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"A Hidden Community": The Experiences of Help-Seeking and Receiving Mental Health Treatment in U.K. Women Veterans. A Qualitative Study

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Abstract

Women veterans are often underserved in both the research into and provision of mental health treatment. This study explored women veterans' experiences of mental health difficulties, help-seeking, and treatment provision. Semistructured telephone interviews with 19 U.K. women veterans who met criteria for posttraumatic stress disorder were conducted and Reflexive Thematic Analysis was used in analysis. Three superordinate themes encompassing participants' experiences were developed: (a) attitudes toward mental health and help-seeking; (b) the need to acknowledge the uniqueness of women veterans; and (c) the structural elements of care provision. The findings indicate that women veterans have additional gender-specific challenges and needs concerning tailored pathways into help and support, as well as the environment and modality of treatment delivery, as distinct from veteran men.

Keywords

veteran, military, female, treatment, trauma, women, help-seeking

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The number of women serving in North Atlantic Treaty Organization (2019) armed forces has doubled since 2000, with 85% of members allowing women to serve in all roles. Nonetheless, servicewomen remain a minority within often hypermasculine military environments, and face unique challenges both during and postservice.

Compared with servicemen, servicewomen are disproportionately more likely to be the victims of military sexual trauma (MST). A meta-analysis of 69 studies showed 38.4% of women and 3.9% of men reported experiences of MST—encompassing sexual harassment, bullying and assault—during service (Wilson, 2018). Although most studies are of U.S. cohorts, similar prevalence and ratios have been reported in French (Moreau et al., 2021), Belgian (Buyse et al., 2021), and Canadian (Mota et al., 2022) military samples. A study of U.K. women veterans found that 22.5% reported sexual harassment, 5.1% reported sexual assault, and 22.7% reported emotional bullying during service (Hendrikx, Williamson et al., 2021). However, all such figures are most likely underestimates due to frequent under-reporting of harassment (Blais et al., 2018).

The military veterans of today also faced era-specific systemic stressors as the service personnel of yesterday. Until 1990, U.K. servicewomen faced automatic discharge from military service should they become pregnant. Furthermore, despite the decriminalization of homosexuality in wider society commencing from 1967 onwards, a "gay ban" on serving in the armed forces continued until 2000. Those suspected or confirmed as being lesbian, gay, bisexual, transgender and related (LGBT+), faced discrimination, bullying, imprisonment and dismissal from service without financial or practical support (Paige et al., 2021).

In many studies, women veterans have been shown to have a higher prevalence of probable posttraumatic stress disorder (PTSD), anxiety and depression, physical health problems, somatization, and loneliness compared with men (Baumann et al., 2022; Hendrikx,Williamson et al., 2021; Shapiro et al., 2022). Sexual assault and sexual harassment in particular were shown to lead to a greater than two-fold increase in odds of developing PTSD as a woman veteran (Hendrikx, Williamson & Murphy, 2021). Furthermore, while the prevalence of adverse childhood experiences in military populations is elevated compared with the civilian populous, this difference appears particularly notable for servicewomen (McCauley et al., 2015; Oakley et al., 2020). Such adverse early life experiences have in turn been shown to be strongly associated with the subsequent risk of experiencing in-service adversity, and resultant psychological and physical ill health (Katon et al., 2015; C. Williamson et al., 2022).

In the general population, gender differences in help-seeking behaviors for mental health difficulties have been observed. Staiger and colleagues (2020) reported that seeking support potentially ran contrary to internalized traditional masculinized norms around strength, success, and self-reliance, and thus acted as a salient barrier. As such, women have been demonstrated to seek

support more readily than men for mental health difficulties (Thompson et al., 2016; Wendt & Shafer, 2016). Furthermore, gender differences in coping strategies and preferences for treatment modalities have also been observed (Liddon et al., 2018), which may also impact help-seeking behaviors.

When compared with the general public, veterans often report underutilizing health services (Stevelink et al., 2019). Internalized stigma around mental ill health, poor recognition of one's need for support, perceived negative public attitudes and understanding of the military, and lack of awareness and timely access to support services (Brown et al., 2011; Coleman et al., 2017; Mellotte et al., 2017; V. Williamson et al., 2019) have all been demonstrated as acting as barriers to veteran help-seeking. Compared with other disorders, these barriers are particularly acute for those with PTSD (V. Williamson et al., 2019). In addition, heightened symptom severity has been linked to increased stigmatizing views of the self and mental ill health (Hoge et al., 2004).

