



**THE MENTAL  
WELLNESS NEEDS OF  
MILITARY WOMEN:  
COMMUNITY DRIVEN  
SOLUTIONS**

2018 REPORT

**SERVICE  
WOMEN'S  
ACTION  
NETWORK**



YOUR VOICE, AMPLIFIED

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## YOUR VOICE, AMPLIFIED.



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# LETTER FROM THE CEO

February 15, 2018

Dear Friends and Colleagues,


I present this report on the Mental Wellness Needs of Military Women on behalf of SWAN's Board of Directors, staff members, fellows and volunteers. It is the culmination of significant effort and could not have been accomplished without the assistance of a volunteer Advisory Committee of academic experts who supported SWAN's work. SWAN engaged in this effort because of what we heard directly from service women; that their mental wellness needs are largely unmet.

The call for gender-specific mental wellness services is not new. In April 2015, the Department of Veteran Affairs (VA) issued its *Study of Barriers for Women Veterans to VA Health Care* in which gender-specific mental health services and gender-sensitivity were noted as critical to enhancing women veterans' health. In September 2017, the VA issued another report noting that the suicide rate of women veterans is 250 percent higher than that of their civilian counterparts. In January 2018, the VA and the University of Connecticut co-issued a report that indicated married women veterans face a much higher risk of suicide than their unmarried counterparts, and slightly higher than married male veterans. In these reports, the need for gender-specific services and gender-sensitivity were cited as necessary to address these startling statistics.

The service women behind these statistics have names; they are our friends, our family, and they are suffering and unable to find their way clear of the shadows of depression, anxiety, PTS, TBI and related conditions. But many service women remain hopeful that with care they can overcome their challenges. SWAN is determined to do more than simply issue a report with recommendations. We are working to develop and move forward initiatives to drive policy and programming within the Department of Defense, the Department of Veteran Affairs and Veteran Support Organizations so service women and women veterans receive the assistance and support they need and deserve. Additionally, SWAN will continue its decade-long endeavor to address the epidemic of Military Sexual Trauma (MST), which this report finds is too often the catalyst of poor mental health outcomes.

SWAN stands with the service women who contributed their stories and experiences to this report, and will continue to work hard on their behalf for real reform and real solutions.

Sincerely,



Lydia C. Watts, Esq.  
CEO

# EXECUTIVE SUMMARY

On a range of indicators military women's mental health is not good. Service women, who often deal with a culture of bias, harassment and sometimes assault, as well as long family separations and combat deployments, can have long-term mental health impacts that must be acknowledged and addressed while on active duty and when they become veterans. Women veterans are significantly more likely to face mental health challenges than civilian women and veteran men. Department of Veteran Affairs (VA) data shows that women veterans are 250% more likely than civilian women to commit suicide, and recent research on veteran homelessness revealed that while women veterans do not fit the traditional definition of homeless, they are disproportionately categorized as "housing insecure."

Women's mental wellness appears to be negatively impacted during military service and this impact follows them after they leave service. In SWAN's 2017 mental wellness survey, 60% of participants said that military service had a negative impact on their mental wellbeing. Furthermore, 61% of survey participants said they have been clinically diagnosed with some form of depression and 51% have received a clinical diagnosis of a stress injury. Finally, 20% said they had engaged in some form of self-harm.

When survey participants were asked, "What specifically about military service most positively or negatively impacted, or is impacting, your mental health?" Forty-nine percent said that bias, harassment or assault during military service had negatively impacted their mental health. During the focus group discussions this was explored in depth. Three of the four focus groups discussed developing a protective outer shield or shell during military service, likening it to wearing a mask and linking it to resilience. However, when they discussed resilience further they found that this was a "fake resilience" that did not contribute to mental wellness at all but had a negative secondary effect of isolation. The "resilience" that women learn in the military is not really resilience at all but a method of suppressing negative experiences in order to "drive on" which invariably, eventually, takes a toll on their mental health. In fact, "resilience" is misunderstood and misconstrued as "toughing it out" and ultimately makes it hard to engage in actual resilient practices like reaching out to others and forming strong personal relationships.

On the positive end of the spectrum veteran women are increasingly likely to seek care for mental health needs. Over 30% of the survey participants have used therapy or counselling and over 85% believe that mental wellness treatment and practices can improve their quality of life. According to the most recent Veteran Health Affairs (VHA) report there is a significant uptick in women turning to the VA for their health care needs and it is improving outcomes. For women who use VHA services there is a 2.6% lower rate of suicide than for those who aren't using VHA services.

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<sup>1</sup>The term "military women" refers to all women who are currently or have previously served for any length of time in one of the military services. "Service women" refers to women who are currently serving in an active, national guard or reserve status. Women veterans are women who have served for any period of time and includes those who have retired from service and will, or do receive a military pension.

# EXECUTIVE SUMMARY CONTINUED

Although military women believe that therapy and counseling can have positive benefits, many are disappointed with their ability to access quality care in a timely or consistent manner. Many report that when they do see therapists the therapist is unfamiliar with the unique situation and needs of military women. In order to understand the needs of military women and to provide recommendations to providers, policy makers and advocates, SWAN conducted a two-part study designed to arrive at recommendations for improving the mental wellness of this group of service members and veterans. The first part of the study was a mental wellness survey that was conducted in late summer of 2017. The second part was a 2-day Summit that brought together over 60 service women and women veterans to look at the data and make community driven recommendations for improving the lives of military women.

