcare knowledge. Study participants did not consistently describe nurses with inadequate knowledge, however nurses with veteran-centered healthcare knowledge are well positioned to educate other healthcare providers.

Lastly, embracing an interprofessional approach by engaging the disciplines of social work, religious studies, psychology, physical therapy, occupational therapy, nutritional science, and exercise science to collaborate on the development of innovative educational and practice strategies. Nurses will provide direction and leadership on this initiative thereby fostering creation of a culturally competent and comprehensive veteran-centered curriculum.

Implications for Nursing Practice

Providing evidence based nursing practice to women veterans requires education on veteran-centered care. Therefore, implications for nursing practice includes ongoing education on evidence-based interventions, knowledge of results from qualitative and quantitative studies that provide the evidence for best practices, and being informed of current policy and opportunities to advocate for changes that affect nursing practice for women veterans.

Interviews with this study's participants reinforced the need for gender-specific, service-related care for women veterans across their life span. Women veterans seek healthcare at VA and civilian healthcare facilities. Nurses who are employed at a VA health system are immersed in the veteran culture. However, remaining vigilant of changes in behavioral symptomology such as MST and PTSD and other comorbidities is requisite to prevent further negative sequelae. Being cognizant of any barriers to gender-specific care, or presence of gender bias within the VA calls for nursing advocacy and change in practice. Without a military uniform or identification, distinguishing a woman veteran from a civilian woman is challenging. Civilian nurses can begin by asking every female patient, "Have you ever served?" Responses to this question may facilitate dialogue that leads to further revelation of underlying issues. Women veterans who choose to receive care in a civilian healthcare facility should be routinely screened for anxiety, depression, MST, PTSD, substance abuse, genitourinary and reproductive health issues, sleep issues, pulmonary issues, musculoskeletal conditions, and other related health issues. As such, the complexity of healthcare issues for many women veterans requires a coordinated care approach including disciplines such as social work, psychology, psychiatry, and spiritual support. The lack of knowledge about VA benefit eligibility was commonly described by study participants and corroborated through the literature reviewed. Nurses and social workers can offer assistance with navigating this process and minimizing the experience of fragmented healthcare, particularly through the VA healthcare system. The Veterans Health Information Exchange (VHIE) is available to Veterans enrolled and receiving care at a VA medical center. This program gives VA and participating community care providers secure access to certain parts of an electronic health record. This access reduces the need for veterans and their families to request and carry paper medical records from one health care provider to another. It also

provides other potential benefits to Veterans and their providers. (VA.gov, 2018). Nurses may inquire about availability through their practice.

Results from the DCS scale used in this study did not indicate presence of decisional conflict in all participants, however some participants indicated a delay in decision-making (a factor of decisional conflict) as they considered their healthcare options. Nurses can reduce the level of decisional conflict that may be a factor in the decision-making process. This occurs through provision of knowledge, exploration of meaningful experiences, value clarification, collaborating with other healthcare providers such as social workers who can probe further into the aforementioned concerns. Administering the DCS would be a valuable method of collecting information about a WVs decision-making during an initial assessment. Advanced Practice Nurses can incorporate specific veteran-centered assessments with the use of brief screening instruments such as the decisional conflict scale (DCS), MST and PTSD screening questionnaires. Other instruments that measure perceived satisfaction such as the Patient Satisfaction Inventory (PSI) and caring behaviors (CBI-24) would provide useful data that indicates the quality of care experienced and may offer suggestion to improve practice.

Patient decision aids (PtDA) are tools, such as pamphlets and brochures that assist patients in decision-making relevant to treatment options (Ottawa Hospital Research Institute, 2018). PtDAs involve patients in the decision-making process through collaboration with a healthcare provider. Many PtDAs exist for decision-making required in the treatment of acute and chronic disease conditions, and more recently end-of-life care. To date, a PtDA does not exist for veterans, specifically WVs. Availability of a PtDA for WVs would assist them to make informed decisions that align with their military culture and personal values and preferences. Additionally, all of the women who participated in this study used their mobile devices for the

interview. Development of a PtDA mobile application (app) would provide a convenient method of exploring their healthcare options.

The development of veteran-centered evidence based practices (EBP) will provide nurses and other healthcare providers with interventions rooted in qualitative and quantitative science to improve the outcomes of the healthcare received by this population. A component of nursing practice is research. Nurses are obligated to respond to unanswered questions and search for answers that will contribute to this body of knowledge. Development of a veteran-centered healthcare for nurse's organization does not exist. Nurses who provide care to WVs in both VA and non-VA settings can create a gender specific space while waiting for an appointment and within the practice environment. This supports the culturally sensitive and culturally competent delivery pf nursing care to the WVs who are part of the military and veteran culture.

Implications for Research

Improving healthcare practices that result in optimal patient care outcomes relies on evidence steeped in science. The role of the nurse is critical to the conduct of ethical research of women veterans**.** As mentioned in Chapter One, there is no shortage of quantitative studies that examined different variables related to WVs, and a dearth of qualitative studies. The current study is one of few qualitative studies that explored healthcare decision-making by women veterans. Experience with this grounded theory study involving WVs indicated that this population feels "unheard and misunderstood". Voices that describe experiences and perspectives cannot be measured with quantitative methodology. The G.R.I.T. Theory of Decision-Making by WVs explains that having inner resolve supports decision-making to access and utilize healthcare. The concept of inner resolve is not represented in the literature. A concept analysis of inner resolve would provide nurses and other disciplines involved with the care of

WVs and other vulnerable populations with information on how to maintain or increase their inner resolve that might result in improved quality of life experiences, such as receiving healthcare.