Although extant research has been dominated by U.S.-based populations of serving and formerly serving men (Godier-McBard, Wood, et al., 2022; Randles & Finnegan, 2022), nascent studies suggest that gender differences may also exist regarding help-seeking behavior and interaction with health services. When compared with men, serving and ex-serving women are significantly more likely to report accessing health care support through formal sources such as family doctors and specialist care, rather than seeking informal help from friends and families (Jones et al., 2019; St Cyr et al., 2021). Preliminary evidence from studies using online surveys has shown that while barriers and facilitators to accessing health care for women veterans mirror those found in cohorts predominantly consisting of men, women veterans may also face additional obstructive factors. These include heightened stigma around disclosing mental health difficulties, a sense of exclusion from men-dominated and orientated support services, and the lasting impact of gender-specific adversities during service (Godier-McBard, Cable, et al., 2022; Graham et al., 2022).

However, to date, no in-depth interview-based qualitative studies have been conducted into the experiences of help-seeking and mental ill health in non-U.S. women veteran cohorts. This study aims to further expand the understanding of the interaction between former servicewomen and health care by exploring the experiences of help-seeking and treatment in U.K. women veterans with mental health difficulties via interviews. It encompasses both those who have and those who have not received therapeutic or supportive interventions.

Method

Participants and Measures

This study was approved by King's College London Ethics Committee (RESCM-21/22-23236). Participants were recruited from a cohort of 750 veterans from a U.K. women veterans' charity, who had previously taken part in

research into their experiences of military service (Hendrikx, Williamson & Murphy, 2021) and had consented to be contacted for follow-up studies. The cohort had previously completed the PTSD Checklist for *DSM*-5 (PCL-5; Weathers, Litz, et al., 2013) with a cut-off score of 31 and above indicating probable caseness. A subcohort of 68 participants who met likely case criteria were invited via email to take part in the current study. Participants were contacted up to three times or until a response had been received. In total, 26 veterans indicated their willingness to take part, of whom 6 disengaged during the consent process and were not contactable. One additional veteran was withdrawn as they could not take part in a telephone interview. A final sample of 19 women veterans took part in the study.

Participants completed an online version of the Life Events Checklist for *DSM*-5 (LEC-5; Weathers, Blake, et al., 2013) which asks respondents to endorse exposure to any of 16 potentially traumatic experiences across their lifetime. The LEC-5 measure was modified to record whether an event was experienced before, during, or after military service. A free text entry was provided for additional details of events not otherwise listed, and demographic information was also collected.

Procedure

Veterans participated in a semistructured online or telephone interview ($M = 59$ min, $SD = 14.9$, range: 41–102), conducted by a researcher (VW) in 2022. Participants were reminded of the purpose of the study and were asked for their views and recollections on their experiences of mental ill health and help-seeking. This included: experiences of any mental health difficulties and any associated events; whether or not they had sought and received psychological interventions including their decision-making processes; influencing factors and individuals on whether or not to seek help; their views of their own mental health; recollections and impressions of their treatment experiences; whether they felt the treatment they received had been beneficial and why; and any improvements they felt would have been beneficial. All participants were invited to discuss their thoughts and feelings around each topic, with interviewer prompts provided to encourage elaboration. The interview schedule is available as supplementary material. Participants were provided signposting to help and support services postinterview and received follow-up welfare communication from the interviewing researcher 1 week after participation where it was deemed appropriate and/or necessary. Interviews were audio recorded and transcribed, with all identifying information removed prior to analysis. Recordings were destroyed after transcription.

Qualitative Analysis

A Reflexive Thematic Analysis (RTA) framework as outlined by Braun and Clarke (2006, 2021a) was used to identify and interpret themes of shared

meaning in the dataset. RTA was viewed as an appropriate approach as a combination of both inductive and deductive positions on analysis could be held. An inductive critical realist approach was primarily favored in which coding was led by the content of the dataset. However, a deductive orientation was also accommodated in that pre-existing expertise on salient themes and areas of interest informed both the development of latent codes during the coding process, as well as areas of focus for the semistructured source interviews. Thus, RTA allowed both the subjectivity of the participants' experiences to be expressed and communicated, while also allowing the influence of the researcher's prior knowledge and interpretation of the dataset. For example, the authors were aware that in-service adversities such as those previously described in this paper—and MST in particular—were likely to be commonplace among the cohort. As such, these experiences, how they related to help-seeking behaviors, and also any salient comparisons with those of servicemen or men veterans, were viewed as areas of focus.

The dataset was read for familiarization by GMC, before being re-read and initial codes generated line-by-line, facilitated by QDA Miner Lite (v2.0.9; Provalis Research). Peer debriefing was conducted. Once coding was completed for the first ten transcripts, preliminary superordinate themes and subthemes were generated from groups of codes, and a thematic map was created. Discussion and modification of these materials took place subject to consultation with VW. Coding for the remaining transcripts then continued until complete, with resultant grouping into the two different thematic levels continuing as an iterative process.