## Policy recommendations:

- Provide gender-specific mental wellness assessments with feedback and recommended care options during transition **and** demobilization activities.
- Develop women-specific transition and demobilization services. Service women have a very different experience of deployment and transition and programs must be tailored to meet women's specific needs. (DOD)
- Increase access to appropriately trained counselors/therapists in DOD and the VA. Access is often slow, inconsistent and of variable quality. Many therapists have not been trained in how to handle cases of harassment and sexual assault. (DOD and VA)
- Provide funding for alternative therapies like meditation, yoga, massage therapy, acupuncture, etc. Many military women pay out of pocket costs for therapies that they find to be more effective than traditional approaches which rely almost solely on counseling and medication. (DOD and VHA)
- Establish social support groups/networks for military women. (VA/VSO/MSO)
- Improve resource access via a single, cross community resource site. (DOD/VA/MSO)

There is still much to be accomplished to ensure that service women are fully accepted and respected members of the military community, and that women veterans are cared for and understood in society. Not only do service women face all of the challenges of military service that men face, including long family absences and combat deployment, service women must also cope with a culture of bias, discrimination, harassment and assault. As a marginalized and discriminated against minority group their mental wellness challenges are significant.



Left: Retired Lieutenant General Patricia Horoho presents key health findings from America's Health Rankings.

Right: Kayla Williams, Director of the Center for Women Veterans, provides an update on the status of women veterans.

## INTRODUCTION

Service women and women veterans face a wide range of challenges. Some of these challenges make headlines, while others — such as health and wellness issues — are often invisible to the public, policy makers and those around them. In SWAN's 2016 needs assessment survey mental health was raised as a top concern by both active duty and women veterans. In response, SWAN's 2017 annual Summit focused on the mental health challenges that service women and women veterans face, and explored how to bridge the gap between needs and solutions.

SWAN's research and Summit examined mental health along the continuum from active duty to veteran status. Service women, who often deal with a culture of bias, harassment and sometimes assault, as well as long family separations and combat deployments, can have long-term mental health impacts that must be acknowledged and addressed while on active duty and when they become veterans. Women veterans are significantly more likely to face mental health challenges than civilian women and veteran men. Veteran Affairs data shows that women veterans are 250% more likely than civilian women to commit suicide, and recent research on veteran homelessness revealed that while women veterans do not fit the traditional definition of homeless, they are disproportionately categorized as "housing insecure".

Unfortunately, responses to mental health challenges have been developed, by default to meet the needs of men and often do not address women's unique needs. To fully understand the scope of this issue and to offer possible solutions, SWAN took a two-part approach to researching the problem and to developing solutions for policy makers and health care providers.

# RESEARCH DESIGN

This research was approved by the Institutional Review Board of Charleston Southern University.

Part 1 was comprised of a survey of the mental wellness of military women. The survey was designed to be both quantitative and qualitative. Survey participants answered a series of quantitatively scored questions that included questions from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS questions were included in order to provide population comparison data. Participants were also prompted with four open ended questions that they could respond to in an unlimited written format.

Part 2 was comprised of a series of focus and working group sessions that took place at SWAN's annual Summit on 13-14 November, 2017. After a series of speakers and data presentations, including SWAN's survey data presentation, participants broke into focus groups to discuss and flesh out the survey findings. On the second day participants joined working groups to discuss and develop possible policy recommendations for meeting the mental wellness needs of military women.



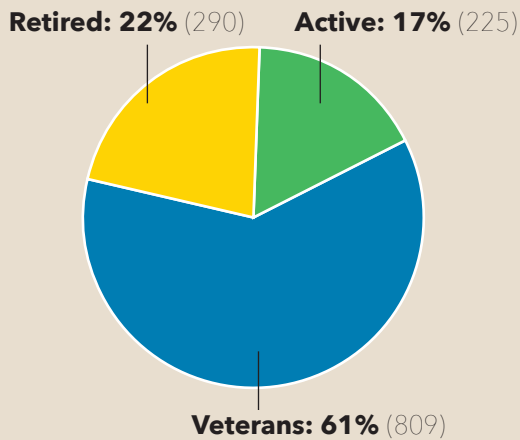
Women Veteran Network Peer Leaders Cat Corchado and Tina Brice with Dr. Amy Street

