

The health and wellbeing of female Vietnam and Contemporary Veterans

Final Report

June 2012

Dr Samantha Crompvoets

Principal Investigator

Building 95, Fulton Muir Building
Corner Barry Drive & North Road
The Australian National University
Canberra ACT 0200
Australia

ACN 008 548 650



Table of contents

Executive summary	iv
Empirical data overview.....	vi
PART A BACKGROUND AND METHODOLOGY	
1. Background.....	1
1.1 Introduction.....	2
1.1.1 Knowledge based rationale.....	2
1.1.2 Policy based rationale.....	3
1.2 Women in the Australian Defence Force.....	4
1.3 Women and VVCS.....	5
1.3.1 Uptake of VVCS by female veterans.....	6
2. Methodology.....	8
2.1 Introduction.....	8
2.2 Sample size.....	8
2.3 Recruitment.....	9
2.4 Narratives.....	9
2.5 Validation.....	10
2.6 Analysis of data.....	11
2.6.1 Theoretical framework.....	11
2.6.2 Career.....	13
2.6.3 Deployment.....	13
2.6.4 Motherhood.....	15
2.6.5 Seeking help.....	16
2.6.6 Stakeholders.....	17
PART B DEMOGRAPHICS	
3. Demographics of research participants.....	19
PART C FINDINGS AND RECOMMENDATIONS	
4. Findings.....	20
4.1 Introduction.....	20
4.1.1 Overview of key findings.....	22
4.2 Barriers to accessing existing services for female veterans	23
4.2.1 Lack of an authentic veteran identity.....	23
4.2.2 Lack of trust in confidentiality of DVA/ADF funded services.....	24
4.2.3 Stigma associated with mental health issues and treatment seeking	24
4.2.4 Lack of trust in the DVA ‘system’ of claims processing.....	25
4.2.5 Disconnect between information given at time of transition/discharge and perceived/actual time of needing information.....	26
4.2.6 Perceived and/or experienced lack of understanding from others about gender issues related to transitions (discharge and deployment).....	27
4.2.7 Perceived and/or experienced lack of understanding from others relating to maternal separation and parenting	28
4.3 Significant gaps in available and appropriate information, resources and DVA policies for female veterans.....	29
4.3.1 Lack of support services developed for or targeted to female veterans.....	29
4.3.2 Lack of resources to facilitate continuity of learned coping strategies.....	30
4.3.3 No resources, information or DVA policies relating to military sexual trauma.....	31
4.3.4 Lack of appropriate or available information on female specific issues, including maternal separation, reproductive and gynaecological health, domestic violence, lesbian, transgender, and same-sex attracted women, and military sexual trauma.....	32
4.4 Gaps in knowledge of female veterans that impact health and wellbeing and	

service provision.....	36
Limited understanding of trauma exposure experienced by veterans by their civilian and DVA service providers.....	33
4.4.1 Significant gaps in evaluation and best practice guidelines of health care provision for female veterans.....	33
5. Recommendations.....	35
5.1 Develop targeted support and resources for female veterans.....	35
5.2 Increase the visibility of experiences of and services for female veterans.....	35
5.3 Facilitate continuity of learned coping strategies post-discharge.....	36
5.4 Implement and evaluate family friendly practices.....	36
5.5 Provide training to civilian health care providers on issues for female veterans.....	36
5.6 Set a strategic research agenda for female veteran health.....	36
6. Conclusion	37

Tables

1. Percentage of women on Operations Slipper, Astute & Anode 2002-2011.....	4
2. Occupational categories for ADF women by number and percentage.....	5
3. Percentage of female veterans presenting to VVCS 2008-2011.....	A66
4. Presenting problems of female veterans 2008-2011.....	A66
5. VVCS support provided following intake assessment 2008-2011.....	A67
6. Marital status of female veterans presenting to VVCS 2008-2011.....	A67
7. Female veteran referral type.....	A68
8. Age of participants at time of interview.....	A74
9. Age at enlistment.....	A74
10. Relationship status.....	A74
11. Number of women by deployment and average length of deployment.....	19
12. Career duration.....	A75
13. Distribution of participants across services.....	A75
14. Years since discharge at time of interview.....	A75
15. Reserve service.....	A76
16. Overview of health issues attributed to service.....	21

Diagrams

1. Mapping empirical evidence to key findings.....	vii
2. Methodology overview.....	11
3. Theoretical framework.....	12

Appendix

1. Selected empirical data.....	A3
2. DVA data: Treatment population by conflict, card and sex.....	A64
3. Aggregate VVCS data.....	A66
4. Media.....	A70
5. Code list.....	A72
6. Demographics.....	A74

Executive summary

This report presents findings from a three year in depth study into the health and wellbeing of Australian female veterans.

Empirical research was collected through face-to-face interviews with 60 female veterans who had deployed from the Vietnam era onwards, including Vietnam, Rwanda, the Gulf War, Cambodia, Timor Leste, Bougainville, Solomon Islands, Iraq and Afghanistan. The sample were a heterogeneous group comprising women from Army, Airforce and Navy, soldier and officer categories, and a range of ages, ranks and lengths of service. A third of women in the study had deployed more than once, some up to four times. Women represented a range of occupational categories, including health, administration, communications, transport, logistics, signals, engineering, and intelligence.

Participants gave complex accounts of their experiences of deployment, broader military career and life since discharging from the ADF. This complexity has been summarised and translated into evidence for action to improve the health and wellbeing of all female veterans.

In addition interviews were conducted with 30 stakeholders in the health and care of female veterans, including staff from Veterans and Veterans families Counselling Service (VVCS), Veteran's Access Network (VAN) and Defence Community Organisation (DCO). This data contextualised and validated many of the themes that emerged in interviews with veterans.

This research found that overwhelmingly women highly valued their careers in the ADF, they enjoyed the opportunities afforded them and the close knit team environment. Despite significant structural barriers that impede some women's career progression (for example the lack of a sustainable model of part-time work), and the intensity of experiences their military career involved (deployment, maternal separation, belonging to a minority group), female veterans framed their experiences mostly positively.

Mental, physical and reproductive health and wellbeing issues that emerged as a result of operational deployment manifested in various ways, and opportunities to address them with timely and appropriate support and services were often limited.

The duality of the empowering and satisfactory elements of an ADF career superimposed upon inadequate health and wellbeing resources and resultant negative outcomes gives rise to an empowerment/disempowerment paradox: women were both empowered by their career and achievements and disempowered through a lack of appropriate resources and support.

Readjustment to life after the military is a common challenge for military personnel. For female veterans they face many ambiguities in relation to their gendered sense of self; as mothers, partners, carers, or forging a new professional identity in a more gender balanced workplace.

Another ambiguity exists in relation to women's veteran identity. As ADF personnel who have given much to their country and sacrificed much to serve on operational deployment, veteran status is something they should embrace. In contrast many distance themselves from this epithet. The implications of this are more than symbolic. Rather they manifest as barriers to accessing existing support services aimed at 'veterans'. This is then compounded when women do try to access services, only to find that they are limited, developed for a largely male clientele and incompatible with carer responsibilities. Seeking support and care from a more general civilian health care provider is also experienced as inadequate as a result of perceived limited understandings by practitioners of the experiences or needs of female veterans. The current state for female veterans is one that leads to potentially worsening health and wellbeing.

Findings in this report evidence that there are:

- 1. Significant barriers to accessing existing support services for female veterans**
- 2. Significant gaps in available and appropriate information, resources and DVA policies for female veterans**
- 3. Gaps in knowledge of female veterans that impact health and wellbeing and service provision**

Barriers to accessing existing services include:

- Lack of an authentic veteran identity
- Lack of trust in confidentiality of DVA/ADF funded services
- Stigma associated with mental health issues and treatment seeking
- Lack of trust in the DVA 'system' of claims processing
- Disconnect between information given at time of transition and perceived/actual time of needing this information
- Perceived and/or experienced lack of understanding from others about issues related to discharge or deployment
- Perceived and/or experienced lack of understanding from others about issues related to maternal separation and parenting

Significant gaps in available and appropriate information, resources and DVA policies for female veterans include:

- Perceived lack of support services developed for or targeted at female veterans
- Lack of resources for facilitating continuity of learned coping strategies
- No resources, information or DVA policies relating to military sexual trauma
- Lack of appropriate or available information on female specific issues, including: *maternal separation, reproductive and gynaecological health, domestic violence, lesbian, transgender and same sex attracted women, and military sexual trauma*

Gaps in knowledge of female veterans that impact health and wellbeing and service provision include:

- Perceived limited understanding of trauma exposure experienced by veterans by their civilian and DVA service providers
- Significant gaps in evaluation and best practice guidelines for health care provision for female veterans.