For example, the initial codes "the military are different to civilians," "women are different to men," and "a sense of military belonging" were felt to coalesce around a preliminary superordinate theme reflecting issues of identity and uniqueness. On reflection, it was decided that "the military are different to civilians" better represented a higher order subtheme of "military versus civilian" rather than a lower order code. This subtheme was reflected in a variety of manifestations which included the code "a sense of military belonging." By contrast, on reflection, it was felt that another initial subtheme of "women versus men" did not sufficiently reflect a discreet enough focus. Instead, this was subsequently subsumed into the other subthemes focusing on identity and uniqueness, as well as being reflected across constituent elements of other superordinate themes.

This process continued until thematic saturation was achieved; the point at which no new themes are generated or deemed applicable by the authors to the dataset (see Braun & Clarke, 2021b for a discussion on this point). The resulting themes and subthemes were subject to further refinement via discussion among the research team.

The themes discussed in this study specifically refer to the experiences described by women veterans in relation to their gender. Although the authors have used gender-related terms throughout in the text, participant quotes have

been included as transcribed and also include the use of sex-related terms in which a degree of interchangeability is inferred.

Results

Participant Characteristics

The age of participants ranged from 47 to 67 years old ($M = 57.3$, $SD = 6.1$), with a mean PCL-5 score of 48.7 ($SD = 11.2$). The majority (57.9%; $n = 11$) defined as heterosexual, with 84.2% ($n = 16$) serving for 4 or more years. The majority of participants (89.5%; $n = 17$) identified as White-British. One participant identified as Mixed Bangladeshi-White and one identified as Mixed White-Black British. A minority (15.8%; $n = 3$) reported leaving school with no formal qualifications. In total, around half (52.6%; $n = 10$) had children, of which most (80%; $n = 8$) had become a parent after military service had ended.

Participants left military service a mean of 26.3 years ($SD = 11.0$) prior to interview. In total, 89.5% ($n = 17$) reported one or more traumatic experiences during military service. Participants reported experiencing a mean of 6.7 types of potentially traumatic event (mode = 8; range: 0–10) in their lifetime. A mean of 4.5 types of event occurring during service (mode = 5; range: 0–8). Unwanted sexual experiences were the most commonly reported event both during military service and over the life course. In total, MST was reported by 73.7% ($n = 14$), of which 43.9% ($n = 6$) also reported being sexually assaulted while serving.

Qualitative Findings

Participant accounts of their experiences of experiencing, accessing, and receiving help for mental ill health divided into three distinct but interrelated and interacting superordinate themes. These in turn were each divided into subthemes (Table 1).

The first—"attitudes towards mental health and help-seeking"—could be further characterized as a combination of views about the self in relation to poor health and help-seeking, the invalidation of traumatic experiences, and fears about the consequences of help-seeking. These subthemes acted as emotional barriers to accessing health care.

The second superordinate theme—"acknowledging uniqueness of women veterans"—comprised two subthemes encompassing opposing identities salient to women veterans: belonging to the military and not the civilian world; and identifying as a woman veteran and not a man veteran. As such, the unique identity of being a woman veteran corresponded to a sense of belonging that was important in the access, delivery and maintenance of therapeutic intervention.

Table 1. Identified Superordinate Themes and Subthemes

Superordinate theme	Subtheme	Illustrative quotes
ST1: Attitudes toward mental health and help-seeking	Views about the self	"most military people will not take medicine … you don't go sick because it's seen as a signal of failure."
	Invalidation of traumatic experiences	"I tend to think what I went through wasn't worth it [seeking help]."
	Consequences of seeking help	"[if] you'd have kicked up a fuss, you'd have been kicked out."
ST2: Acknowledging uniqueness of women veterans	Military versus civilian	"It's that bond that you have with somebody who is an ex-squaddie."
	Woman veteran versus man veteran	"It's like you are a weird entity [as a woman veteran]."
ST3: Structural elements of care provision	Validation and outreach	"[women] are falling through the net because you just seem to think that the men keep it all in but I think some of the ladies must do."
	Informed gatekeepers to treatment	"They [medical professionals] didn't ask [about military experiences]—because I was a woman."
	Applicability of treatment	"there are more military people that are not going to fit into those square boxes that you've got to neatly fit into and when it comes to females you are even less likely to fit into that square box."

The final superordinate theme—"structural elements of care provision"—related to the practical and systemic structural delivery of health care for women veterans. Informed and responsive to the first two themes, it was further delineated into subthemes: the need for validation and outreach by professionals; the importance of informed gatekeepers to accessing care; and the applicability of care to women veterans.

Superordinate Theme One (ST1): Attitudes Toward Mental Health and Help-Seeking

Participants' views about ill health, asking for help, and the intersection with their experiences during military service reportedly served as a barrier to seeking help. Participant P7 explained that:

> It's quite difficult that step to seek help … [The] big hurdle is to actually mentally make that first step happen . . . you are dealing with people that have got their pride, they've probably been through an awful lot just to exist in the military.