# SURVEY RESULTS

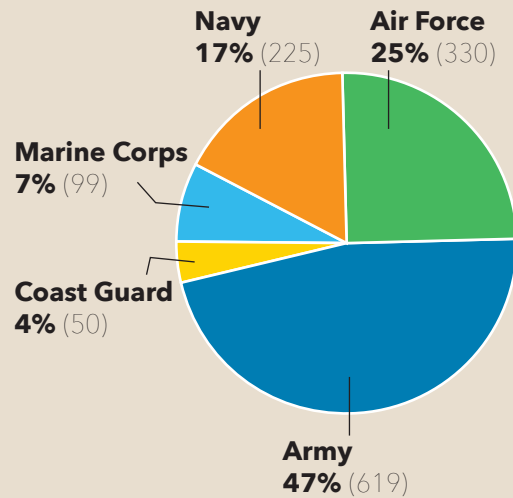
Survey Demographics: 1,295 Participants

## DEMOGRAPHIC DATA

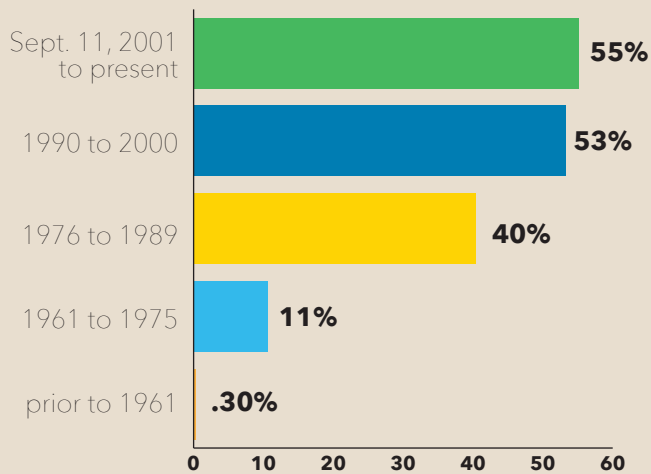
### Survey Participant Status



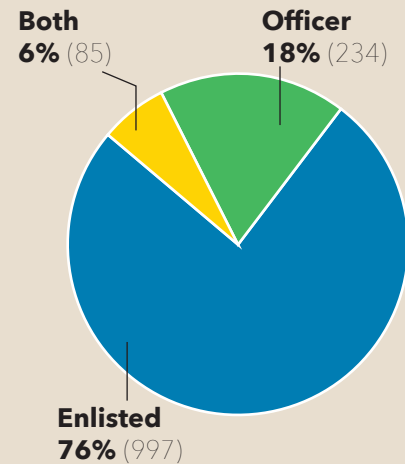
### Service Branch



### Era of Service



### Officer/Enlisted Demographics

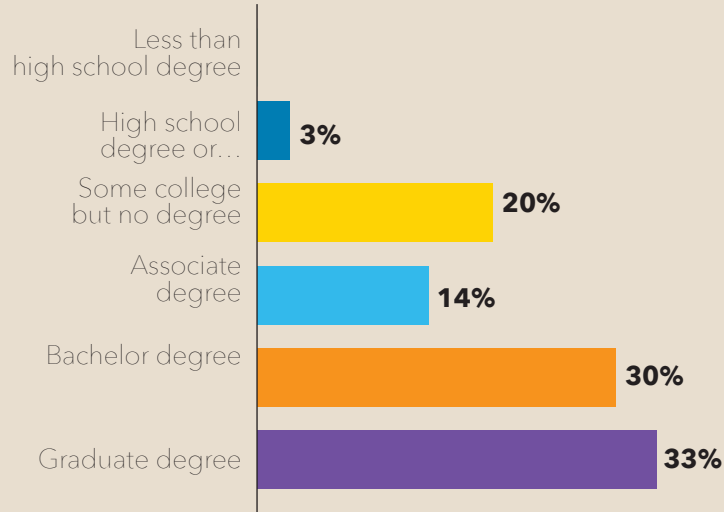




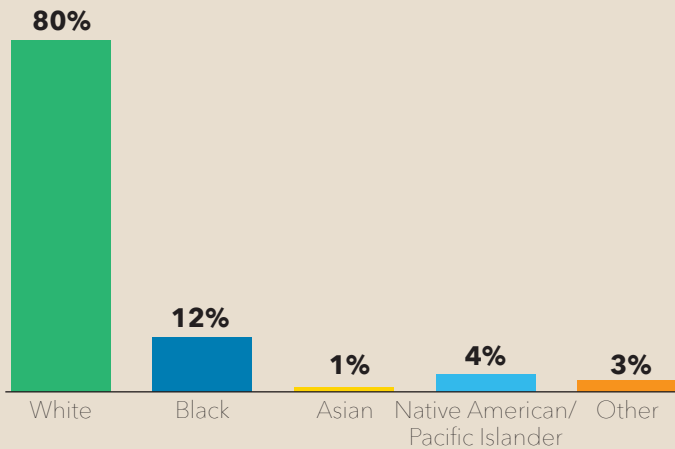
# SURVEY RESULTS CONTINUED

## DEMOGRAPHIC DATA CONT.

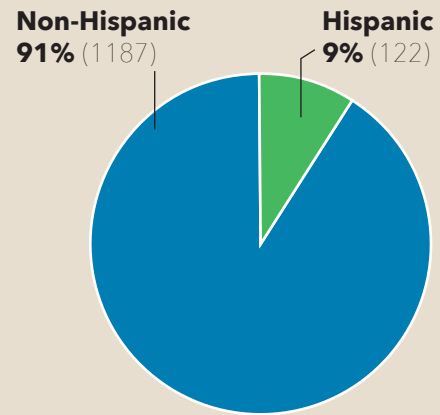
### Participant Level of Education



### Racial Group Breakdown



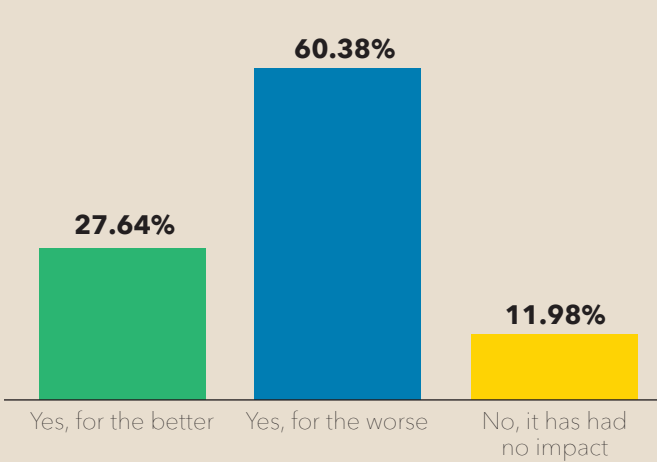