In addressing the above issues this report recommends:

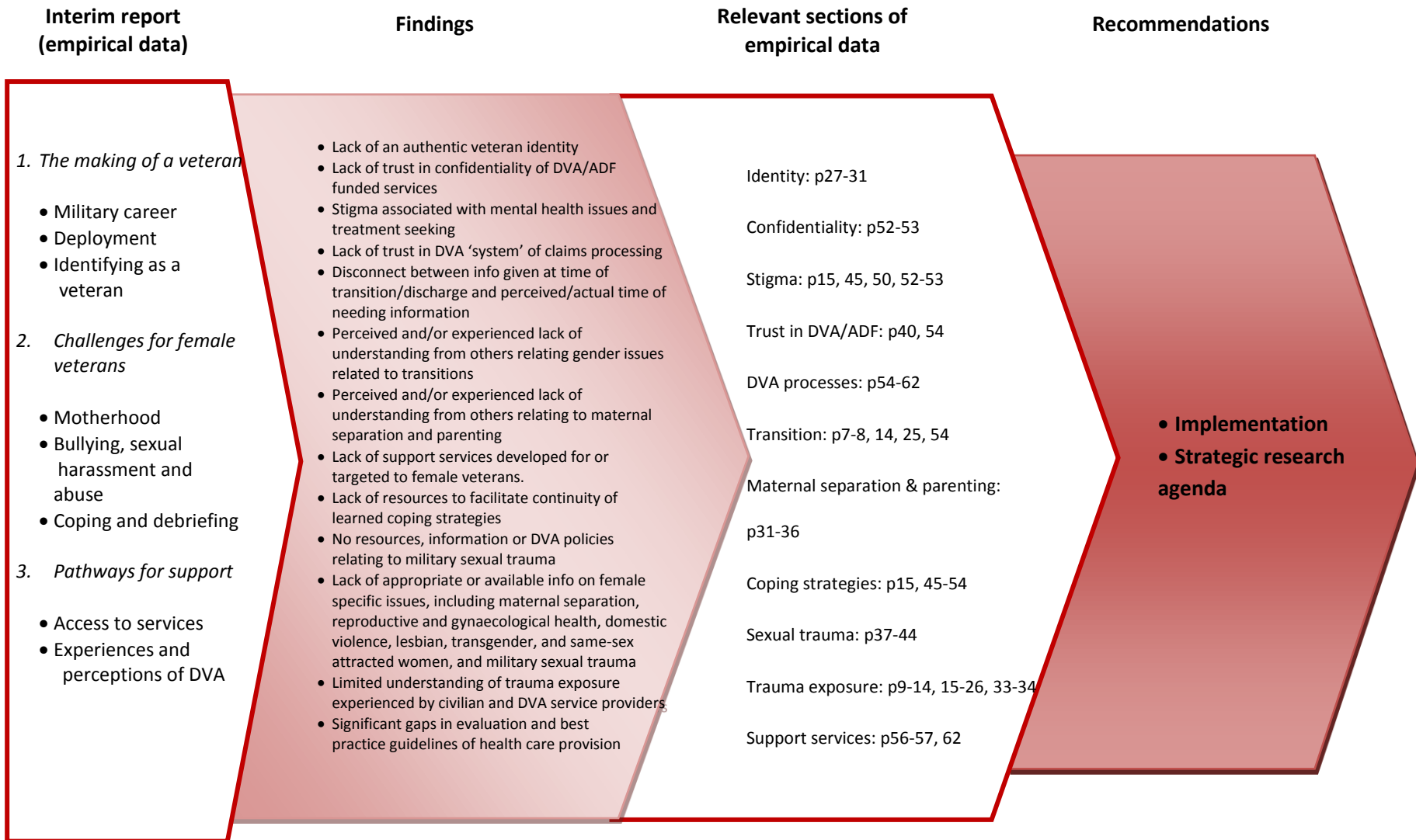
- 1. Developing targeted support and resources for female veterans**
- 2. Increasing the visibility of services for and experiences of female veterans**
- 3. Facilitating continuity of learned coping strategies post-discharge from the ADF**
- 4. Implementing and evaluating family friendly practices in DVA**
- 5. Providing training to civilian health care providers on issues for female veterans**
- 6. Developing best practice guidelines for the treatment of female veterans**
- 7. Setting a strategic research agenda on female veterans health**

Underlying the above findings and recommendations is the need for women to have access to self-directed strategies for both preventing and/or recovering from physical and mental health issues. These findings go to far more than issues of readjustment post-discharge, rather they highlight a critical need to adjust the health care delivery and support model for female veterans. In doing so the empowerment/disempowerment paradox may be reconciled, ultimately improving female veteran's health and wellbeing.

Empirical data

The interim report (December 2011) for this study presented to DVA a large, carefully edited, quantity of the qualitative data collected throughout the research project. This empirical evidence formed the basis of development of key findings and subsequent recommendations.

This empirical data has been further edited and included as Appendix 1. Diagram 1, below, maps this report's key findings to relevant sections of this qualitative data set.



PART A BACKGROUND AND METHODOLOGY

1. BACKGROUND

1.1 Introduction

This research project aimed to identify the experiences and effects of war service upon female Vietnam and contemporary veterans up to forty years after deployment. A veteran is defined by the Department of Veterans' Affairs as: "a current or former member of the ADF who has been on operational service"¹. The research contributes to theory and policy information regarding women's experiences of military service and their support needs as veterans.

This crosses the following Department of Veterans Affairs (DVA) research priorities:

1. Veterans physical and mental health needs: A wellness approach
2. Ageing issues for veterans and war widows

Broadly, the objectives of the research were to a) mobilise the experiences of a largely unknown group, and b) inform gaps in current DVA policy.

This study began with the intention of collecting data from the cohort of female Vietnam veterans registered on the *AIHW Vietnam Veterans and Civilian Health Register*² and evolved to include women who have served in every major and many minor operations since Vietnam. These include deployments to Vietnam, Rwanda, the Gulf War, Cambodia, The Solomon Islands, Bougainville, Timor Leste, Iraq and Afghanistan. More than a third of women in the study had deployed more than once.

As the project moved from a focus on Vietnam veterans to contemporary veterans as well, the decision to broaden the recruitment of participants beyond health personnel was also made. This enabled a more accurate reflection of the diversifying of women's occupational roles within the Australian Defence Force (ADF).

Throughout the duration of this project the roles and experiences of women in the ADF have become a topic receiving increased political and media attention. Debates about women's inclusion in front line combat, physical standards for women in various occupational roles, and highly publicised 'sex scandals' have focused attention in a limited way on how gender is constructed in the military. A result of much of this debate has been the recent suite of *Culture reviews* into the ADF, including a review into the treatment of women at the Australian Defence Force Academy (ADFA) and broader ADF³.

What is missing, and what this report aims to evidence, is the critical need to move beyond these debates to look at the impact of service, and deployment in particular, on female veteran's health and wellbeing.

This report is the culmination of three years of in-depth research into the lived experience of Australia's female veterans: Army, Navy, Airforce, soldiers, officers, mothers, partners, carers. The participants in the study were a heterogeneous group with often only two common variables: woman and veteran.