Accordingly, attitudes toward help-seeking for mental and general health concerns were further divided into the subthemes of (a) views about the self; (b) invalidation of traumatic experiences; and (c) the consequences of seeking help.

ST1 Subtheme: Views About the Self

For women participants, the military mind-set is one whereby "you just get on with it" (P16) and any sign of illness runs contrary to these values. P5 explained that "most military people will not take medicine . . . you don't go sick because it's seen as a signal of failure." Other participants talked of needing to overcome their "pride" (P7) and that accepting any health intervention was "a sign of weakness" (P5). This sense of failure could be internalized as a negative self-view. P12 expanded:

> I was ashamed after doing 22 years in the Army, coming out and being told that I'm the best of the best . . . In civvy street, I was ashamed to go and ask [the doctor]. The shame of it. And a lot of soldiers have that, they're ashamed to ask for help.

Negative self-views were also particularly salient for those with interpersonal traumas. One veteran (P2) who was sexually assaulted and harassed during their military service said "I've blamed myself for a long time." They added that they didn't want "that label" of a diagnosis and therefore did not seek formal help because "I didn't know what to say. I didn't know how to start the conversation." Similarly, other veterans felt that they had "missed the opportunity" (P11) or that it was "too late" (P4) at their age to now seek help for any mental health problems.

However, this reluctance to seek support could be overcome by health care professionals. For example, P6, who served for two decades and reported a complex mix of psychological and physical health needs, described a positive engagement with health care. She said that "[the doctor] was able to persuade me that it wasn't weakness to go and see someone" and that health care professionals "tried to re-educate me" in realizing that a military mind-set on ill health was no longer appropriate and was potentially acting as a barrier to help-seeking.

ST1 Subtheme: Invalidation of Traumatic Experiences

Women participants described that the severity and legitimacy of their traumatic experiences were often minimized by both themselves and others. This in

turn affected their perceived worthiness of seeking and receiving help and support. Despite meeting case criteria for likely PTSD, participating veterans described their experiences of trauma as less severe or that they were not as affected as others because they did not serve in combat roles. P9, 52-year-old who served for 5 years and recounted exposure to high-threat and suffering, said:

> I feel a bit of a fraud in one respect because I didn't really see—apart from doing Bosnia—I didn't really see much action or anything like that and there are a lot of people who are far more worse off than me.

P11 drew a similar comparison in stating "somebody who has served in The Falklands needs help far, far more than I did." P14 served in conflict zones and reported physical and sexual assault during their 14 years of service. When a friend suggested they sought help for probable PTSD, they replied: "I was like no, no because I never think that, I suppose is it that I didn't deserve to get help. I tend to think what I went through wasn't worth it."

This minimizing effect was often connected to the veteran participants' experiences specifically as a woman in the armed forces, and reflects aspects of both superordinate themes two (woman veteran identity; ST2) and three (applicability of treatment; ST3). P1, who served in the military police recalled encountering the (erroneous) attitude of health care professionals and other veterans that as a woman she "couldn't possibly have gone into combat" and therefore her experiences were invalidated. P19 who experienced sexual harassment and a serious accident while serving, had her experiences belittled in a therapeutic environment by another veteran:

> I felt really, really upset at that because I thought 'oh yes to be acknowledged by anybody of being worthy you've got to have been shot or blown up.' In some ways, I can understand why the people who have been shot or blown up might be prioritised help more than me . . . but [a man veteran] made me feel that I was completely insignificant, I didn't count.

Legitimizing women veteran participants' accessing of care and support was contingent on two factors. First, a recognition by both others and the veterans themselves that servicewomen were indeed exposed to combat-type traumas. Second, acknowledging and understanding that servicewomen faced what one participant (P12) characterized as military service colored by "verbal abuse, physical abuse, bullying, harassment, [and] victimisation." Accordingly, P16 said it needed to be acknowledged that "PTSD is not just about being on the frontline, being in a war zone. PTSD can happen through . . . bullying." This acknowledgment of the specifics of the experience for servicewomen by others, also overlapped with the positive impact of group belonging inherent in ST2, and a need to feel worthy of help (inherent in ST3). According to P14:

> It was friends from the breakfast club going "you *are* [emphasis added] worth it, you have gone through some things that guys here have not gone through" and I said to them 'it's not a competition' because it's not.

ST1 Subtheme: Consequences of Seeking Help

Help and support during service for mental health problems or in the wake of traumatic experiences typically "wasn't really part of the equation" (P13) or "just wasn't offered" (P5). In addition, seeking help while serving was not only seen as contrary to military values and mind-set, but was viewed as potentially detrimental in itself. Participants stated that "nothing in the military is totally confidential" (P5). P17 who was "sexually assaulted seriously twice" during service explained that if "you'd have kicked up a fuss, you'd have been kicked out." Similarly, servicewomen who were the victims of domestic violence and rape faced a lack of support from women welfare officers, and were in a position where "I didn't know if I would have been believed" (P14).