### Hispanic Breakdown



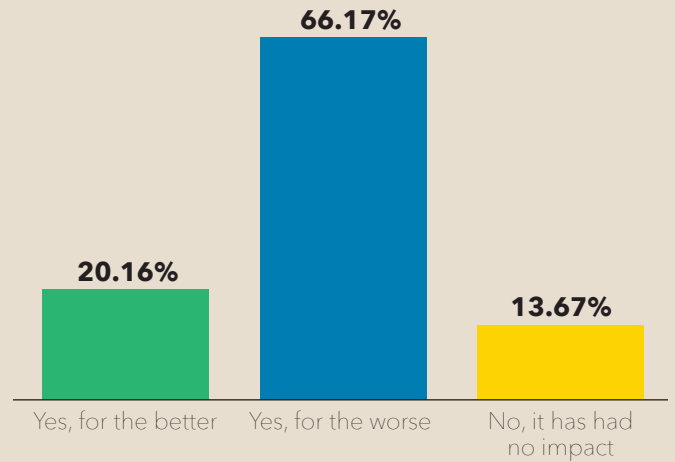
# SURVEY RESULTS CONTINUED

## SERVICE EXPERIENCE

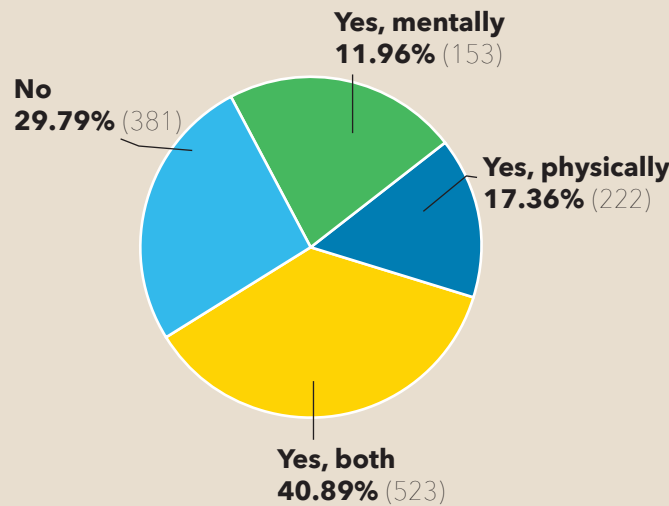
Has military service impacted your mental well-being?



Has military service impacted your physical well-being?



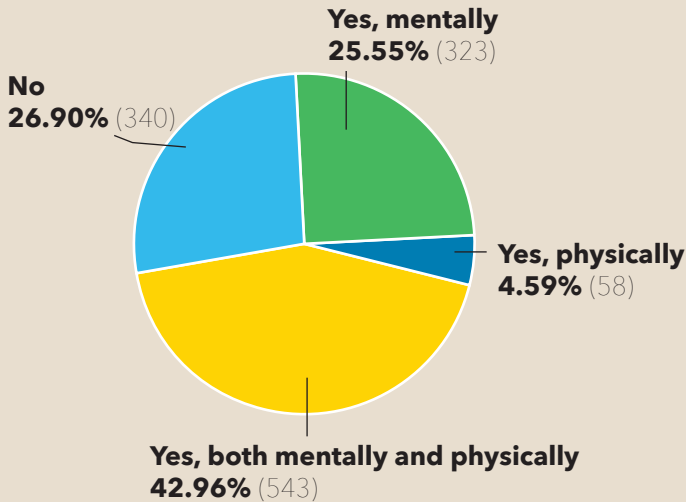
Do you consider yourself limited in any way as a result of your service?



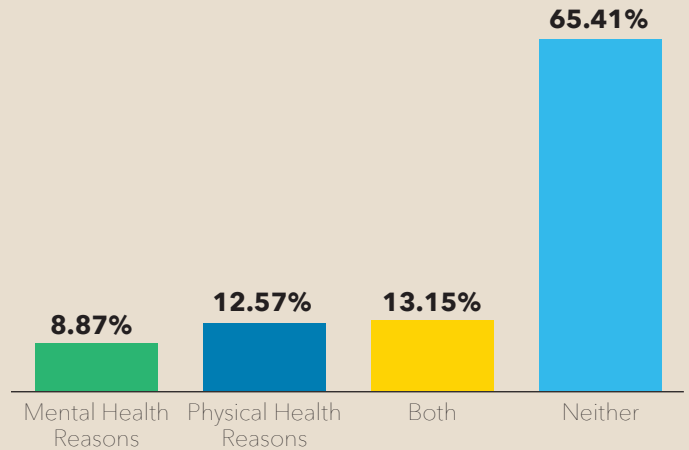
# SURVEY RESULTS CONTINUED

## SERVICE EXPERIENCE CONT.

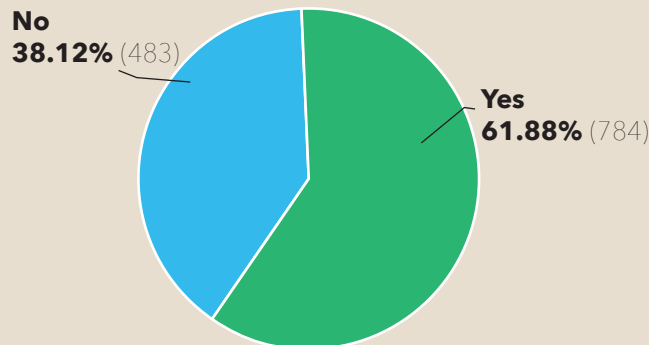
**Do you consider yourself strengthened/improved in any way as a result of your service?**