¹ http://www.dva.gov.au/serving_members/adf/Pages/debunking%20myths.aspx

² The Register is a record of Australian women who participated in the Vietnam War in various roles and contains information intended to be used as a basis for future health studies. Although the register is now closed it was operated by the AIHW on behalf of the Department of Veterans' Affairs. Further information can be found at: <http://www.aihw.gov.au/veterans-health>

³ <http://www.defence.gov.au/culturereviews/explained.htm>

The narratives collected evidence this heterogeneity and with it the inherent complexity. This can begin to be comprehended in interview transcripts, excerpts of which are included in the appendix of this report. For the purposes of the report this complexity has been summarised and translated into evidence for action to improve the health and wellbeing of all female veterans.

1.1.1 Knowledge based rationale

A morbidity survey of female Vietnam veterans in 1998⁴ found that female veterans are less likely than other Australian women of the same age to classify their overall health as excellent or very good, and more likely to report their health as good or fair (1998: 4). This gave weight to the hypothesis that the general health of female Vietnam veterans is worse than that of other Australian women of comparable age. However their view of their health was more positive than that of male veterans.

This raised a number of questions about gendered responses to service, the different roles men and women played, and the different support structures that were available on their return from service. Whilst considerable research efforts have explored these issues for male Vietnam veterans, similar studies for women are scarce. Additionally, despite the existence of literature capturing the experiences of US women who served in the Vietnam war, these do not necessarily translate to those of Australian female Vietnam veterans⁵.

The 1998 DVA *Morbidity of Vietnam Veterans* report found there were some conditions for which there was apparent statistically significant excess in female Vietnam veterans in comparison to the general Australian community⁶. This is reflected in the empirical data gathered in this study.

Of particular note in the 1998 DVA study was that PTSD did not appear to be excessive in female veterans. However, other psychiatric conditions, for example panic attacks, and depression, appear to be “significantly in excess” (1998: 5).

How these conditions affected the lives of the group, how much they attribute these conditions to their service, and how they have negotiated their health and wellbeing, was a focus of this study.

International research has shown that the newest generation of female veterans may face growing occupational challenges⁷ and unique threats to their mental health⁸. A review of the literature on the health and wellbeing of female veterans indicates the overall lack of research into recent female veterans⁹. Components of wellbeing that emerged in the review include ability to cope, access to services and support, satisfaction with parenting, the effects of sexual harassment, and symptoms of PTSD. Perceptions of wellbeing were both informed and challenged by women’s individual and collective identities, for example a professional identity, military identity, being a parent and being female.

⁴Commonwealth Department of Veterans’ Affairs (1998) *Morbidity of Vietnam Veterans: A study of the health of Australia’s Vietnam veteran community. Volume 2: Female Vietnam Veterans survey and community comparison outcomes*. Canberra: Department of Veterans’ Affairs.

⁵Fontana, Alan., Spoonster Schwartz, Linda., & Rosenheck, Robert. (1997) ‘Posttraumatic Stress Disorder among female Vietnam veterans: A causal model of etiology’, *American Journal of Public Health* Vol 87 (2): 169-175.

⁶For example, asthma, breast cancer, depression, eczema and dermatitis, gastric reflux, haemorrhoids, hearing and ear problems, hepatitis (A & B), ischaemic heart disease, live births with labour complications, malaria, overall total cancers, panic attacks, self-assessed rating of fair or poor health, and stillbirths.

⁷Smith, T. C., Jacobson, Isabel G., Smith, Besa., Hooper, Tomoko I., Ryan, Margaret A K., & For the Millennium Cohort Study, Team., (2007). "The occupational role of women in military service: validation of occupation and prevalence of exposures in the Millennium Cohort Study." *International Journal of Environmental Health Research*17(4): 271-284.

⁸Street, A. E., Vogt, Dawne., & Dutra, Lissa., (2009). "A new generation of women veterans: Stressors faced by women deployed to Iraq and Afghanistan." *Clinical Psychology Review*29: 685-694.

⁹Crompvoets, S (2011) “The health and wellbeing of female veterans: A review of the literature” *Journal of Military and Veterans Health*19 (2) p 25-31.

Findings in this report indicate that female veterans are a group who need health services that understand their unique physical, mental and reproductive health needs, with well informed and appropriately trained health care providers.

1.1.2 Policy based rationale

The increasing proportion of females that are war, peacemaker or peacekeeper veterans have instigated new questions about their health and wellbeing needs and use of healthcare services. This policy relevant research identifies gaps in services for these and future clients. Complimenting DVA's policy framework, this study has taken a wellness approach.

Comparing experiences of Vietnam and more recent veterans provides a unique opportunity to see what has changed, what has been done well by the ADF, DVA, and more broadly, society, and what can be improved upon for future integration and rehabilitation.

Recent DVA statistics indicate that 8,090 female veterans hold white/gold cards¹⁰, compared with 131, 826 male veterans¹¹. These numbers only represent those who have approached DVA with accepted claims, not the wider veteran community or those with claims being processed. Further details of treatment population by card, gender and conflict can be found in Appendix 2.

'Treatment population' is defined as those with treatment entitlement cards (Gold or White) including veterans or dependants. Entitlements for serving and former members of the ADF fall under four separate pieces of legislation that provide compensation, income support, rehabilitation and health care. They are:

- Veterans' Entitlements Act 1986 (VEA)
- Safety, Rehabilitation and Compensation Act 1988 (SRCA)
- Military Rehabilitation and Compensation Act 2004 (MRCA)
- Defence Act 1903 (DA).

The Act which applies when claiming for compensation, and therefore the benefits that may be received depend on:

- the date on which the injury or illness occurred (for SRCA, DA and MRCA purposes), or
- the period of service to which the injury or disease can be related (for VEA purposes).

For injury, disease or death related to service before 1 July 2004, applicants are likely to be covered under the SRCA or VEA. For injury, disease or death related to service on or after 1 July 2004, they will be covered under the MRCA¹². These various Acts are complex and which Act a claim is determined under can depend on: date of injury; date of clinical onset; date of enlistment and type of service. Persons may be eligible to submit claims under one or more Acts depending on their circumstances.

In 2012 female dependants (not veterans) receiving gold cards total 91,065¹³. Because statistics of female veterans and war widows are often conflated as one treatment population in DVA data, it is difficult to ascertain exact statistics on the female veteran population. What is known is that the number of females in the treatment population is projected to decrease along with the larger veteran population¹⁴. This is likely due to deaths of older card holders (eg WWII female veterans and

¹⁰ For more information on treatment cards go to:

http://www.dva.gov.au/service_providers/treatment_cards/Pages/index.aspx

¹¹ Table 6: Treatment population by conflict, card and sex, as at 30 March 2012 p15

<http://www.dva.gov.au/aboutDVA/Statistics/Documents/TpopMar2012.pdf>

¹² http://www.dva.gov.au/serving_members/adf/rehab_comp/Pages/which%20act.aspx

¹³ Ibid

¹⁴ Table 9: Treatment population trends - actual and projections as at 30 June p18

<http://www.dva.gov.au/aboutDVA/Statistics/Documents/TpopDMar2012.pdf>

dependants) over next ten years not outweighing the increase in numbers of contemporary female cardholders.

The number of contemporary female veterans can be approximated by looking at the number who have received the Australian Active Service Medal (AASM), introduced in 1988 to recognise service in prescribed warlike operations since 14 February 1975, or the Australian service Medal (ASM), which may be awarded for service in, or in connection with a prescribed non-warlike operation. Since 2006 1217 women have been awarded the AASM and 993 women have been awarded the ASM¹⁵. This indicates that more women have deployed to war like operations than non-war like during this time.

Women have contributed to a number of operations over the last decade, including Operations Slipper (Middle East Area of Operations), Astute (Timor), and Anode (Solomon Islands). In 2011 women comprised 10.2% (n = 1033) of the total personnel deployed across these three major operations. Table 1 indicates the contribution women have made on these deployments since 2002¹⁶.

Table 1. Percentage of women on Operations Slipper, Astute & Anode 2002-2011



More broadly, female veterans are not included as a sub group in the national women’s health agenda¹⁷ and are not represented in either the 1989 or 2010 National Women’s Health Policies¹⁸. Female veterans remain a largely invisible sub group of Australian women who have particular needs that need to be appropriately addressed.