Qualitative studies should be targeted from both nursing education and nursing research perspectives. Nurse researchers in academia with an interest in veteran-centered healthcare should begin with a survey of faculty knowledge of military and veteran culture. Data collection of these results might lead to an exploratory and descriptive analysis of faculty perceptions of veteran-centered content embedded in their courses, or the development of a specific veteran-centered healthcare course. Exploration of the barriers and facilitators with integration of veteran-centered course content might also be considered. Many faculty at this PI's college of nursing subscribe to Dr. Jean Watson's Theory of Caring. A qualitative study might include the application of the Caritas and their integration within veteran-centered content in nursing curricula.

Other suggestions for qualitative studies include, (a) exploration of the role that inner resolve has in healing from MST and/or PTSD, (b) how do WVs with MST decide to access and utilize health care, (c) what role does spirituality play as a personal intervention to heal from trauma, (d) an exploration of what moral and soul injury means to WVs, and, (e) exploration of WVs perceptions of caring behaviors by healthcare providers.

Despite the volume of quantitative studies with WVs, researchers may consider, (a) correlational studies that look at the relationship of empowerment and healthcare utilization among OEF/OIF and Gulf War WVs, (b) development and evaluation of a veteran-centered assessment tool to measure risk factors for homelessness among WVs with MST, (c) examination of healthcare access practices by WVs through a correlational study of the most

common barriers, (d) examination of satisfaction with care received by WVs through the VA in a study not funded by the VA, (e) development of a scale to measure inner resolve and test with the GRIT model, and (f) examination of the WV PtDA use as a valid and reliable tool for improving healthcare decision-making by women veterans.

Implications for Policy

The upcoming 116th congress will contain this country's highest number of women, and a record number of women veterans (Kurtzleben, 2018). Women veterans are the fastest growing subpopulation of veterans and have healthcare needs unique and specific to being women. Major reforms at the VA have resulted in some progress to bridge the chasm of gender-specific healthcare, but many needs remain unmet. Most study participants representing all regions of the United States, reported negative VA healthcare experiences and resulted in a decision to not return for care. Further, WVs in this study described their experiences with transitioning out of the military and returning to civilian life as chaotic and uncertain. Most of the women related feeling lost in the process and learning that the VA did not recognize them as veterans, thereby affecting their knowledge of healthcare eligibility and other VA benefits. Cultural and policy changes to remove barriers and provide women veterans with equitable access, benefits, and transition services is necessary. An improvement to the communication system between the Department of Defense (DOD) and the VA is requisite prior to the return and post-deployment period for women veterans.

The impetus for this research study derived from this PI's experience with seeing many homeless women who were veterans and homeless on the streets of New York City. Quality, availability, and services provided at homeless programs are inconsistent and in some cases pose danger to women veterans and their children. Local congresswomen and congressmen can close

this chasm by passing Bills that provide necessary funding and resources. Coordination between community agencies, volunteer organization needs to continue. Nurses working at community agencies can be pivotal towards affecting change and improvement.

More than half of the women veterans in this study sample reported experiences with MST. Further, they described failed attempts to report their abuse or were discouraged from reporting incidents. Every branch of the United States Armed Forces should aim to prosecute sexual assault claims. The VA needs to improve on their review of files and award women veterans appropriate benefit coverage. Nurses at both VA and civilian healthcare facilities can advocate for women veterans as their patients.

Several of the study participants described exposure to burn-pits or were told they had "Gulf War Syndrome" .At the time of our interviews, most of the participants were still fighting for accurate diagnoses so they could receive healthcare and the appropriate level of disability benefits. Lawmakers in every state must pass bills that remove the obstacles for women veterans seeking healthcare, disability, and other benefits.

Services and programs for women veterans throughout the US range from provision of special license plates to having a designated women veterans coordinator. There should be uniformity of policies to ensure that every state has a designated coordinator who oversees state benefits and services.

In 2016, Congress granted APRNs almost full practice authority (the exception was the role of the certified nurse anesthetist) at all VA facilities (AACN,). This level of practice authority by APRNs might expedite provision of healthcare for veterans thereby decreasing healthcare disparities and improving healthcare access issues.

Nurses working with WVs must identify and engage stakeholders at both VA and non-VA facilities. Implementing any practice change related to veteran healthcare, specifically for WVs requires their interest and buy-in. Identifying key stakeholders will facilitate implementation of evidence-based practices derived from a growing body of scientific knowledge relevant to the healthcare of WVs.

Summary

This chapter presented the significant findings of the research study that asked, "What is the decision-making process by women veterans to access and utilize healthcare?" The G.R.I.T. theory was identified as the substantive theory that fit this study's findings. The categorical components of the core concept, having inner resolve reflected the foundation through which women veterans rely on for decision-making. Together the categories and core concept evoked grit. Although, the findings are consistent with previous studies that explicate how the presence of barriers influence a woman veteran's decision to access and utilize healthcare, these extant quantitative and qualitative studies failed to demonstrate how women veterans overcome challenges associated with barriers to make healthcare related decisions. Theoretical linkages and components between the G.R.I.T. theory and other theories were analyzed and examined for similarities and differences. Major concepts from the Theory of Cultural Diversity and Universality were fitted to the theoretical linkages within the G.R.I.T. theory thereby demonstrating applicability in nursing practice. Implications for nursing education emphasized the importance of a veteran-centered care focus at all programmatic levels. Integration of veteran care courses or components within existing courses, will have an impact on nursing practice. Nursing practice where veterans, particularly women veterans access their healthcare, will improve with an increased knowledge level of veteran-centered care. Specific recommendations

were provided for advanced practice nurses who can assess for the presence of decisional conflict through use of a valid and reliable scale, and distribute patient decision aids that describe healthcare options. Suggestions for qualitative and quantitative research studies were presented, particularly those that will extend this study's findings. The decision-making process to access and utilize healthcare by women veterans is hindered by insufficient policy. Several areas for policy improvement were discussed. Changes and improvements to healthcare policy for women veterans requires advocacy. Nurses are well positioned to inform, advocate, and demand change for one of our nation's most vulnerable populations. Nurses working with women veterans whose inner resolve is a hidden resource, must foster their G.R.I.T. to continue their fight, this time it's a fight for quality of life.