**If you left the service, did you leave for any of the following reasons?**



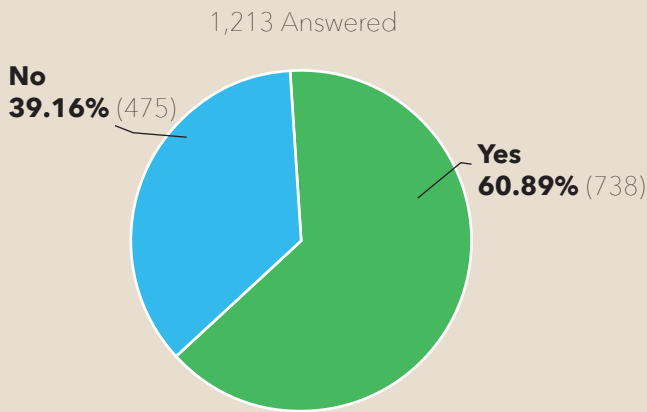
**Do you have a service-connected disability rating with the Veterans Administration?**



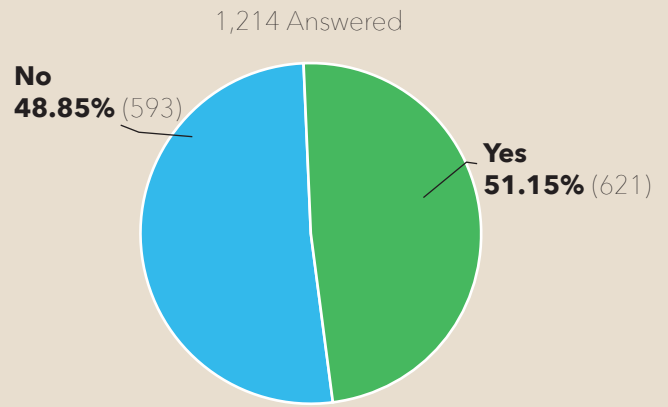
# SURVEY RESULTS CONTINUED

## MENTAL WELLNESS

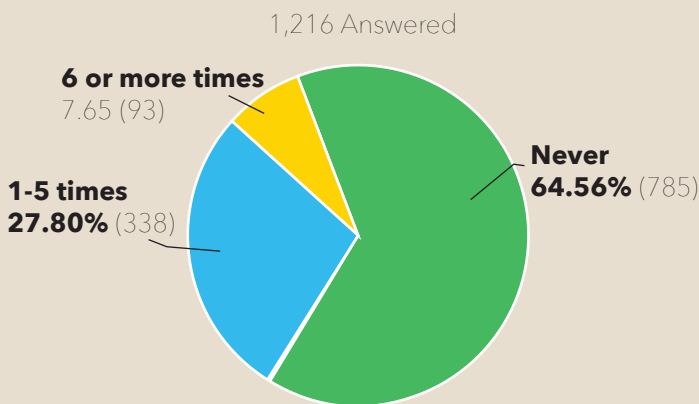
Have you ever been told by a professional clinician that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?



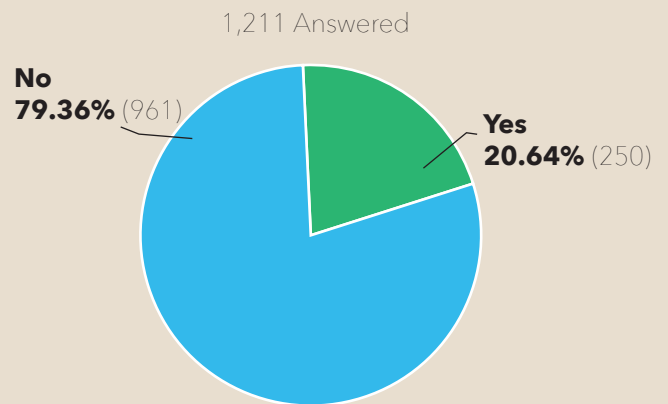
Have you ever been told by a professional clinician that you have a mild, moderate, or severe stress injury (sometimes called post traumatic stress disorder)?



On how many days in the past month have you consumed 4 or more alcoholic beverages on a single occasion?



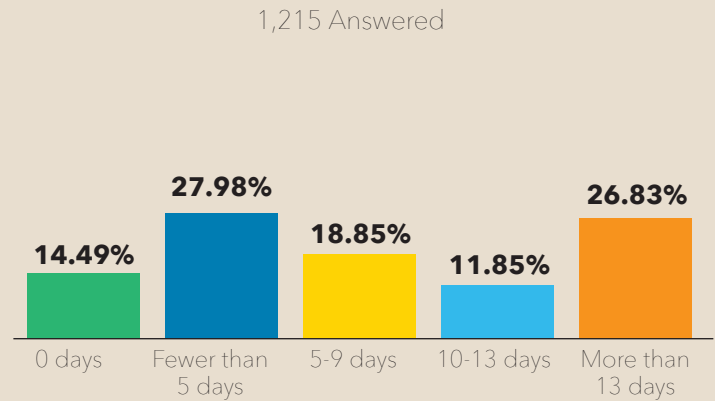
Have you ever intentionally harmed yourself?