1.2 Women in the Australian Defence Force

The percentage of women in the defence forces is increasing, with women comprising 13.8% of Australia’s Defence Force, 14.6% of the US military and 9.1% of the British Armed Forces.

Figures from late 2011 indicate that 8006 women make up 13.8% of the permanent full time ADF: 18.6% Navy, 10.1% Army, and 17% Airforce. Women hold 8.6% of the Colonel or equivalent and above ranks in the ADF¹⁹.

¹⁵

¹⁶ All deployment statistics provided to the author by Head Quarters Joint Operations Command (HQJOC), Department of Defence, Canberra.

¹⁷ See for example the Australian Women’s Health Network <http://www.awhn.org.au/> or http://www.whnsw.asn.au/AWHN/AWHN_Position_Paper.pdf

¹⁸ <http://www.health.gov.au/womenshealthpolicy>

¹⁹ <http://www.defence.gov.au/fr/RR/Womenindefence/History.html>

Women typically comprise the majority percentage of health and administration occupations (See Table 2).

Table 2 Occupations categories for ADF women by number and percentage²⁰

Occupation categories with highest number of women			
	ARMY	NAVY	RAAF
1	Ordnance corps n=847	Supply n=552	Clerical n=478
2	Transport corps n=395	Seaman n=394	Supply n=341
3	Medical corps n=325	Communications n=346	Support ops n=224
Occupation categories with highest percentage of women			
1	Dental corps 65.35%	Admin 100%	Dental 90.48%
2	Nursing corps 62.26%	Management exec 60.61%	Clerical 70.50%
3	Psychology corps 50.81%	Health services NS 56.73%	Medical 63.08% (includes nurses)

Recent changes to historical restrictions on female employment in some ADF occupations, means that future selection for all positions in the ADF will be based on the ability to do the job rather than gender²¹. Despite this one major structural barrier hindering women's participation remains: the lack of a true permanent part-time employment option beyond the current inadequate part-time leave without pay (PTLWOP) workaround scheme that carries many structural and cultural barriers to optimal utilisation.

A provision in the *Defence Act 1903* provides that members of the Permanent ADF component are bound to render continuous full-time military service²². The implications of this provision are that Defence is unable to offer a true part-time scheme that allows for job sharing, in a way that is familiar to civilian workforces.

PTLWOP was introduced in 1996 as an alternative to seeking legislative amendment of the *Defence Act 1903* to enable a form of part-time service for Permanent personnel. It is available to Permanent members only, has low uptake due to strong cultural resistance arguably underpinned by the structural barriers to job sharing to PTLWOP and is an expensive option for the ADF as full time conditions of service are still paid. PTLWOP is viewed as a temporary arrangement in an otherwise full-time military career and as such there is an expectation that it will be a short-term arrangement. In addition there is a stigma associated with PTLWOP and the potential for those seeking it to be viewed as unprofessional or uncommitted to their Service.

The recent Reserve Reform Survey indicates that only 1% of Permanent Navy, 2% of the Permanent Army and 2% of Permanent Air Force are currently working on a PTLWOP arrangement²³. In contrast women represent 46% of the current Australian labour market, and of those women, 43% work part time²⁴.

²⁰ Australian Defence Force (2011). *PMKeys Reporting 14 January 2011*. ADF HR Reporting and Analysis, Data provided to the author.

²¹ <http://www.defence.gov.au/fr/RR/Womenindefence/Roles.html>

²² Defence Act 1903 <http://www.comlaw.gov.au/Details/C2005C00217>

²³ Unpublished findings from this survey provided to the author by Cadet, Reserve, & Employment Support Division, Department of Defence, Canberra, March 2012.

²⁴ ABS Labour Force September 2011

The implications of this current legislative barrier are that many women faced with the dual challenges of career and family commitments only have a binary option to either separate from the permanent ADF (and possibly join the reserve component) or stay engaged on a full-time basis. As a result many women exit their military careers prematurely, leading to a number of negative outcomes for women that this report evidences.

1.3 Women and Veteran and Veterans Families Counselling Service (VVCS)

The VVCS – Veterans and Veterans Families Counselling Service - provides counselling and group programs to Australian veterans, peacekeepers and their families. It is promoted as a specialised, free and confidential Australia-wide service.

VVCS is DVA's only direct service delivery arm.

VVCS staff are qualified psychologists or social workers with experience in working with veterans, peacekeepers and their families. They provide a range of treatments and programs for war and service-related mental health conditions including post traumatic stress disorder (PTSD)²⁵.

The VVCS has evolved over the years, expanding the range of services it offers and opening its door to not only Vietnam veterans and their families, but those involved in more recent conflicts and peace operations.

Those eligible for VVCS service now include:

- ALL Australian veterans of all conflicts and peacekeeping operations
- Partners, ex-partners and dependent children of veterans/peacekeepers with issues arising from the veteran's service
- Sons and daughters (regardless of age) of Vietnam veterans with issues relating to their parent's service.

In 2000 the Department of Veterans' Affairs signed a Memorandum of Understanding with the Australian Defence Force, enabling eligible ADF members to access VVCS services and programs. This MoU was reviewed and re-signed in 2008 as an Agreement for Services.

In 2007 the Vietnam Veterans Counselling Service was renamed VVCS – Veterans and Veterans Families Counselling Service: "ensuring the benefits of the service founded by Vietnam veterans are shared with all Australian veterans and their families, now and into the future"²⁶

1.3.1 Uptake of VVCS by female veterans²⁷

Between 2008 and 2011, 1440 female veterans presented nationally to the VVCS. During this time the number of women presenting annually to VVCS has almost doubled, from 244 in 2008 to 492 in 2011 (see Table 3 Appendix 3).

According to VVCS intake data the average age of female veterans at the time of intake over the four years was 40.3 years. This represents a weak downwards trend in age at date of presentation (significant at $p < 0.05$), which matches the general trend in the veteran population seeking assistance through VVCS (see Table 3 Appendix 3).

²⁵ http://www.dva.gov.au/health_and_wellbeing/health_programs/vvcs/pages/index.aspx

²⁶ "History of the VVCS." from http://www.dva.gov.au/health_and_wellbeing/health_programs/vvcs/background/Pages/history.aspx

²⁷ VVCS Aggregate Data: Female Veterans (2008-2011) for this section of the report was generously collated and provided by VVCS.

The major presenting problems were:

1. Relationship problems (25%)
2. Depression (22%)
3. Anxiety (16%)
4. Health and wellness²⁸ (14%)
5. Family relationship issues (12%)
6. Military discharge (8.5%)

There were some changes in presenting problem over each year (see Table 4 Appendix 3). The pattern observed over the period of electronic data collection suggests an increase in relationships, health and wellness, discharge from the military and information seeking as presenting problems over the 4 years. Over the same period there was a decrease in female veterans presenting with depression, and PTSD.

There has also been a pattern of change over time in the intervention requested (see Table 5 Appendix 3). This data suggests that there is an increase in the percentage and number of female veterans seeking Group Programs and/or family counselling. There is a decrease in the percentage of female veterans who are seeking individual counselling, but an increase in the numbers seeking this type of intervention, from 172 in 2008 to 258 in 2011. This pattern is statistically significant at $p < 0.001$. This data is relevant to the findings in this report as participants indicated a desire for group programs tailored to women rather than participating in male dominated groups.

There is also a pattern of change in the marital status of female veterans presenting to the VVCS though this is less statistically significant ($p < 0.01$) (see Table 6 Appendix 3). This data suggests that female veterans who have more recently sought assistance from the VVCS are more likely to be in a defacto relationship and more likely to be married. They are also less likely to not have their marital status recorded.

The data shows a general trend toward self referrals, from Defence or medical referrals by female veterans over the 4 years (see Table 7 Appendix 3).

The aggregate data from VVCS presented here reflects a number of issues that emerged in interviews with women in this study. Family and relationship problems, mental health issues, and other general health issues not clearly defined, for example, poor fitness, and discharge from service were common problems identified by women.