Such negative effects were "more stigmatising for women as well because they'd see you as weak" (P3) thus confirming negative gender stereotypes that servicewomen encountered during service. Indeed, P7 who served during the 1980s confirmed that "for me to then acknowledge that, 'oh maybe I can't cope now because I'm just a stupid woman' kind of like cancel[s] out everything that I'd endured to get there."

P7 noted that there was felt to be a strong need to hide any mental health difficulties as, once diagnosed, it would be impossible to conceal the fact from others as "they would remove your pistol from you then everybody would know that you are in a mental health thing."

However, the association between openness and negative consequences was not limited to the time in uniform, and remained salient as a veteran. As P15 described: "I would say no way am I going to see a psychiatrist just because of my conditioning in the Forces."

Superordinate Theme Two (ST2): Acknowledging Uniqueness

Acknowledging the uniqueness of women veterans was a seen as important for participants in accessing and engagement with therapeutic interventions. P12 recounted:

> When you speak to some of the specialists even the ones that have been involved with military people they tend to get involved with mainly the male military people . . . They've not experienced it from a female veteran.

The unique needs and experiences of women veterans were comprised of two subthemes, centered on the individual's position in relation to other

contrasting identities: (a) military versus civilian and (b) woman veteran versus man veteran. Women veterans were found to straddle multiple roles and histories as they "have the normal life experiences of civilian females but we also have the male element of the going on [military] deployment" (P12). These competing identities were bound together by a need for health services to address the distinctiveness of women veterans and counter any feelings of isolation or lack of belonging that could arise.

ST2 Subtheme: Military versus Civilian

A divergence between those with military experience and civilians was highlighted by almost all participants. "The military family" (P1) brings "that sense of belonging" (P10). Civilians—whether as close friends, health professionals, or fellow treatment recipients—were seen as not understanding or sharing the *lingua franca* of military experiences, attitudes, culture, language, and humor. As P10 who served just over 4 years explained:

> If you go and talk to a veteran you've got to have some idea of what they've gone through. It's that bond that you have with somebody who is an ex-squaddie, you can sit there and you can talk all night about total nonsense.

The desire for veteran kinship permeated experiences of treatment unrelated to experiences military service. P16 reported attending a therapy group that included nonveterans and which primarily addressed childhood adversity, and commented: "I think it would have been better for me if there had been other . . . ex-military personnel there because . . . there's a kind of bond."

ST2 Subtheme: Woman Veteran versus Man Veteran

Although women veteran participants viewed themselves as separate from civilians, they also felt apart from men veterans. P18 who served for 8 years including time living abroad, questioned her inclusion in the term "veteran" specifically as a result of her gender: "I get a newsletter through and I thought 'I wonder if I'm a veteran?' I didn't know if I would be veteran. I thought it was just for men."

Military support services were described as tailored toward and dominated by men, and a continuation of "the old boys' network" (P8) that was at the root of much in-service gender discrimination. P12 stated:

> I know a lot of female veterans that are struggling with mental health and they're just being pushed to the side and the men are being taken care of and the women are just being shoved and forgotten.

Those who did engage with veteran-specific support groups such as P3, recounted how she was viewed as "an outsider" at veteran peer-support groups when "it's been all male and they've just all looked and kind of, not ignored me but, not really known how to speak to me." She continued: "all the banter that you heard as you are coming in and you think this is going to be a good laugh it just stops as soon as you walk in. It's like you are a weird entity."

Although a military environment could foster a sense of belonging, a men-dominated miliary milieu could not only feel isolating, but also risk being potentially harmful or exacerbate distress, especially when the consequences of gender-based violence and discrimination were being discussed. P2 who experienced sexual assault and harassment during military service, reported that she "wouldn't want to talk to a man about it I don't think . . . Especially if they are ex-Forces." Similarly, P1 who reported sexual harassment and homophobic bullying in the armed forces, said of men-dominated veteran peer-support groups: "I was the only woman there and it felt unsafe. It wasn't unsafe, but for me it was taking me back into an environment where I had to hide who I was again."

Superordinate Theme Three (ST3): Structural Elements of Care Provision

The final superordinate theme concerns the structural and systemic elements to accessing and engaging with health care and support which P8 summed up as "right place, right time, right person to talk to." Although distinct from the internal attitudes and beliefs in ST1, and the need for belonging in ST2, this third superordinate theme interacted with the other themes to influence the perceived success or otherwise of care provision. Participants highlighted three subthemes: (a) validation and outreach; (b) the importance of informed gatekeepers to accessing treatment; (c) the need for treatment to feel applicable both in terms of a successful treatment modality and their specific needs as women veterans.