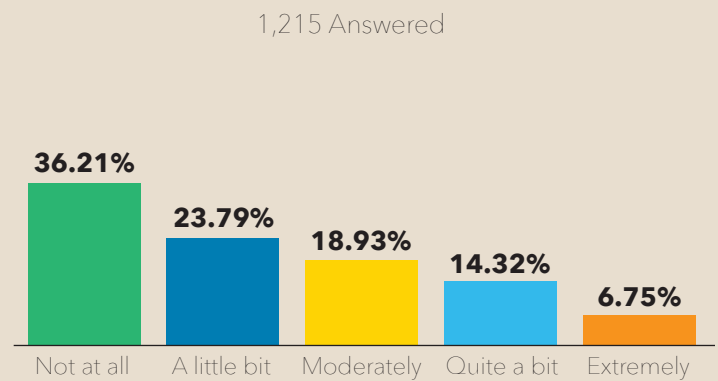
# SURVEY RESULTS CONTINUED

## MENTAL WELLNESS CONT.

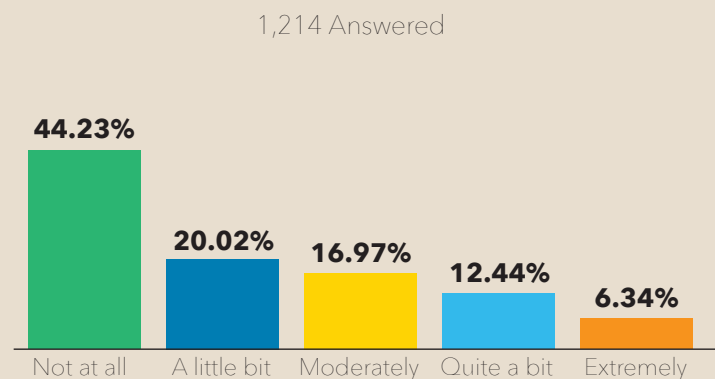
**Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?**



**How much have you been bothered by repeated, disturbing memories, thoughts or images of a stressful military experience in the past month?**



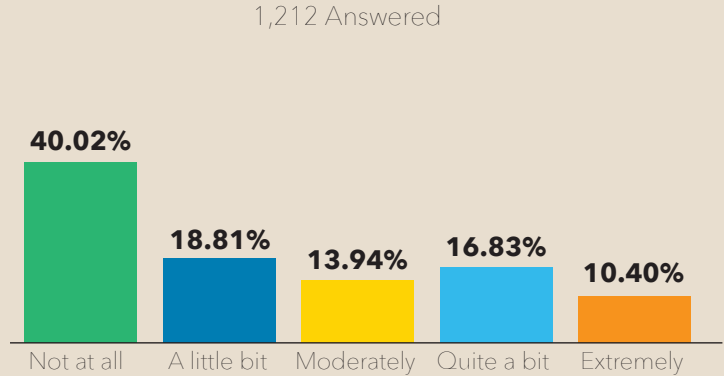
**How much have you been bothered by physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful military experience in the past month?**



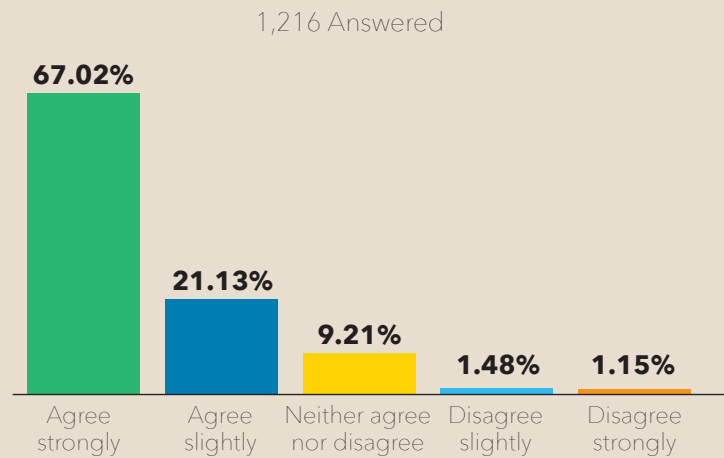
# SURVEY RESULTS CONTINUED

## MENTAL WELLNESS CONT.

**How much have you avoided thinking or talking about a stressful military experience, or avoided feelings related to it in the past month?**



**Mental health treatment can help people improve their quality of life.**



# SURVEY RESULTS CONTINUED

## THE QUESTIONS

Participants were invited to respond to the following four open ended questions.

**1. What specifically about military service most positively or negatively impacted, or is impacting, your mental health? (963 answered)**

- 30% said military sexual trauma or sexual abuse
- 11% said sexual harassment
- 9% said combat deployment
- 8% said sexism or gender discrimination

Responses to this question fell overwhelmingly in the negative category. Some responses included being sexually harassed or assaulted while on deployment and were coded as both deployment and assault. In total, 49% of survey participants reported that some aspect of bias, harassment or assault during military service had negatively impacted their mental health. Only 11% of respondents said that, for a variety of reasons, military service had positively impacted their mental health.

**2. How do you take care of your mental health? (1,023 answered)**

- 34% of survey participants said they use therapy or counselling
- 21% said they take medication
- 19% said they exercise
- 15% said they pursue hobbies
- 15% said they talk to friends and family
- 14% said they rely on alternative therapies with mindfulness/meditation mentioned most often
- 08% said they rely on faith and prayer

Most respondents listed more than one strategy for taking care of their mental health while others listed none. Some said they didn't have time to take care of their mental health and a few said they were concerned about seeking care because of a perceived potential impact on their security clearance.