Women comprise only a small percentage of veterans accessing the available services. Findings in this report contextualise some of the barriers to more women accessing VVCS and emphasise the critical gap in service provision and accessibility for female veterans.

²⁸Health and wellness is defined by VVCS as general health and lifestyle issues for example obesity, smoking, poor fitness, that do not relate to a specific medical condition.

2. Methodology

2.1 Introduction

Qualitative research is social research in which the researcher relies on text data rather than numerical data, analyses those data in their textual form rather than converting them to numbers for analysis, aims to understand the meaning of human action²⁹, and asks open questions about phenomena as they occur in context rather than setting out to test predetermined hypotheses.

Previous quantitative studies into the veteran population have yielded results that deemed the female proportion of the sample too small to allow statistically significant results. The comparatively small number of female veterans and the exploratory nature of this project therefore lent itself to a qualitative methodology.

A qualitative research framework founded on epistemology, methodology and method³⁰ was developed to explore the following research questions:

- What are the experiences of Australian female veterans?
- How do women define their experiences?
- How have women negotiated challenges to career, family, gender and identity?
- How did their sense of self impact health and wellbeing?
- What are the barriers and enablers to seeking support?

Diagram 2 overviews the methodological process.

2.2 Sample size

Small scale interview based research is intentionally conceptually generative. It is the nature of exploratory studies to indicate rather than conclude. That is, such studies formulate propositions rather than set out to verify them³¹.

Interview based studies are a labour intensive method of research whereby the researcher is completely immersed in the field collecting data until 'saturation' is reached. Saturation is the point at which no new concepts, themes, issues or problems are emerging from respondents.

The question of sample size is important because the use of samples that are larger than needed is an ethical issue (because they waste research funds and participants' time) and the use of samples that are smaller than needed is both an ethical and a scientific issue (because it may not be informative to use samples so small that results reflect idiosyncratic data and are thus not transferable)³².

Estimating the number of participants in a study required to reach saturation depends on the quality of data, scope of the study, nature of the topic, amount of useful information obtained from each participant, the use of shadowed data (participant's reflections on others experiences), and the study design used. A sample size between 30-60 is generally accepted as optimal for rich, valid qualitative data³³.

²⁹ Schwandt, T. A. (2001). *Dictionary of qualitative inquiry* (2nd ed.). Thousand Oaks, CA: Sage.

³⁰ For an overview of the relationship between epistemology, methodology and method see: Carter, Stacy M., and Little, Miles (2007) 'Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research' *Qualitative Health Research* Vol 17 No 10 pp1316-1328.

³¹ Crouch, M. & McKenzie, H (2006) 'The logic of small samples in interview-based qualitative research' *Social Science Information* Vol 45 No 4 p483-499

³² Francis et al (2010) 'What is an adequate sample size?' Operationalising data saturation for theory-based interview studies' *Psychology & Health* Vol 25 No 10 p 1229-1245

³³ Morse, Janice M (2000) 'Determining sample size' *Qualitative Health Research* Vol 10 No 3 pp3-5

This study had a sample size of 60, although ‘saturation’ was reached after about 40 interviews. Given the importance of validity for this study another 20 were conducted, and in addition to this 30 interviews with stakeholders in female veterans’ health.

In terms of a qualitative research project 90 interviews is considered substantial for what is needed for validity. Particularly given that the data was high quality (in depth, focused, rich) and almost all interviews contained useful information. Much of this was the result of the effort employed by the researcher to travel to the homes of participants where they were comfortable, under no time pressure, and were often incredibly appreciative of the effort made. The interviewer travelled to each state and territory multiple times, driving up to five hours from the nearest airport to reach some interviewees. Many were located rurally, and some remotely, for example western NSW, far North Queensland and inland Western Australia.

Many women mentioned never having participated in research studies before and of the ones that had a high number stated they had previously not given anywhere near the amount of information they had compared to in our face-to-face interview.

2.3 Recruitment

Information for participants was sent out to a range of ex-service organisations, nursing organisations, and military medicine organisations³⁴. Emails and or/letters were sent to heads and secretaries of these organisations asking for the information to be disseminated amongst relevant members and/or included on their website or newsletters.

In addition a media release was sent out from ANU which resulted in a number of national radio interviews (mostly via the ABC) and articles in national newspapers (for example *The Sydney Morning Herald*, *The Australian*, *The Age*)³⁵.

In excess of 100 women eligible to be in the study contacted the researcher wanting to participate. Of these 60 were interviewed. These were chosen on the basis of diversity of experiences: deployment, occupation, and service.

AIHW Vietnam Veterans and Civilian Health Register

Of the 96 letters sent out to women on the AIHW register, 37 responded positively wanting to be involved. 7 responded with explicit requests not to be involved, and three going as far as asking to be removed from the AIHW register. 13 were returned to sender.

Stakeholders

Interviews with stakeholders were gained with assistance and approval from DVA. They were from a range of service providers in a number of regional centres and major cities.

2.4 Narratives

In-depth face-to-face interviews were conducted with 60 Australian female veterans who had deployed from the Vietnam era onwards. Interviews were framed by a schedule of open-ended questions designed to elicit women’s experiences of their military career, including expectations, deployment and discharge, their perceptions of the impact of service on their health, wellbeing and selfhood, and barriers and enablers to accessing appropriate healthcare and support.

The interviews were in-depth conversations that lasted between two and five hours, were primarily conducted in participant’s homes, and were dependent on the researcher building rapport and trust with the interviewee. All interviews were tape recorded and transcribed verbatim. For some women

³⁴ Australian Enrolled Nurse Association, Australian Nursing federation, Peacekeepers Association Airforce Association, Navy Association, State and Territory RSL Branches, Young diggers association Australian Medical Corps, 1st Australian Field Hospital Association, Australian Military Medical Association

³⁵ Many of these were articles were variations on an AAP article, see Appendix 4.

this was the first time they had spoken to anyone about some of their military experiences, the challenges they had faced and the ongoing difficulties they were now confronted with.

In addition to the interview, many participants shared with the researcher their photos, log books, personal diaries, letters sent home while on deployment, letters sent from their children, and other memorabilia. On some occasions the researcher was also able to meet and informally speak with the participant's partner, children and grandchildren.

Following the interview many women sent the researcher lengthy emails, adding to their stories, or sending further information deemed relevant to their narrative³⁶.

2.5 Validation

Given the relatively small sample size for this study validating the data was a critical component of the research methodology. Following completion of interviews with female veterans 30 interviews with stakeholders in veteran health and wellbeing were conducted. Stakeholders included staff from Veterans and Veteran's families Counselling Service (VVCS), Veteran's Access Network (VAN)³⁷ and Defence Community Organisation (DCO) from a number of locations in Australia, representatives from veterans associations, and women's health workers. These conversations validated the issues that emerged in the initial interviews, particularly in relation to barriers to accessing services.

The stakeholders interviewed were social workers, psychologists, counsellors (VVCS and DCO), and public servants (VAN). Each was able to draw upon their experiences working with female veterans and describe typical presentations, common issues, and barriers to service provision. These interviews were powerful in that they often drew upon years of experience to give context to and validation of the issues that emerged in interviews with women veterans. Some of the psychologists in particular also had military career experience.

During the data collection phase the researcher received formal structured debriefing with a qualified psychologist to reflect on and process the stories that both veterans and stakeholders described.

Of note is that the Principal Investigator was also involved in other Defence and DVA funded research projects during the course of this study. In doing so she framed a deep understanding and respect for ADF culture and values and impact of service on all military personnel³⁸.