Based on this study's findings, future studies to expand on the theoretical components of the G.R.I.T. theory are warranted to continue the explanation of how the inner resolve of women veterans can be enriched.

Conclusion

This research study used the grounded theory methodology of Corbin and Strauss (1998), including the philosophies of pragmatism and symbolic interactionism to understand the motivation and rationale of healthcare decision-making by women veterans. Twenty-six women veterans were chosen purposively to participate in this study. These participants were interviewed and their interview transcripts provided the source of data. Transcripts were verified for accuracy and then coded using open and axial coding techniques that generated a core concept of having inner resolve and five supporting categories. Analyses of this data resulted in the identification of categorical and theoretical relationships and led to development of The G.R.I.T. Theory of Decision-Making by Women Veterans. This theory explains how G.R.I.T.,

resilience, insight, and trust are fundamental to the healthcare decision-making process by women veterans.

Previous quantitative research has examined specific variables that affect the healthcare decision-making process by women veterans. A paucity of qualitative studies that explains the underlying factors contributes to insufficient knowledge. Findings from this study contribute to the qualitative literature on women veterans by explicating how having inner resolve results in overcoming barriers and challenges. Insight from these findings may be used to develop interventions and programs aimed at recognizing and cultivating grit and inner resolve of women veterans in the United States and surrounding countries.

Appendix A Recruitment flyer

Women Veterans, THANK YOU for your unwavering service and commitment to our country!

As a registered nurse and doctoral student, I would like to speak with women Veterans about what influences your healthcare decisions.

Why should I participate?

- Your participation will provide valuable information for healthcare providers on how to improve the healthcare experience of women Veterans.

What do I need to do for this study?

- Participate in one 60 to 90 minute interview by way of telephone or in a mutually agreed upon private setting.
- Fill out a short questionnaire.

What makes me eligible for this study?

- You must be a female non-active duty military Veteran between the ages of 18-65.
- You must not be a current VA employee.

Amazon gift cards in the amount of $20 will be provided to each participant who completes the interview.

If you are interested in helping with this study, please contact Corinne Lee at [redacted], *or* [redacted]

Appendix B. Recruitment script

Before we can begin, can you confirm that you are a woman Veteran? Any information that you provide remains confidential- that is, your name or other identifying information. A pseudonym (false name) assigned during the interview serves as the identifying information, but you need to sign your real name on the consent form. I will keep the consent forms in a locked cabinet in my office.

I will ask you some questions, which should not take more than one and a half hour. As we talk, I will write some notes to myself, but I will also tape record our conversation, so that if I miss something, I can go back and listen to our conversation. At any time, if you change your mind or decide you don't want to participate, please let me know and we will stop. Any information you have given me will be destroyed- I will shred any papers that have your information and erase the tape recording. At any time, if you need a break, please let me know.

The information you give me will help me with my dissertation. I may publish the results of this study. If I do, I want to assure you, your identity will be kept confidential.

Do you have any questions for me? Would you like to participate in this study?

If yes, we will proceed to the informed consent form.

If no, thank you for your consideration.

Appendix C. Permission to use instrument

Permission is not required to use this instrument. The DCS is protected by copyright but is available for use to the public.

Appendix D The Decisional Conflict Scale

My difficulty in making this choice

A. Where do you prefer to receive your healthcare? Please check one.

- ○ At the VA
- ○ At my doctor's office
- ○ At a community clinic
- ○ Unsure

A. Considering the option you prefer, please answer the following questions:

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
1. I know which options are available to me.	o	o	o	o	o
2. I know the benefits of each option.	o	o	o	o	o
3. I know the risks and side effects of each option.	o	o	o	o	o
4. I am clear about which benefits matter most to me.	o	o	o	o	o
5. I am clear about which risks and side effects matter most to me.	o	o	o	o	o
6. I am clear about which is more important to me (the benefits or the risks and side effects)	o	o	o	o	o
7. I have enough support from others to make a choice.	o	o	o	o	o
8. I am choosing ·without pressure from others.	o	o	o	o	o

9. I have enough advice to make a choice.	o	o	o	o	o
10. I am clear about the best choice for me.	o	o	o	o	o
11. I feel sure about what to choose.	o	o	o	o	o
12. This decision is easy for me to make.	o	o	o	o	o
13. I feel I have made an informed choice.	o	o	o	o	o
14. My decision shows what is important to me.	o	o	o	o	o
15. I expect to stick with my decision.	o	o	o	o	o
16 . I am satisfied with my decision.	o	o	o	o	o

AM O'Connor. Decisional Conflict Scale. 1993 [updated 2005). Available from W\VW oh1i.ca decisionaid .