**3. How do you cope when your mental health is not good? (1,015 answered)**

- 33% said they sleep and/or self-isolate
- 22% reach out to family/friends
- 20% engage in some form of mindfulness, meditation or prayer
- 17% engage in hobbies like journaling, art, music, reading and playing with pets
- 14% exercise
- 11% engage in problem eating/drinking (alcohol)
- 7% use legal and illegal drugs with marijuana being the most commonly cited drug

# SURVEY RESULTS CONTINUED

## THE QUESTIONS CONT.

### 4. What would be helpful to you as you work to optimize your wellbeing? (933 answered)

16% said a support group

10% said access to alternative therapies like yoga, meditation, massage and acupuncture

10% said easy access to affordable, discreet and better trained counselors

Comparing SWAN's data to 2016 BRFSS data reveals that women who took the SWAN survey have a much higher rate of diagnosed depression (61%) compared to the BRFSS population of women veterans (26.5%) or of civilian women (20.8%). This could indicate a survey selection bias, meaning that military women who were willing to complete this voluntary survey are those who are interested in or are concerned with mental wellness. Further analysis of the SWAN data revealed that the prevalence of undiagnosed depression for active duty women is 20% and 8.7% for veteran women. In the comments section many active duty women indicated a reluctance to seek help due to stigma associated with counselling and over fear that it might impact their security clearance.

	Non-veteran BRFSS (n=264,173)	Veteran BRFSS (n=5,692)	SWAN (n=1,213)
Undiagnosed Depression, n (%)	26,643 (10.10%)	499 (8.80%)	128 (10.60%)
Diagnosed Depression, n (%)	55,060 (20.80%)	1,509 (26.50)	736 (60.80%)



# FOCUS GROUP DISCUSSIONS

On Day 1 of the Summit participants were broken into 4 groups according to their service status.

- Group 1 was comprised of actively serving service women including National Guard and Reserve women.
- Group 2 was comprised of women veterans under the age of 45.
- Group 3 was comprised of women veterans 45 and older.
- Group 4 was comprised of women who have retired from military service and receive or will receive a military pension.

During the focus group discussions on Day 1, the groups were asked a series of questions about the data that had been presented that morning. On Day 2, the groups were asked to move into working groups to develop a prioritized list of recommended solutions that would help meet the needs of military women.

## FOCUS GROUP FINDINGS

The groups were asked to respond to prompts about what they thought about the research findings, whether they thought they were accurate or not, what were their biggest mental wellness challenges and how they would prioritize the mental wellness needs of their group. At the end of the day each group was challenged to develop a summative statement that captured the focus group's thoughts and discussion. The findings are summarized below.

**Active/Guard/Reserve Group.** This group did not find the data surprising and did not question the results of the SWAN survey. Members of the group spoke extensively about experiencing a sense of isolation within their units and on their teams. Several members said that they generally feel like they are always on guard. They highlighted a military culture that celebrates strength and resilience while rarely actually training military members in how to be resilient. They said that to cope, they develop a front or a mask and a protective outer shield that is intended to insulate them but may have the effect of further isolation. Their group came up with this summative statement, *"There are ups and downs to mental health for women in the Service. Prepare women for the good and bad. I'm a stronger person now, but did it have to be so hard to get there?"*

**Veteran Under 45 Group.** This group believed that the data was accurate and reflected their personal experiences. One participant's remark generally reflected the views of the group. She said, "I had experiences during my military service that were really challenging. I was sexually harassed on a regular basis and combat deployment was really hard. On the other hand, I also feel like my experience taught me how strong I am and helped me be more resilient." However, when the group further explored the term resilience they found it highly problematic and not a well understood concept. One participant said that in the military it is linked to your ability to "suck it up" and "drive on" rather than actual emotional health. This group also discussed wearing a "mask" to hide their emotional selves. They thought that transition services should be improved for service women and that mental health care should be more focused on preventative care rather than crisis response care. Their summative statement was, *"What does a woman veteran look like? One who journeys through an unknown uninformed transition where image is protected at all cost to wellbeing; with no known language of emotion or self-identity but is expected to be resilient; that leaves a trail of perception."*

# FOCUS GROUPS CONTINUED

**Veteran 45 and Older Group.** This group did not question the validity of the SWAN data findings but expressed dismay by the high level of diagnosed depression. They explained the seemingly contradictory survey data that showed that a majority of women said that military service had negatively impacted them with data that showed that few of them are bothered by repeated or disturbing memories of military service. For this group the negative experiences are distant and don't have the same power to disrupt their lives as they once did. Ultimately, they said that military service had been a challenging and generally negative experience for them but that the experience itself had caused them to become more resilient. Like the previous two groups this group talked about inhabiting a protective shell that they developed to protect themselves. This group's summative statement was, *"Women Veterans, through a variety of backgrounds and levels of traumatic experiences, have difficulties finding ways to connect to a network or solution. They may perceive themselves to be forgotten and overlooked. They may engage in self-neglect as they internalize society's views of what a woman veteran should be, yet at the same time, continually work hard at reinventing themselves in amazing ways."*

**Retired Group.** This group was concerned with the generalizability of SWAN's survey findings. They did not believe the findings are representative of their experiences in the military. Although they thought the findings might not be generalizable they spent the bulk of their time discussing instances of harassment and assault that they had experienced in the military. They identified problems accessing consistent and appropriately trained mental health care providers. They said that providers are not MST trained nor do they understand the unique needs of service women, a marginal minority group, that doesn't have the same support network as their male colleagues. Some believe that this causes service women to have trouble making personal connections. Their summative statement was, *"The research presented and the sample size is a good start — however, it needs to be administered to a broader population and with more specificity in the sample questions."*



Summit Participants

# WORKING GROUP SOLUTIONS

On Day 2 of the Summit, participants returned to their groups, now called *working groups*, to talk about perceived gaps in service and to develop solutions to address the gaps. After identifying the gaps in care participants developed lists of possible ways to fill the gaps. Following is each group's set of recommended solutions to filling the identified gaps.