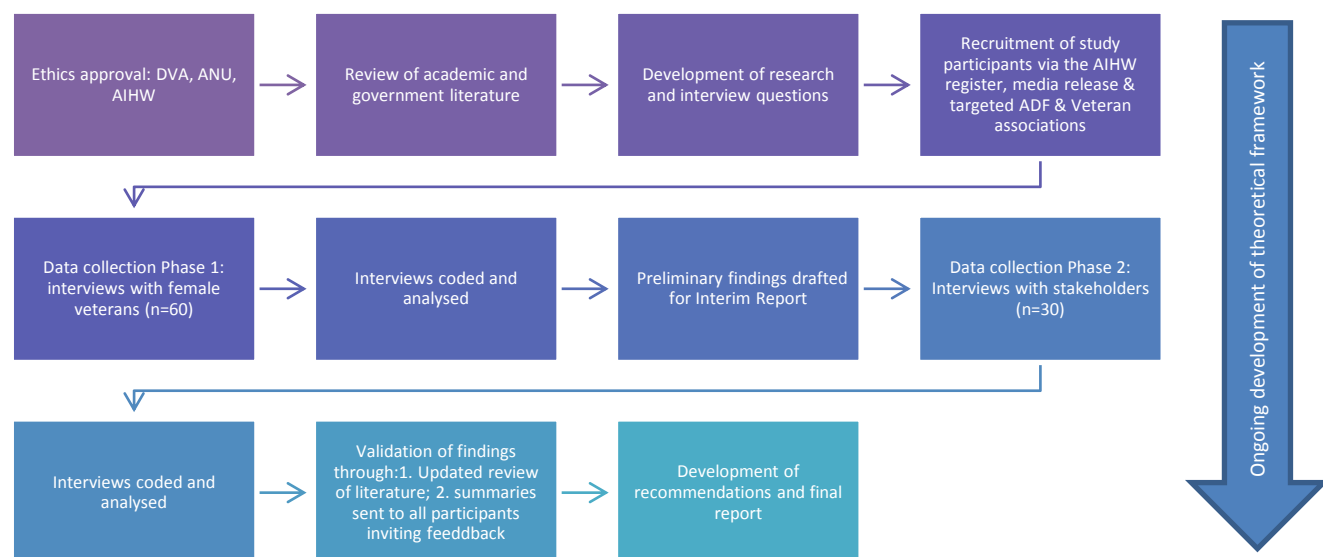
A final phase of validation involved feeding back to participants the findings from the study to ensure that what they had described to the interviewer was accurately reflected. The importance of including participants in this way cannot be underestimated and is an ethical responsibility of research³⁹.

³⁶ For example, some women sent the researcher confidential reports into investigations of misconduct where they were the victim, confidential medical files, and outcomes of DVA assessments.

³⁷ VAN offices are the first point of contact for veterans engaging with DVA.

³⁸ Other projects (ongoing) include examining the health and wellbeing of ADF Reserves and components of the Strategic Reform Program.

³⁹ Of note is that in the recruitment process with the Vietnam cohort some women responded to their invitations to participate declining and indicating they had felt disappointed when involved in previous studies as they never received any feedback following the interview.

Diagram 2. Methodology overview

2.6 Analysis of data

Interviews transcripts were uploaded into a qualitative software program, Atlas Ti. The interviewer made an initial list of themes that emerged in the interviews, which became the 'code list' (see appendix 3). Four research assistants were engaged to then 'code' these interviews which involved line by line categorisation of themes, concepts and demographics. Each interview generated on average approximately 45 pages of text, with a total output in excess of 3000 pages of textual interview data. Each interview was read and coded by a minimum of two people to ensure consistency of coding and interpretation of the data.

2.6.1 Theoretical framework

A theoretical framework to interpret the complexity of the data was developed using ethnographic and phenomenological approaches. Ethnography uses techniques of interviews and observation to better understand the framework of a culture, in this case military culture, and explores the relationships between structures and the actions, meanings and interactions of individuals and groups.

Empirical phenomenological research returns to experience in order to obtain comprehensive descriptions. These descriptions then provide the basis for a reflective structural analysis to portray the essences of the experience. First the original data is comprised of 'naïve' descriptions obtained through open-ended questions and dialogue. Then the researcher describes the structure of the experience based on reflection and interpretation of the research participant's story. The aim is to determine what the experience means for the people who have had the experience⁴⁰.

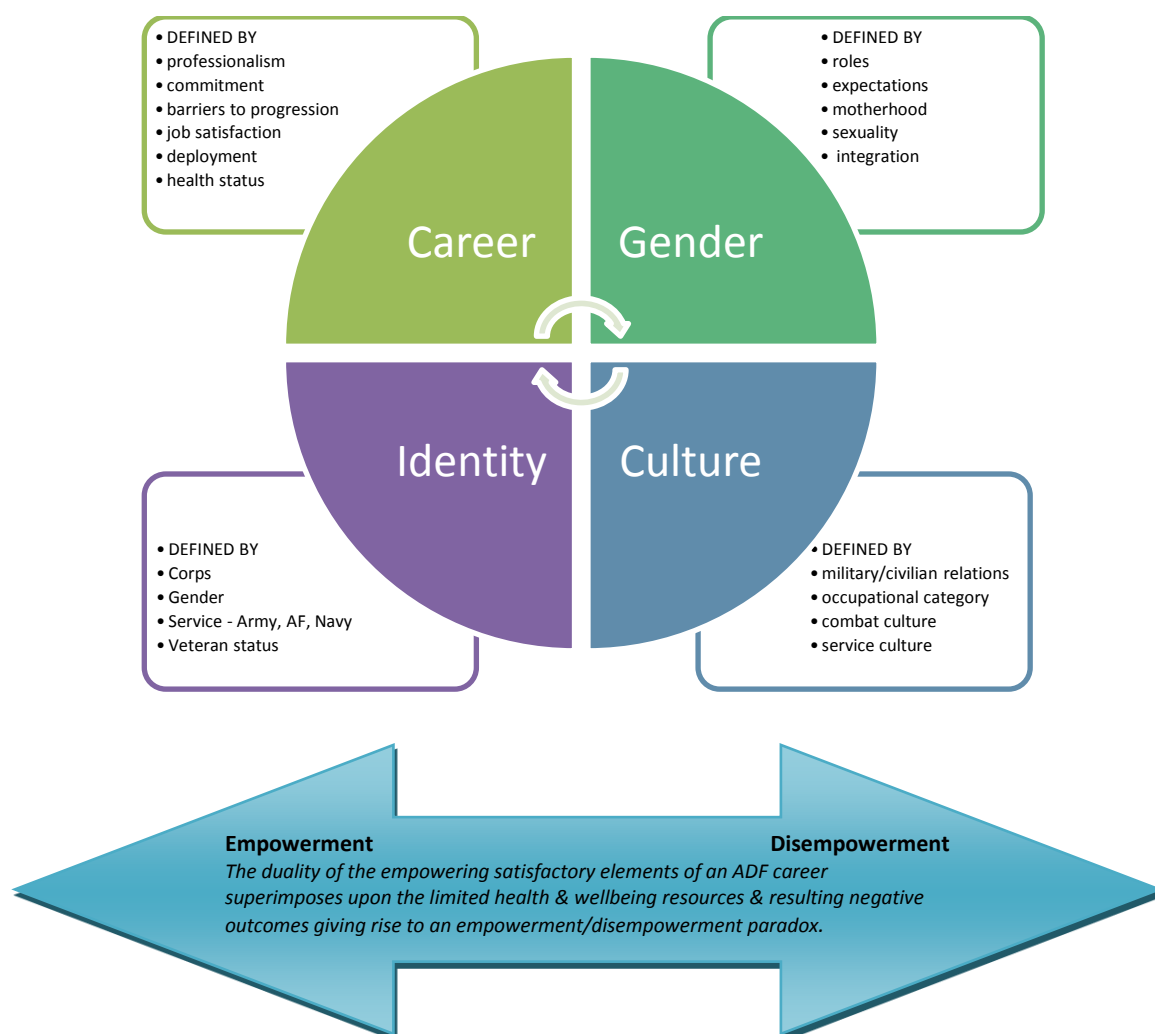
Four key components of experience that impacted female veterans' health and wellbeing emerged. These were career, gender, identity and culture. These were defined by various overlapping and sometime contradictory variables (see Diagram 3). The relationship between these variables emerged as achievements, tensions and challenges in women's experiences. How women negotiated these tensions greatly informed their sense of self and perceived and experienced control (agency) over many of these components impacted their health and wellbeing.