Appendix E Demographic data collection form

1. What is your age?

2. What is your marital status?

    a. Married _____

    b. Divorced _____

    c. Separated _____

    d. Widowed _____

    e. Other_____

3. What is your ethnicity?

4. What is your highest level of grade completed?

5. What is your occupation?

6. Military service history:

    a. When did you join the military? Age_____ Year_____

    b. Which branch did you join?

        i. Army____

        ii. Navy____

        iii. Marines____

        iv. Air Force____

        v. Coast Guard____

        vi. US Merchant Marines____

        vii. Other____

7. What was your period of military service? (i.e., Vietnam War, Persian Gulf War, Iraq, Afghanistan)_____

8. Where do you receive medical care?

    a. VHA _____, what level of care at the VHA are you entitled to? _____
    b. non- VHA _____
    c. Other _____

Appendix F Interview guide

1. “I want to first thank you for your service to our country…” and again, “ I appreciate our time together”… So, what is it like to be a Veteran as a woman?
2. Are there specific healthcare issues that you see as unique to being a woman and a Veteran?
3. What would you describe as your most challenging healthcare issues?
4. What do you do when you need to see a doctor for any of these healthcare issues that you might have? Share with me your experience of getting medical care when it is needed.
5. What factors do you consider when deciding to see a doctor? (probe might involve conversation about individual factors, or what gets in the way?)
6. Now, what are the factors that affect your decision to not see a doctor?
7. If you decided to see a doctor, can you describe specific things that motivated you to seek out healthcare care?
8. How about specific things that got in the way from seeking out healthcare?
9. If you use the Veterans Administration (VA) health care services, please tell me about your experiences. Can you describe your understanding of your VA eligbility?
10. If you do not use the VA health care services, please tell me why and where you go for help and your experiences.
11. The decision to get healthcare that either you or your family sees as necessary can sometimes create some angst. Please tell me about how you feel when you have made the decision to both get healthcare, and then continue to go for care if needed.

12. I realize I have been asking you a lot of questions, and I've enjoyed our time together, but I have one last question…what do you see as the benefit of getting medical care? And, how about the consequence of not getting medical care?

Appendix G**.** The Catholic University of America research consent form

THE CATHOLIC UNIVERSITY OF AMERICA

November 16, 2018

Ms. Corinne Lee
School of Nursing
Room 118 Gowan Hall - Campus

Subject: Project title **"Exploration of the Decision-Making Process to Access and Utilize Healthcare in Women Veterans"**
Protocol No. **18-087**

Dear Ms. Lee:

Your research for the subject project was certified by the Committee for the Protection of Human Subjects (CPHS) as meeting the requirements of the Federal regulations governing protection of human subjects.

CPHS will maintain a copy of your submission on file. You are obligated to follow the research protocol and procedures for obtaining informed consent as you have specified. If you wish to initiate any changes in the research protocol or the informed consent procedure, you should submit this request to CPHS in writing.

The reviewer finds that the protocol does not involve undue risk for the subjects. The protocol is approved and expires **10/25/19**. Investigator must use the enclosed stamped consent forms that accompany the approval letter. If the project continues beyond this period, please resubmit your materials for renewal in a timely fashion so that your research may continue uninterrupted.

Sincerely,

[redacted]

Ralph Albano
Secretary
Committee for the Protection of Human Subjects

Enclosure

cc: [ ] Dr. Agazio

Office of Sponsored Programs
620 Michigan Ave., N.E. | Washington, DC 20064 | 202-319-5218

ARP 11/13/18
[174]

Appendix C. Consent Form

THE CATHOLIC UNIVERSITY OF AMERICA

COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS (CPHS)

APPROVED
CUA IRB 00000082
OCT 25 2019
Expires
Protocol 18-087

RESEARCH CONSENT FORM

Participant Name

Exploration of the Decision Making Process to Access and Utilize Healthcare in Women Veterans
Title of Study

Corinne A. Lee, MSN, RN
Principal Investigator

FWA00004459

INVITATION TO PARTICIPATE
You are being invited to participate in this research study because you are a woman Veteran who has served in any branch of the United States Armed Forces.

Your participation is voluntary. Your decision to not participate will not affect your current eligibility to pursue healthcare services or maintain your current healthcare status. Please read the information below and feel free to contact Corinne Lee at [redacted] with any questions or concerns that you have about this study.

PURPOSE
The purpose of this study is to explore how and why women Veterans decide to get healthcare. Healthcare providers do not know enough about why women Veterans may or may not decide to get the care they require. Information received from this study will assist healthcare providers to offer veteran and gender-specific healthcare services and may improve the quality of lives for Veteran women.

DESCRIPTION OF THE PROCEDURES
If you agree to participate in this study, you will be asked to take part in an interview, either in person, or on the telephone. Our time together will include questions asked about your demographic information such as your age, marital status, education, occupation, military rank and service, and where you receive healthcare. You will be asked to respond to questions about making difficult decisions.
The interview is an individual interview with only you that occurs either in person or on the telephone. The interview will be recorded by digital recording and fully transcribed into a printable document. The interview will take approximately 60 -90 minutes of your time.

DISCOMFORTS AND RISKS
There are no anticipated health or injury risks associated with this study. It is important for you to know that your participation is voluntary. You may decide not to take part in or quit the study at any time, without penalty.
Your decision to participate or not participate in this study will not affect your current eligibility for healthcare or current healthcare benefits through either the Veterans Health Administration (VHA) or through any other healthcare provider.

There are no foreseen risks that might occur if you decide to participate in this study. A minor risk is the possibility that certain questions regarding your decision to use or not use healthcare may cause some psychologically distressing emotions. If this is the case, you will be provided with the contact information of a healthcare professional who will provide guidance and assistance.

CONFIDENTIALITY
You will be assigned a pseudonym, or "code name" for participation in this study. This is done to protect your identity and maintain confidentiality. Records for study use remain confidential in a locked cabinet within a locked office. Your name will not be used in any reports or publications for this study. Once again, your participation is completely voluntary. You may withdraw from the study at any time.

RISKS DURING PREGNANCY
There are no risks to pregnant women who participate in this study.

EXPECTED BENEFITS
There is no promise or guarantee of any medical or psychological benefit to you resulting from your participation in this study. However, you might have a better insight into your own reasons for deciding or not deciding to utilize healthcare services.

WITHDRAWAL FROM THE STUDY
You have the right to withdraw from this study at any time. Your eligibility for healthcare services or utilization of current healthcare services will not in any way be affected.