ST3 Subtheme: Validation and Outreach

Veterans who both had and hadn't accessed psychological intervention spoke of the difficulties when "the onus always seems to be that you've got to go somewhere to ask for help, but if you are suffering with mental health, it's not easy to go and ask for help" (P15) and that there was a need for "proactive" outreach to women veterans (P15). P11 explained:

> I know the decision is ultimately mine but I think if [health care providers] were a bit more "look you really need to talk to me again and tell me to my face . . . why don't you ring us back and we'll talk again and see how you are getting on" and set a date

> and time for that call rather than leave it up to me because I know for a fact that I'm going to walk away.

The effectiveness of being proactively guided or prompted into treatment was echoed by P9 who admitted that "I'm glad that the doctor gave me the boot up the backside because I needed it," while P8 said she accessed help in the first instance "because it was suggested to me."

The need for outreach was seen as particularly pertinent to women. As expressed in ST2, veteran support and care services were viewed as being something tailored for men and thus this barrier needed to be overcome. P4 expanded that "men just seem to think it's a given a woman will go and get their own help" and as a result "they are falling through the net because you just seem to think that the men keep it all in but I think some of the ladies must do." Furthermore, in having health care services reach out to women veterans, their trauma exposure and subsequent psychological difficulties are recognized and validated by those in a position to offer help, as described in ST1.

However, proactive outreach needed to be tempered. For P8, a large number of veterans' charities and organizations can mean "there are too many things available maybe. . . people are swamped and not really knowing where to go." Another veteran remarked that "I had that many people ringing me I don't even know what bloody day it was half the time" (P9).

ST3 Subtheme: Informed Gatekeepers to Treatment

Participating veterans reported the importance of the gatekeeper role-played by frontline health professionals. Respondents such as P18 recalled that they "had to really bang on my [doctor's] desk and say I need help." P12 stated:

> These professionals that are supposed to know about mental health they haven't got a clue about soldiers' mental health because what affects a civilian for their mental health issues is not the same for a military person.

Thus, military-informed or military-experienced GPs and primary care staff were viewed as "very supportive" (P10) or "amazing" (P3) in the successful provision of support and accessing of health services.

Furthermore, women veterans faced the challenge of being what P10 termed "a hidden community" on account of their minority status and lack of professional knowledge about their very existence. P17 recounted that:

> Nobody at any point looked down at my notes and said "you served in the Army, how was that for you?" Not at all. I could have had [posttraumatic] stress and nobody would have known. They didn't ask—because I was a woman.

P1 felt dismissed by her GP as just a "depressed woman, has children, probably struggling that way" rather than a veteran with potentially complex needs. Such experiences furthered the invalidation of trauma or military service for women veterans as a result of their gender in ST1. In addition, this reinforced the feeling of being separate from the (men) veteran archetype more often catered for, as described in ST2.

ST3 Subtheme: Applicability of Treatment

The applicability of the psychological treatment itself was commented on, in terms of both treatment modality and content. Negative experiences of treatment were associated with therapy being seen as a "tick-box exercise" (P1), or too time-limited. Veterans who reported a successful engagement with treatment, spoke of the importance of being given time and space to talk. Making a connection with their therapist was important. Care was viewed as being personalized when perceived as going beyond the expected norm, such as when "[the therapist] kept me on longer than she should have" (P6) or being in receipt of "extra sessions as well just to help me" (P12).

The experiences of harassment, isolation and bullying when invalidated, were seen as salient in ST1, and were part of setting women veterans apart from their men counterparts in ST2. These experiences were also relevant for treatment that needed to address gender-specific experiences in ST3:

> [Mental health professionals] they've not experienced the military female. Some of them have got experience of veterans but they're all males so they don't understand the difficulties that female veterans have gone through in comparison to their male colleagues. (P12)

In addition, women veterans may have gender-specific needs that need acknowledged, that sit outside but interact with, their experiences as servicewomen. P7 highlighted their experience of PTSD combining with perimenopausal symptoms that required bespoke intervention:

> When [PTSD] coincides, for me I think the menopause lowered my defences . . . all the walls [women have] built up to get them through the service life . . . they might crumble when they start hitting that menopause . . . and the whole thing will be mixed.

P5 echoed the need for women's holistic health to be specifically acknowledged in psychological interventions when she "thought maybe my injuries and the shock had affected my fertility, which might not necessarily be the same in mental thoughts as a man."