⁴⁰ For an overview of qualitative research methods and concepts see Grbich, Carol (1999) *Qualitative Research in Health: An Introduction*. Allen & Unwin, Sydney.

These tensions emerged in women’s narratives as discourses of risk, agency, resilience, grief and loss, trauma, belonging, commitment, recognition, family, transitions, relationships, femininity and masculinity. How empowered or disempowered women felt in relation to their career, gender, identity and organisation’s culture significantly impacted their health and wellbeing.

Health and wellbeing issues that emerged as a result of operational deployment manifested in various ways and opportunities to address them with timely and appropriate support and services were often limited. As a result a paradox emerged where women were both empowered by their career and achievements and disempowered through a lack of appropriate resources and support to address health and wellbeing needs.

Diagram 3. Theoretical framework



Readjustment to life after the military is a common challenge for military personnel. For female veterans they face many ambiguities in relation to their gendered sense of self; as mothers, partners, carers, or forging a new professional identity in a more gender balanced workplace.

Another ambiguity exists in relation to women’s veteran identity. As ADF personnel who have given much to their country and sacrificed much to serve on operational deployment, veteran status is something they should embrace. In contrast many distance themselves from this epithet. The implications of this are more than symbolic. Rather they manifest as barriers to accessing existing support services aimed at ‘veterans’. This is then compounded when women do try to access

services, only to find that they are limited, developed for a largely male clientele and incompatible with carer responsibilities. Seeking support and care from a more general civilian health care provider is also experienced as inadequate as a result of perceived limited understandings by practitioners of the experiences or needs of female veterans. The current state for female veterans is one that leads to potentially worsening health and wellbeing.

The complexities described above are a constant in the interviews conducted for this study. Below are a selection of quotes from the empirical data that begin to illustrate some of these issues⁴¹.

All names and any other identifying information have been removed. To protect anonymity deployments have been conflated to the following:

- *Vietnam* (including Butterworth and Malaysia, Singapore)
- *Africa* (Including Western Sahara, Rwanda, Congo)
- *Peacekeeping* (East Timor, Bougainville, Solomon Islands, Cambodia, Christmas Island)
- *Middle East* (including Iraq, Afghanistan, Gulf war)

Occupations have also been conflated to:

- Nurse
- Medic
- Doctor (including surgeon, dentist, anaesthetist)
- Allied health (including dental nurse, physio, psychologist)
- Other medical (including Red Cross)
- Other occupations (including clerical, transport, logistics, signals, mechanic, chef, communications)

2.6.2 Reflections on career

Vietnam, Airforce, nurse, 65

It was just a fantastic opportunity. Even the nursing was certainly part of the best nursing I'd ever done, and most satisfying.

Multiple deployments including Middle East and peacekeeping, Navy, other occupation, 29

I miss the job security, I miss the pay, I do miss the mateship and I guess at the end of the day if you've done a good job well, there's an achievement there, you know I've done my job and done it well.

Peacekeeping, Navy, medic, 43

I loved it, and I say I loved it, because there was some crappy times then too, but you don't remember those times, you know. And there were so many good times. But like I said, I had got to the point where I'd done everything I could. I left on a good... I left before I became bitter and hated it. So I was lucky to get out when I did, I think.

And I just appreciated... I appreciated everything I did while I was in there. It was a great career.

2.6.3 Reflections on deployment

Vietnam, Army, nurse, 78

We had terrible, terrible wounds but one of the things that really hit me was sort of the independence of these guys even as badly wounded as they were...these guys were wheeling each other around in wheelchairs hanging onto their own drip in one hand and pushing them with the other and they were minus legs or one leg and an arm and they were walking around.

⁴¹ A more comprehensive selection of empirical data can be found in Appendix 1.

...Here they were trying to get that little bit out of life that was there to be had. It was just, oh I don't know, it was you know a time in my life that you probably won't forget but at the same time you can't really.

Vietnam, Airforce, nurse, 69

At the time I found it traumatic that the aircraft I was involved in was the very first model of the Hercules, C130A model. We had no toilet facilities and our, of course there were a couple of females on the aircraft...You had a... something set up on the ramp for you to use behind a curtain sort of thing and of course the body bags and that were just behind you so when you went to the toilet you had to, you know...You were baring your bum to those...that's always remained very raw...

As nurses you'd become hardened as you do, lacking in not necessarily empathy but certainly sympathy I think to that extent, just hardened... You can write these things off but that's one thing I've never sort of been able to...to write off.

Multiple deployments, including Africa and peacekeeping, Army, other occupation, 43

You stepped out of there [the base] and you had all your light ammunition and your night vision on and all the rest of it. You didn't know what you were going to come up against and that was all extremely exciting. ... it was exciting because you train to do your job and you were doing your job to the nth degree.

Interviewer: Were you anxious about going?

Respondent: No I was, you know, really ready well and truly. No, I wasn't anxious, I knew that, you know, that we were taking weapons, I was with the infantry. In fact I was really, this might sound funny to you, I was proud, I couldn't wait to be serving with the infantry and supporting them and thinking my god, what a... what an honour, what a role to be, to have had your name put up from the [...] squadron to go down, to have done some training with the infantry [...] platoon and then have them say, yep we're more than happy. 'Cause that's a big thing for them to actually take a female into there, you know, their domain.

For this participant her final deployment was cut short because of an injury that occurred in country.

I am so totally, totally disappointed ...I'll never get over the fact that I had my army career taken away from me because I had wanted it so bad. I hate it when I see people getting deployed overseas. I think God I wish I was there. I mean I really do, it's such a loss.. I...wish I was still wearing a uniform, Yeah.

Peacekeeping, Army, other occupation, 40

Interviewer: So when you got there, when you arrived in [country] did you feel prepared?

Respondent: Oh yeah, in my heart and soul I was. Yeah. I went... the first day you get in country you go for a range shoot to get you squared away, make sure you're safe, did great at that. I was ready. This was it - everything I've ever wanted. So it's the pride, it's the integrity; it's the whole reason why you join the Army, to do those things. But it was also a very hard time for me. I was very isolated really, I was the only woman.

Peacekeeping, Navy, medic, 43

The first day, we had a little toddler come in, and I think maybe now he'd have drowned, or Malaria... whatever happened, end up passed away. And [some] people were devastated. They were just so upset, and walking around upset. And I was too. And I remember going to the bar that night, and the doctor was there, and I was there with the other Able Seaman, and he said, 'Oh, you're not upset by any of this, are you [name]?' He goes, 'I can't understand why they're upset. What did they think was going to happen when they came here?'

And so straight away I just went no, God no, I'm not upset. And it just kicked in there, like just don't let him see you're upset, even if you're upset. It was just, yeah bravado - I don't know what it was, but you just think in a way he's right, but that's pretty harsh too. Like, you know...

There was lots of people dying all the time over there, you know, and I'd never seen a dead person before until I got there. So it was... there's part of you that just kicks in and says just don't let them see it. Just get on with it, and don't let them see, 'cause that's the done thing. It's that harden up sort of perspective, where you don't let them see it.

Multiple deployments including Africa, peacekeeping and the Middle East, Army and Airforce, nurse, 46

It made me grow up very quickly, very, very quickly. I felt very naive, very young, and I was always... I was very much a country girl. I learnt a lot from my hubby but when you leave for a war zone...you have to be your own person, you have to be independent and not rely on anyone. I came back very different, very changed. I didn't realise... I came back and I realised that I was different. And the fact that I was very independent but hard, you know not as soft as I was.

We had a brief from one of the psychs about what to expect as in the trauma, the injuries. Back then they thought it was a good thing to be actually debriefed every time you had a trauma. And it became really annoying and they...

Interviewer: What do you mean like every time you saw...?

Respondent: Like every time we had... we had a Resus [resuscitation] bay in there, we had Resus's coming in day in and day out so we were put on Resus every day. So we had people blown up, machete, a lot of mine accidents. So the nurses would always take the airways, we would always be at the head of the patient.

I thought I had done enough talking because every goddam Resus or someone that got killed we had to always talk about. In the end there was just too many people that had been injured or killed. So we just said, "Look enough, enough we don't want to talk as a group". So we found our way of debriefing by having a drink or meeting with the Infantry boys or going for a run or whatever. And that was our way but obviously it wasn't enough I suppose.