## ACTIVE/GUARD/RESERVE GROUP

1. Training for preventative mental health care for service women. They recommended resilience training for women and training for how to handle or cope with bias and harassment not just assault response training.
2. Increase the number of trained mental health care providers. There is the sense that there are not enough to make them readily available and those who are available are not trained for the unique challenges that face military women.
3. Improve implementation of sexual harassment and assault policies by including them in command climate surveys and taking commanders out of the prosecution chain.
4. Reintegration and demobilization programs must take a gendered approach.

## VETERANS UNDER 45 GROUP

1. Both patients and providers need increased competency and accountability. This requires orientation programs for patients and better trained providers.
2. Cross community resource sharing; DOD to VA to VSO/MSOs. The DOD handoff to VA is highly problematic and challenging for military women.
3. A single site for resources from all communities. It is difficult to navigate the different departments and their various resources.
4. Improve the transition process. Include mental wellness classes, possibly bring veterans back at at different intervals to assess needs.

## VETERANS 45 AND OLDER GROUP

This group provided a list of recommendations by agency.

### VA

1. Provide on-site childcare for veterans' appointments.
2. Expand hours for working individuals to attend appointments.
3. Assign women's health care providers per capita. Ensure that they are appropriately trained for women's care and that they maintain their competency.
4. Provide more "veterans choice" options.
5. Recognize women veterans, remove war pictures from VA lobbies and change the motto of the VA.

### DOD and VA

1. Provide greater access to alternative therapies
2. Eliminate stigma associated with mental health care

**Veteran and Military Support Organizations:** Place more women in VSO/MSOs to help process women's claims and ensure that women providers are present at compensation/pension exams.

# WORKING GROUPS CONTINUED

## RETIRED GROUP

This group provided a list of recommendations by topic.

### **Improve transition services to:**

1. Incorporate mental health and wellness classes as a part of transition.
2. Establish a community partnership to accept a soft handoff from active duty to veteran status. This could include a buddy check program to stay connected to other veterans.
3. Develop a mentorship program to link service women with women veterans in conjunction with a veterans panel during transition.

### **Community building through resource sharing, to include:**

1. Community veteran liaisons (ie. police officers, EMTs)
2. Call to action for community partnerships
3. Women-specific accredited VSOs
4. Awareness campaign (women as vets, resources for women veterans)
5. Family support resources
6. Resource navigation/support guide
7. Written resources
8. Funding for nontraditional (holistic) options
9. Rural outreach opportunities
10. Sister veteran support network
11. Call or text support network

### **Develop patient and provider competency and accountability, to include:**

1. New patient orientation at first VHA appointment
2. Allow veterans to have a say in their care
3. Providers competent in working at the intersection of womanhood and military
4. Competent sexual health counseling
5. Training for providers on women veterans' specific risks and health needs
6. Professional training for providers
7. Action taken at VHA's that exhibit unacceptable behavior toward women veterans

# SUMMARY AND POLICY RECOMMENDATIONS

Despite the fact that the four demographic groups were separated during both the focus and working group discussions many of their findings and recommendations are similar and in some cases identical. For example, all of the focus groups discussed women's unique experience of military service that included feelings of isolation, alienation and sometimes threat. Three groups likened it to wearing a mask or developing a protective outer shield or shell that makes it hard for them to connect to others even after they leave the military. All of the groups discussed the need to access mental health providers who are trained in the unique challenges that impact military women's lives like those of isolation, bias and harassment. All of the groups discussed improving transition services whether it be reintegration when they are leaving military service or demobilization after a combat tour. They believe that existing services fail to take into account women's unique needs. Many of the recommendations would likely improve the mental health outcomes for men as well as women if they were implemented.

The recommendations that were similar or the same across three or more groups are outlined below.

- Provide gender-specific mental wellness assessments with feedback and recommended care options during transition **and** demobilization activities.
- Develop women-specific transition and demobilization services. Service women have a very different experience of deployment and transition and programs must be tailored to meet women's specific needs. (DOD)
- Increase access to appropriately trained counselors/therapists in DOD and the VA. Access is often slow, inconsistent and of variable quality. Many therapists have not been trained in how to handle cases of harassment and sexual assault. (DOD and VA)
- Provide funding for alternative therapies like meditation, yoga, massage therapy, acupuncture, etc. Many military women pay out-of-pocket costs for therapies that they find to be more effective than traditional approaches which rely almost solely on counseling and medication. (DOD and VHA)
- Establish social support groups/networks for military women. (VA/VSO/MSO)
- Improve resource access via a single, cross community resource site. (DOD/VA/MSO)

Most of the findings and recommendations in this report are not new. The fact that women veterans mental health is not good has been clearly established in multiple VA studies. The fact that active duty women also struggle with mental wellness but are less willing to seek help is less well documented but not surprising. Recommendations for gender-specific transition and demobilization assessments and services have been made by many groups. Although some effort has been made by DOD to address this gap it appears to be inadequate because mental wellness is not improving. DOD and the VA must come together and jointly develop a response that provides a continuum of care model that is gender specific if there is to be any lasting improvement in the mental wellness of the women who serve this nation.

<sup>i</sup> United Health Foundation. 2017. *America's Health Rankings Health of Women Who Have Served Report*. [https://assets.americashealthrankings.org/app/uploads/hwwhs17\\_final.pdf](https://assets.americashealthrankings.org/app/uploads/hwwhs17_final.pdf)

<sup>ii</sup> Lehavot K., Katon JG, Chen JA, Fortney JC, Simpson TL. 2018. Post-traumatic Stress Disorder by Gender and Veteran Status. *American Journal of Preventative Medicine*. Jan;54(1):e1-e9.

<sup>iii</sup> U.S. Department of Veterans Affairs. 2017. *Suicide Among Veterans and Other Americans 2001–2014*. <https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf>

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