However, participants counseled against being seen only through a military-colored lens. P3 stated of an unsuccessful engagement with health care that

Table 2. Challenges Faced by Women Veterans and Potential Responses

Challenges faced	Potential responses/ mitigations
Women do not always identify as a veteran	Education and targeted awareness raising for women veterans
Women veterans do not always feel worthy of support	Proactive outreach by health care professionals
Women not typically seen as veterans	Increased education for health care professionals on women veterans
Lack of understanding on gender-linked military challenges	Increased professional education on prevalence of MST and other gender-related experiences
Formal support may not be seen as welcoming, as a veteran and as a woman	Establishment of women veteran-only support groups and networks; further provision of remote/tele-health delivery
Treatment seen as not applicable to experiences	Additional research into gender-linked interaction with trauma, to further inform service provision (including MST and menopause)
Treatment seen as a too narrow and military-focused	Greater incorporation of veteran health care knowledge in mainstream services to avoid siloed "military-only trauma" care

"they tend to put everything down to my military service and I know a lot of it wasn't just my military service. I had a lot going on." P11 added: "I said from the word go that PTSD is not from my military time, it's from what's happened to me since. But the military gets dragged into it." Although specialist military services were seen as a good thing, personalized therapy reflecting on the whole life course of the individual was seen as particularly desirable. Specialist services focusing on single diagnoses or categories of experience such as combat-related trauma were seen as potentially exclusionary, especially for women veterans:

> I think there are more military people that are not going to fit into those square boxes that you've got to neatly fit into and when it comes to females you are even less likely to fit into that square box. (P19)

Discussion

This study explored the experiences of help-seeking and receiving support from a cohort of U.K. women veterans for the first time via in-depth interviews. The findings coalesced around three superordinate themes which encompassed both positive and negative experiences: attitudes toward mental health and help-seeking; acknowledging the uniqueness of women veterans; and structural elements of care provision. Although the study did not explicitly focus on barriers and facilitators to treatment so as to fully encapsulate the participants' experiences, the findings of this study are commensurate with much of the existing

literature on veteran help-seeking. However, they also diverge from and add to the corpus. The potential challenges faced by women veterans as identified in the dataset, and potential mitigation measured to be considered are outlined in Table 2.

The Importance of Attitudes to Help-Seeking

A meta-analysis by Randles and Finnegan (2022) found that stigma, military-nurtured stoicism and self-reliance, practical difficulties accessing support, and a need for greater military understanding among health care staff all act as significant barriers to help-seeking by veterans. The centrality of stigma is further expanded by Coleman et al. (2017) who found the concept to be a multidimensional construct. This encompassed key themes of nondisclosure, individual beliefs about mental health, anticipated and personal experiences of stigma, concerns about one's career, and other factors influencing help-seeking. As such, all themes are reflected in the current study.

Although the need to overcome internalized stigmatizing views on mental ill health were evident in the present study, the concept of public stigma—namely perceived negative views of those with mental health problems—was less evident (V. Williamson et al., 2019). Although fears around a lack of confidentiality, negative career outcomes, and disadvantageous treatment in a military context persisted into life as a veteran, there was no mention of participants holding a negative perception by others of veterans with mental ill health once outside the military environment. Significant strides have been made in correcting negative views about both veterans and mental health, both within a military context and in wider society. Therefore, it is possible that respondents are viewing their experiences of help-seeking in a more broadly understanding contemporary context.

The Othering of Women Veterans

This study demonstrates that women veterans experience additional barriers to help-seeking in the individual, provision, and systemic domains, comparable to those of other minority groups (Scheppers et al., 2006). In comparison to the wider veteran majority dominated by men (Mellotte et al., 2017), this study demonstrated that women veterans uniquely report the addition of cross-domain gender-specific discrimination. Specifically this related to not being recognized as a veteran and being treated differently by frontline professionals, or dealing with the psychological or learnt behavioral consequences of in-service discrimination (Graham et al., 2022). This study's finding that women veterans potentially felt "othered" in veterans' groups (ST2) and had their traumatic experiences minimized (ST1) are two further such examples.

Furthermore, although women veterans have been found to be more likely to access formal support than men (Jones et al., 2019), such support was often

found to be nonveteran specific, with general health services preferred (Godier-McBard, Cable, et al., 2022). Service practitioners have themselves reported that veteran services are regarded as both men-dominated and focused (Godier-McBard, Gillin, et al., 2022), thus this preference may be based on implicit and explicit beliefs and choices. A sense of exclusion from men-centric veteran services may lead to an implicit belief among women veterans that such services are not for them, or that their traumatic experiences are minimized and consequently viewed as less deserving of treatment. The reported invalidation or denial of their traumatic experiences from others could act as a disincentive to accessing treatment. Hence why women veterans looked positively on both being guided—or indeed pushed—into seeking help by informed gatekeepers, and proactive outreach from health services (ST3). Such a desire could also be seen as reflective of the generalized finding that veterans tend to wait until moment of health crisis before seeking help and support (Murphy et al., 2014), thus the perceived need for promoting early engagement and intervention. For others, it may be an explicit choice not to engage with veteran-specific services, particularly women who have experienced sexual traumas in which the perpetrators are overwhelmingly men, in positions of authority, and military. Thus a need for further provision and examination of women-only treatment environments, or alternative therapeutic delivery such as telemedicine to overcome such systemic barriers can be inferred (Acierno et al., 2021). Furthermore, the need to further explore gender-based differences in treatment access and delivery has implications for help-seeking in other men-dominated and masculinized environments such as the police, fire and other frontline services (Berg et al., 2006; Hom et al., 2018; Lane et al., 2022).