COSTS AND PAYMENTS
There are no costs associated with participation in this study. Upon completion of the interview process, participants will receive a $20 Amazon gift card.

CONTACTS
If you have any questions about this study, please contact me directly, Corinne Lee, MSN, RN at [redacted] or through email, [redacted]

RESEARCH SUBJECT RIGHTS: I have read or have had read to me all of the above.

_____ *has explained the study to me and answered all of my questions. I have been told of the risks or discomforts and possible benefits of the study.*

I understand that I do not have to take part in this study, and my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at any time without penalty or loss of benefits to which I am entitled.

I understand that any information obtained as a result of my participation in this research study will be kept as confidential as legally possible.

The results of this study may be published, but my records will not be revealed unless required by law.

NOTE:

If I have any questions about the conduct of this study or my rights as a subject in this study, I have been told I can call **The Catholic University of America, Office of Sponsored Programs 202-319-5218**

I understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form

APPROVED
CUA IRB 00000082
OCT 25 2019
Expires
Protocol 18-087

Signature of Subject	***Date***	
Signature of Subject's Representative*	***Date***	***Subject's Representative (Print)***

Appendix H The CITI Certificate

CITI PROGRAM

Completion Date 09-Apr-2018
Expiration Date 09-Apr-2019
Record ID 26467451

This is to certify that:

corinne lee

Has completed the following CITI Program course:

Social & Behavioral Research (Curriculum Group)
Social & Behavioral Research (Course Learner Group)
1 - Stage 1 (Stage)

Under requirements set by:

The Catholic University of America

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wc54ae831-5695-4055-93bc-623cefcb746c-26467451

Appendix I The Catholic University of America Committee for the Protection of Human Subjects

CUA THE CATHOLIC UNIVERSITY OF AMERICA	**GUIDELINES** FOR REVIEW OF RESEARCH INVOLVING HUMAN SUBJECTS

Subject Name: _____ Date: _____

Title of Study: Exploration of the Decision-Making Process to Access and Utilize Healthcare

In Women Veterans

Principal Investigator: Corinne A. Lee **FWA00004459_____**

1.0 Introduction

Federal regulations and CUA policy require the research projects involving human subjects be reviewed and approved in advance by the CUA Committee for the Protection of Human Subjects (CPHS) for research with human subjects. According to the Office of Human Research Protection (OHRP) "awardees and their collaborating institutions are 'engaged' in human subject research whenever their employees or agents intervene or interact with living individuals for research purposes; or obtain, release, or access individually identifiable private information for research purposes." This stipulation applies to all research projects regardless of which Agency is providing the funds or to which Agency the report is to be submitted for financing to be provided. This includes research projects that are supported by CUA funds and also those not supported by CUA funds. Researchers and investigators are responsible for compliance with relevant federal and state laws and institutional policies.

All CUA researchers and administrators are required to complete training in the protection of human subjects. A way to do this is to visit the NIH Training Link at: http://ohsr.od.nih.gov/irb_cbt/ or http://cme.ncu.nih.gov/. A certificate will be issued upon completion of the computer-based training.

The CPHS has the authority to approve, require modifications in or not to approve research involving human subjects if the researcher is deemed not to conform to federal regulations or institutional policy.

These guidelines are intended to provide guidance to researchers and investigators in compliance with regulations involving human subjects.

1.1 Student research and faculty responsibilities

Students conducting research investigations such as for a thesis and for class projects also need to seek approval from CPHS prior to conducting investigations. The faculty supervising such research or investigation is required to insure that approval has been sought from CPHS.

Research that may not require CPHS review includes that which is conducted primarily for instructional purposes in a formal classroom context and not designed to contribute to generalizable knowledge as long as the instructor is prepared to accept professional and ethical responsibility for all such research. In such circumstances, it is the responsibility of the instructor to ensure that professional and ethical priority are adhered to and maintained by applying criteria stipulated in this document. The instructor is advised to seek CPHS review when doubt about the ethical propriety as it affects their research proposal.

2.0 The review process

In keeping with federal regulations and guidelines, the CPHS may process protocol in 3 ways:

- by full review
- by expedited review
- by exemption certification

2.1 Procedures for Expedited (or Full) Review

Investigation must complete and submit to the Office of Sponsored Programs copies of the CPHS Human Subjects Protocol Application form along with copies of the statement before they start investigations or research involving human subjects. The forms may be obtained from the Office of Sponsored Programs or at their web site (sponsoredprograms.cua.edu) or from Room 213, McMahon Hall in the Office of Sponsored Programs.

The protocol form must have information spelling out the following:

a) Name and department(s) of the investigator(s)
b) Title
c) Signature of responsible faculty members
d) Whether or not external funding is proposed
e) Purpose of the study
f) Description of the subjects
g) Description of the methodology
h) Potential scientific benefits of the research
i) Qualifications of the investigator(s)
j) Description of any deception

k) Procedures for protecting the anonymity of the subjects
l) Methods for ensuring informed consent, including a copy of the proposed informed consent statement.

2.2 Protocols Eligible for Expedite Review:

An expedited review is permitted under Federal regulation (45 CFR 46.11D and 21 CFR 56.110). Under and expedited review procedure for protocols that meet certain eligibility requirements, the review may be carried out by the chair of the CPHS of by one or more experienced reviewers from among the members of the committee. The reviewers may exercise all the authority vested in the committee in the reviewing the research, but may not disapprove the research. However, the research may be disapproved in accordance with the non-expedited procedures. Upon submission of the Human Subjects Protocol Form to the committee, a researcher may request an expedited review if the following criteria are met:

2.2.1 Applicability

Where there is no minimal risk to human subjects and where certain procedures are involved, the CPHS may conduct a review through the expedited review procedures as stipulated in 45 CFR 46.11D and 21 CFR 56.110. The activities listed should not be considered to be of minimal risk by virtue of their being included on this list. Inclusion on the list may simply signify that the research activities proposed may be eligible in accordance with expedited review procedures when specific circumstances of the research involve no more than minimal risk to human subjects. The categories in this list shall apply regardless of age of subjects except as noted.

The expedited review procedure **may not be** applied in the following cases:

a) where the subjects are identifiable
b) where the subjects responses would reasonably place then at criminal, civil or other liability or risk financial standing, employment, insurability, reputation or cause them to be stigmatized unless reasonable and appropriate protection is undertaken or implemented so that the risks are removed or minimized. The human subject's right to confidentiality and privacy must be upheld,
c) Where classified research involving human subjects is undertaken.
d) The standard requirements for informed consent (or it's waiver, alteration, or exception) apply regardless of the type of review.

Categories 1-7 below pertain to both initial and periodic review by the CPHS.

2.2.2 Research categories

a) Clinical studies of drugs and medical devices only when (i) or (ii) is met.
   i) Research on drugs for which an investigational new drug application (21 CFR part 312) is not required. NOTE: Research on marked drugs that significantly increase the risk or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.
   ii) Research on medical devices for which
      a. An investigational device exemption application (21 CFR part 812) is not required; or
      b. The medical device is clearly/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

b) Collection of blood samples by finger stick, ear sick, or venipuncture as follows:
   i) From healthy non-pregnant adults who weight at least 110 lb. For these subjects amount drawn may not exceed 550 mL during a period of 8 weeks and the collection may not occur more than twice weekly; or
   ii) From other adults and children, considering the age, weight and health of subjects, the collection procedure, the amount of blood to be collected, and frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 mL or 3 mL per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

c) Prospective collection of biological specimens for research purposes by noninvasive means.[1]

d) Collection of data through non-invasive procedures (not having general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. If medical devices are employed in the investigations/research, approval or clearance to market them should be sought. (Studies aimed at assessing the effectiveness of medical devices are not normally eligible for expedited review, including those that have already been cleared for new indications.)[2]

e) Research involving materials (data, documents, records or specimens) that have been collected or will be collected solely for non research purposes (such as medical treatment or diagnosis). NOTE: Some research in this category may be exempt from HHS regulations for the protection of human subjects. 45 CFR 46.101 (b)(4). This listing refers only to research that is not exempt.)

f) Collection of data from voice, video, digital, or image recordings made for research purposes.

g) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

NOTE: Some research in this category may be exempt from HHS regulations for the protection of human subjects. 45 CFR 46. 101 (b)(2) and (b)(3). (This listing refers only to research that is not exempt.)

h) Continuing review of research previously approved by the convened CPHS as follows:
   i) Where:
      a. The research is permanently closed to the enrollment of new subjects.
      b. All subjects have completed all research-related interventions and;
      c. The research remains active only for long-term follow up of subjects or;
   ii) Where no subjects have been enrolled and no additional risks have been identified; or
   iii) Where the remaining research activates are limited to data analysis.

i) Continuing review of research, not conducted under an investigational new drug application or investigational exemption where categories two (2) through eight (8) do not apply but the CPHS has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

Investigators who believe that their research meets the above criteria may request expedited review when they submit to the Human Subjects Research Protocol Form to the committee. Protocols should be submitted to the Office of Sponsored Programs.

2.3 Research categories exempt from review:

In cases where an investigator believes that the proposed research projects are exempt from review, it is required that she or he submit an exemption certification form to the CPHS through the CUA Office of Sponsored Programs. It is the responsibility of the researchers and investigators to carefully review the federal exemption criteria or categories and to have a clear understanding of the CPHS's interpretations of the exemptions. The office shall notify the researcher/investigator in writing whether the proposed research is exempt or not and where such research is not exempt it shall be required that the researcher submit a Human Subjects Protocol form to the CPHS for expedited or full review. The CPHS has the authority to determine within the provisions of the law and federal guidelines those categories of research protocols which may be subject to limited review or which may be exempt from review by the committee.

Researchers are asked to note that the exemption categories **do not apply** when research activities include

a) Prisoners, fetuses, pregnant women or human in-vitro fertilization
b) Surveys or interview techniques involving minors as subjects
c) The review of medical records which have information that may clearly identify the subject in those records
d) Research techniques that may cause the human subjects to feel harassment of discomfort beyond levels that may be encountered in normal daily life
e) The deception of human subjects

The federal categories of research activities eligible for exemption certification are as follows:

a) Research involving usage of educational tests (cognitive, aptitude, diagnostic, achievement) survey procedures or observations of public behavior unless the human subject can be directly or indirectly identified from information obtained.
b) Research where the human subjects involved may be placed at higher risk of criminal or civil liability or be damaging to financial standing or employability or reputation.
c) Research conducted in established or commonly accepted educational settings involving normal educational practices such as
    i. Research on regular and special education instructional strategies or,
    ii. Research or investigations into the effectiveness of or comparisons among instructional techniques, curriculum or classroom management methods.
    iii. Research involving the use of educational tests (cognitive, diagnostic, aptitude achievement), survey procedures, observation of public behavior that is not under exempt under (1) of this section are if:
        a. The human subjects are elected or appointed public officials or candidates for public office federal statue(s) require(s) without exemption that the confidentiality of the personally identifiable information will be maintained during the research and subsequent to the research
    iv. Research involving the study or collection of existing data, records, documents, pathological or diagnostic specimens, where these sources are available to the public or if the investigator has recorded relevant information in such a fashion that the human subjects involved in the research cannot be directly or indirectly identified
    v. Research and demonstration projects which are designed to study, evaluate or otherwise investigate the following:
        1. Public benefits or service programs
        2. Procedures or systems for obtaining benefits or services under those programs
        3. Likely changes in the way payments, benefits or services under those programs
        4. Likely changes in the way payments, benefits or services are made

vi. Taste or food quality evaluation and consumer acceptance studies:
    1. If wholesome foods without additives are ingested or
    2. If food is ingested that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemicals or environmental contaminants at or below the level found to be safe, by the food and drug administration or approved by the EPA of the food safety and inspection services of the US Department of Agriculture

If the project is determined not to be exempt, it is required that the investigator or researcher submit the Human Subjects Protocol Form to the CPHS through the Office of Sponsored Programs for a full or expedited review.