The Need for Bespoke Treatment

It is of note that women participants commented widely on the need for care tailored to their needs as both veterans *and* women, and the perceived limitations of care that was overly focused on their time in the military to the detriment of their preservice and postservice life. Comorbidity and complexity in veterans is the norm (Murphy et al., 2021). For example, both men and women veterans demonstrate a higher prevalence of adverse childhood experiences compared with civilians (Carroll et al., 2017; McCauley et al., 2015), with multiple life course traumas producing poorer psychological outcomes (Baca et al., 2021). More widely, a study of U.S. veteran men being treated for military-related PTSD found that 90% of the sample also reported trauma that was nonmilitary in nature, with childhood abuse, adult sexual trauma, and postmilitary physical assault all significantly associated with PTSD symptom severity (Clancy et al., 2006).

Such findings may indicate an ongoing challenge for veteran-specific health care services. Although the mechanisms for engaging with specialist veteran health care are context and country-dependent, access to specialist veteran care

is frequently contingent on index traumas that are directly attributable to military service. These traumas in turn are then the target for veteran-specific treatment. Thus, further investigation may be required into the merits and practicalities of a shift from *veteran-specific* to *veteran-informed* mental health service provision, particularly delivered within existing mainstream health care. In this respect, rather than veteran treatment taking place in specialist silos, the latter position is orientated toward considering a whole life course perspective on trauma. This perspective is viewed through a lens colored by an awareness of the experiences, clinical presentation and treatment responses idiosyncratic to veterans.

Strengths and Limitations

The study employed a cross-sectional design and used a convenience sample drawn from the membership of a single, Army-only, veteran association. It should be noted that this association is not offering clinical or social welfare services, rather its purpose is to connect women veterans postservice. As such, the sample is more reflective of a community, rather than clinical, population. Accordingly, the participating cohort is not necessarily representative in age or military experience of the wider U.K. women veteran population. Indeed, the service experiences of women in the U.K. armed forces markedly differ in several aspects compared with more recent times. Notably, 42.1% ($n = 8$) of the sample identified as LGBT+ with many serving during the "gay ban," as well as the prohibition of pregnancy during military service. Nonetheless, the military and life experiences described by the participants are viewed as broadly indicative of the range expected to be found in the veteran population of today, the majority of whom are over 65 years of age (Ministry of Defence, 2019).

Traumatic experiences as captured by the LEC-5 were most probably underreported, as selecting multiple incidences was not possible in the questionnaire. However, this study did not focus on the index traumatic experiences *per se*, although future research into the specificities of trauma histories and salient factors in treatment experiences would be welcomed. In addition, the PCL-5 scores from which eligibility was determined were gathered 2 years previously and may not reflect the current level of symptomology. However, these scores were not seen as a *de facto* diagnosis, rather they were indicative of the likelihood that experiencing psychological difficulties and entering mental health treatment would have been a possibility. While acknowledging these limitations, the study provides a qualitative snapshot of the experiences of a cohort of women veterans whose voices and experiences often go unheard. This snapshot is offered a basis on which themes can be explored in future research, and as such no claims of extensive wider generalizability are made. Indeed, the applicability of the identified themes to women veterans of other demographic profiles and national contexts, as well as how they interlink with specific

experiences of veteran mental health service quality and provision, would merit further research.

Conclusion

This study is one of the first to explore in depth the experiences of help-seeking in U.K. women veterans. In addition to the established personal, treatment provision, and structural challenges to accessing care faced by veterans in general, women veterans report gender-based idiosyncrasies that cut across all domains. As such, participants identified the salience of women veteran-specific personal attitudes to mental health, views on traumatic experiences, and the consequences of help-seeking that affected pro-engagement behaviors. Similarly, the positive influence of treatment environments in both a women and veteran milieu was identified, as well as increased awareness of women veteran-specific needs among health care gatekeepers and pathways into treatment. Finally, the need for treatment itself to adequately fit the whole life course experience of women veterans was explored. Consequently, delivering treatment in veteran-informed, rather than veteran-specific contexts may be an area for further exploration to ensure that the servicewomen of the past receive the most appropriate and effective care as the veterans of today.

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Supplemental Material

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