3.0 Criteria for Approval of Research:

The CPHS reviews protocols for research in accordance with federal regulations governing research with human subjects. In its deliberations, the committee may also apply such codes of professional ethics as the committee may deem appropriate. It is the policy of CUA that in order for any research protocol to be approved, the committee must determine that all of the following requirements are met:

- Risks to subjects are minimized and are reasonable in relation to anticipated benefits of the research;
- Selection of subjects is equitable given the purposes and setting of the research;
- Appropriate informed consent will be sought from each subject of the subject's legally authorized representative, and such consent will be appropriately documented;
- The research plan makes appropriate provision for monitoring the data collected to insure the safety of subjects;
- Appropriate provisions are made to protect the privacy of subjects and to maintain the confidentiality of data; and
- Where some or all of the subjects are likely to be vulnerable to coercion or undue influence, appropriate additional safeguards have been included to protect the rights and welfare of these subjects.

3.1 Investigator's Right of Appeal:

It is CUA policy that the final decision regarding approval or disapproval of all protocols rest with the CPHS. In accordance with federal regulations, no research involving human subjects may be conducted under CUA's auspices without prior and continuing approval of the Committee. Any investigator who disagrees with a decision of the Committee, may request a hearing of special appeal at any duly convened meeting of the Committee, during which he/she may present relevant arguments and/or witnesses. The investigator may also request that the Provost be informed of the appeal. However, the final decision rests with the Committee.

3.2 Periodic Review of Research

After a research protocol has been reviewed by CPHS, it is the investigator's responsibility to report to the Committee any proposed changes in the research as well as any previously unanticipated problems which may arise involving risk to subjects. Upon receipt of such information, the Chair of the Committee may determine that reconsideration of the protocol by the full Committee is justified. If such a determination is made, the procedures governing initial review of protocols will apply.

In addition, federal regulations require that the Committee conduct continuing review of approved research at least once per year. At the time of the review, the investigator will be required to complete the Periodic Review Form (download a Word 97 file) which (a) determines whether or not the research is continuing, and (b) details any changes from the original protocol by the full committee. The Committee will review the project annually until it has been completed, unless otherwise determined by the CPHS.

4.0 Instructions for the Proposal to External Funding Agencies:

The relevant letters of approved from the CPHS are required by researchers ONLY if projects are funded. It is the investigator's responsibility to obtain the letters after notification of approval of funding and submit them to the Research Committee. Standard review procedures will be followed.

The CPHS is not directly involved in the grant/contract process involving external funding agencies. Therefore, it is critical that an investigator who plans to submit a proposal to and external funding agency be familiar with the agency's and the University's policies regarding CPHS certification and the approval procedure.

4.1 Overview of Funding Agencies' Requirements:

Each agency has its own certification requirements. For example, some agencies have a special form or "item" on the application which must be completed by the applicant and signed by the University's Authorized Institutional Official. Other agencies accept the University's CPHS approval letter which is signed by the Chair of the Committee.

Agencies also differ with respect to their flexibility in accepting certification notices after the proposal has been received. For example, when submitting an application to the National Institutes of Health (NIH), it is critical that certification of approval be transmitted to the agency as soon as possible after the submission of the grant proposal. Other agencies may not require that certification be sent until the final decision with respect to funding status has been made. On the other hand, some agencies will not accept and application unless CPHS certification is included. Questions regarding agency CPHS certification policies should be directed either to the individual agencies or to the Office of Sponsored Programs staff.

4.2 University Certification Procedures:

a) Whenever possible, the research proposal should be submitted to the CPHS prior to submission of the grant/contract application to the agency. The investigator is responsible for submitting the protocol for CPHS review in a timely fashion.
b) If, due to time constraints on the investigator's part, the research proposal has not been submitted to or reviewed by the CPHS by the time of submission of the grant/contract application to the agency, then the investigator is responsible for submitting the protocol to the CPHS as soon as possible thereafter. NOTE:

The Office of Sponsored Programs does not submit protocols to the CPHS; it is the investigator's responsibility to do so.

c) After the final CPHS approval has been obtained, the investigator should request the Office of Sponsored Programs to prepare the certification document. The Office of Sponsored Programs will prepare the form, obtain the authorizing official's signature and transmit the form to the relevant agency.

4.3 Resubmission of Grant Application

a) In the event that an investigator proposes to resubmit a research protocol previously approved by the CPHS to an external funding agency, it is his/her responsibility to contact the Office of Sponsored Programs to determine the current CPHS status of the protocol before submitting the grant/contract application to the agency.
b) If an existing CPHS approval was obtained prior to the 12-month period preceding the agency's submission deadline, it will be necessary for the investigator to submit a new protocol to the CPHS as necessary. A new certification document cannot be issued until the Committee has reviewed the study in accordance with the regular review procedures.
c) If CPHS approval has been obtained in the 12 months preceding the agency's submission deadline, a new Human Subjects Protocol need not be submitted to the Committee, provided no changes have been made in the research activities which affect the human research subjects. The investigator is responsible for submitting either (a) a letter to the CPHS indicating that the revised application does not include modifications regarding the human subjects' participation; or (b) a revised Human Subjects Protocol Form, if appropriate. The investigators must request that the Chair of the Committee prepare the certification document, as specified by the funding agency.
d) If a revised grant application includes changes which affect the human subjects, it will not be necessary for the investigator to submit a new Human Subjects Protocol Form to the CPHS, provided the previously reviewed study had received CPHS approval in the 12 months preceding the agency deadline. The investigator is required, however, to submit to the CPHS the following: (a) a description of the proposed changes; (b) revised consent and/or assent form; and (c) a revised copy of the grant application. Instructions for submitting the request for approval of modification may be obtained from the Office of Sponsored Programs. After the proposed modifications have been approved by the CPHS, the certification document will be prepared and The Office of Sponsored Programs will transmit the form to the agency.

4.4 Related Grant Proposals: No Plans for Resubmission or Implementation of Research

If the grant proposal is rejected and if the investigator does not intend to implement the research project, the investigator should notify the CUA Office of Sponsored Programs, in writing, so that the file may be deemed closed.

4.5 Externally Funded Projects: Annual Recertification Procedures

Most funding agencies require that funded research projects involving human subjects receive a continuing review by the CPHS at least once every 12 months. The agencies also require that an updated certification document be submitted at specified intervals. The Committee cannot provide an updated certification document unless the project has been reviewed and approved in accordance with the University's Periodic Review of Research procedures. Once Committee approval has been obtained, the investigator is responsible for transmitting the certification to the agency.

5.0 Special Populations:

5.1 Including Women and Minorities as Subjects in Clinical Research

In 1994 the National Institutes of Health issued new guidelines on the inclusion of women and minorities as subjects in clinical research. It is the responsibility of the CPHS, to ensure that NIH protocols follow those guidelines for clinical trials. Investigators conducting clinical trials should contact the Office of Sponsored Programs for more details.

5.2 Including Children as Subjects in Clinical Research

In 1988 the National Institutes of Health (NIH) set forth policy and guidelines on the in clusion of children in research involving human subjects. It is the responsibility of the Human Subjects Committee, as the Institutional Review Board, to ensure the NIH protocols follow these guidelines for clinical trials. Investigators conducting clinical trails should contact the Office of Sponsored Programs for more details.

5.3 Requesting Data from the Student Information System

Departments within the University requesting data from the student information system for the purpose of conducting research must submit to the Registrar's Office a notice of review approval from CPHS. Departments within the University requesting student data for research that is exclusively and directly linked to the University and not intended to contribute to generalizable knowledge may be given such data without prior review by the Committee. However, if the research involves collections of "sensitive" information, the request must be accompanied by a notice of review and approval by the Committee. ("Sensitive" information includes, but is not limited to, information regarding sexual behavior, use od controlled substances, illegal activities, voter registration, religious preference and practice, and similar information.)

6.0 Research Involving a Student Thesis or Dissertation

Graduate students who plan to conduct a thesis or dissertation must file a completed form titled "Petition for Topic Approval" with the Graduate School. This form is available from the Graduate School. If the thesis/dissertation involves the use of human subjects, then the student must attach a copy of the CPHS approval form to their petition.

7.0 Deadline Dates and Meeting Dates

The CPHS establishes regular monthly meeting dates throughout the school year. All material for review by CPHS is to be submitted to the Office of Sponsored Programs by 5 p.m. on the specified deadline date. Protocols submitted after 5p.m. on the deadline date will be scheduled for the next meeting. Investigators may be asked to attend a CPHS meeting in order to answer questions and clarify research projects. Contact the Office of Sponsored Programs at x5218 for scheduled meeting times.

8.0 CPHS Membership

The CPHS is appointed by the Associate Provost for Research in accordance with the federal regulations governing the composition of Institutional Review Boards for research utilizing human subjects. The committee consists of at least six members, with varying backgrounds to promote complete and adequate review or research activities commonly conducted at CUA. It is made up of persons of both sexes and includes at least one persons whose primary concerns are nonscientific areas, as well as at least one member who is not otherwise affiliated CUA (nor part of the immediate family of Persons affiliated with CUA).

Members of the Committee are appointed for terms of three years, and are replaced at staggered intervals. No member of the Committee may participate in the Committee's review of any project in which the member has a conflicting interest, except to provide information requested by the Committee.

9.0 Human Subjects Committee Forms (Word 97 downloads)

"Requirements for Informed Consent"

Investigators may request paper copies from the Office of Sponsored Programs.

[1]Examples:

- Hair and nail clippings in a non-disfiguring manner;
- Deciduous teeth at time of exfoliations or routine patient indicates a need for extraction;
- Permanent teeth if routine patient indicates a need for extraction
- Excreta and external secretions (including sweat)
- Uncannulated saliva collected either in unstimulated fashion or stimulated by chewing gumbase or wax or by applying dilute citric solution to the tongue
- Placenta removed at delivery
- Amniotic fluid obtained at the time of rupture of the membrane prior to or during labor
- Supra and sub-gingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic techniques
- Mucosal and skin cells collected by buccal scrapping or swab, skin swab, or mouth washings
- Sputum collected after saline mist nebulization

[2]Examples:

- Physical sensors either applied to the surface of the body or at a distance which do not involve input of significant amounts of energy into the subject and will not be an invasion of the subject's privacy.
- Weighing or testing sensory acuity
- Magnetic resonance imaging
- Electrocardiography, electro-encephalography, thermography, detection of naturally occurring radio activity, electro retinography, ultrasound, diagnostic infrared imaging, Doppler blood flow and echocardiography
- Moderate exercise, muscular strength testing, body composition assessment, flexibility testing where appropriate give age, weight and health of the individual.

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