In the following quote this veteran is showing and describing a photo from her deployment to the interviewer:

This little girl was found face down. She had been shot through the nose and no-one claimed her. And eventually through bush telegraph an uncle found her and she was re-united because her family got shot and killed. She was lovely. She was with us for Christmas. She was about six or seven and we had a little blue jumpsuit on.

Interviewer: She lived?

Respondent: Yeah she lived. This is what it was like, it looked a bit serious but this is what it was like. When we got mortared we had to don our Kevlar helmet and jacket and do our work. ER it was OK because those orange mattresses you could pull down and we would treat them on the ground. Because people are attached to ventilators we had to actually... it was quite unsafe for us. We would work in these, and sometimes air conditioning wasn't working well and we would be up to 50 degree heat working in this up to about four hours. Great weight loss!

2.6.4 Reflections on motherhood

Multiple peacekeeping, Army, nurse, 40

I didn't want to come back [to work]. I had six months off for each baby I would have preferred twelve or maybe a part-time option to come back, but I've always just done the... I breast-fed my first boy until he was two and my second boy until he was three... [he] was two when I deployed ... for six months that was really hard. He was just starting to talk at that age.

...I actually weaned him the day I got on the plane. So I gave him his last feed and I knew that was going to be the last feed. And I'm telling him this is your last feed now. I was in tears. I was a mess. It was hard. What I did as well I walked out of the house in the morning, like really, really early so everyone was still asleep.

Interviewer: Oh my goodness. How do you prepare yourself for that?

Respondent: You just do it.

Interviewer: Did you think if you couldn't cope you would come back?

Respondent: I never thought of that I just knew that I would do it. And I was excited, I mean I'm going into... it was a new job, it was on the land, it was meeting locals. It was a chance for me to get a medal which has always been one of my personal goals. I want to be able to sit my grandchildren on me knee and go, "Look I've got some medals". This was my one chance for a medal and if I don't get any more in the future I don't care, but it was one of my personal goals.

Interviewer: What was it like coming back after six months?

Respondent: It was good. Well, it was hard...I knew that [my son] might not be that attached to me, and I expected that. You know if he was hurt and mum and dad were there I didn't get upset if he went to dad, because it is like hey I haven't been there for six months I get it. But yeah he's come around now, but it's taken awhile to get over it.

Multiple deployment including peacekeeping and Middle East, Army, Medic, 38

My daughter was nine months old when I went over, so I was a bit peeved with it all. But again, you do what you do. My daughter was actually... she really didn't cope at all. She was just learning... like she was starting to talk and she developed a stutter, and actually towards the end she just completely shut down and wouldn't talk. And it was separation anxiety.

When we had our big welcome home parade, the day I put my Cams on, she started stuttering once again. And I thought it just affects a lot more people than you actually realise...It's the whole family that's affected, it's not just the individual who deploys.

Multiple deployments including Africa, peacekeeping and the Middle East, Army and Airforce, nurse, 46

Back then they didn't have any part time option so I had to go back to work after six weeks [postpartum], it really was not nice.

Interviewer: And how old was your oldest son?

Respondent: He was about two. Yeah it was all moving really fast, so I just skedaddled over to [deployment].

Interviewer: So how long after the birth did you go to [deployment]?

Respondent: [My baby] died in September on father's day, he was 8 days old, and I left October or something like that I think. I don't know. I can't remember now.

This veteran goes on to describe some of the challenges whilst on her deployment, including the trauma of having to care for a number of local women delivering stillborn babies.

Interviewer: That story... I mean that's... how did you cope, or try and cope? How did you...?

Respondent: I guess I didn't really handle that. I'm talking very... I've learnt over the years how to talk very superficial, but deep down it affects me. But you know I was going through a lot too with my own child, coming to grips and grieving as well.

Peacekeeping, Army, other occupation, 40

Well this is what happened, because initially one of the Captains put me on the list because I had a truck driving licence, I had all my qualifications, I was mature age, I had my baby sorted because she was only two then, and I was prepared to send her back down to Brisbane to be with my mum I went to DCO to find out what support there was - there's none. Basically it's your issue, you deal with it.

...Anyway I ended up getting appendicitis and then they sent me home, wouldn't let my partner come home to support me when I had three children under five...and that afternoon I took tablets and overdosed, and the next thing you know was in hospital.

You know, at the time I thought I was frigging Superwoman - you know, I could take on the world, and I could get through anything. But eventually it just wore me down, and I broke. You know, putting up with it for like ten years now, it was like I'm losing everything - everything I've put my entire life into I'm losing.

If I was given a choice to be here or go to Afghanistan and be on the frontline, I'd go in a heartbeat. I would. If they asked me to come back tomorrow, I'd go in a heartbeat. And I know that sounds stupid after the way I've been treated, but that's all I know.

2.6.5 Reflections on seeking help

Multiple deployments including Africa, peacekeeping and the Middle East, Army and Airforce, nurse, 46

So after [my last deployment] I had eight weeks off and I still didn't feel any better. I was fatigued and I was so tired still and that tiredness lasted for about year and half. I thought yeah I'm getting sleep and all of this but it was just amazing, I felt like an old woman.

Then one day I just thought, "Oh god I need help", and the psych department was downstairs at [workplace]. I was very embarrassed when I walked down there because I knew the people down there. I just said, "Oh I need to talk to someone". ... From then on I have been seeing the psych. I was still in denial.

Interviewer: So 20 years after your first deployment?

Respondent: Yes! But still thinking I'm alright. Then they gave me these pamphlets saying I think you have got PTSD. No, no this is not me I am a nurse I treat everyone else who has got PTSD. But yeah I guess it just got worse.

...I couldn't sleep, dreamt a lot, very, very jumpy. I still am jumpy now. I have to sit in an area where I can see people coming because I wanted to be in control. Very much like that still now.

...I was just getting more and more down, getting more depressed and a little bit suicidal and I was just not coping. I was always waking up at 2.00 o'clock in the morning, could not watch TV you know anything that had to do with

Afghanistan or Iraq. I avoided talking about anything about that place unless I spoke to the people that I've been with. I have all these books that I am going to read but I read a chapter and put them down.

Anyway I took some time off. I was at home. I was like a housewife and I'm not used to being a housewife, just a career woman all the time. Then I went back and I thought, "Oh my gosh!" I had no desire to actually... even though I wanted to go back. But as soon as I was in my uniform I was like I don't want to do this, I don't want to do this anymore. I was just like get me out of here. I went to see my doctor and he was an old school doctor. He wasn't any help at all. He says, "No you will get over it". He said, "If we ask you to deploy you will deploy again". Oh like far out. I said, "You are not hearing me I cannot..."

Interviewer: This is a doctor in the Military?

Respondent: A doctor in the Military. He was a doctor that I got on well with, so well I used to work with him. He even set me up with someone when I was single. Yeah and then I thought, "Oh my god I can't believe this reaction". It took so much for me to go and say look I am not coping, I don't think I can do this anymore. It was such a big decision for me. So I went to another doctor, the one who used to be the CO who let me go over to [deployment]. He was so good and he understood me. And he sent me off to the psychologist and psych. From then on the ball got rolling. Then the reports came back from the psych saying, "If she does another deployment then she will lose it". So all of this went through in a medical report down to Canberra. They made a decision and they said, "Because she is not deployable she can't deploy, and it is detrimental to her health". And basically they were very blunt, they said, "We've got no job for her to do in service and she is not suitable for service life".

Interviewer: How did you find that?

Respondent: It was a bit blunt but that was what I was expecting I suppose... But you know what it's amazing since getting out that you realise that there's not a lot of support for female veterans. I've noticed through... you know VVCS?

Interviewer: Yeah.

Respondent: They have been really good too. But there's so many things out there for Vietnam Vets or male veterans. And a lot of these courses are written for men. I said, "What about women? I'm a young veteran"... I think even the community the wider community has to understand too that when you show your gold card or you say that you are a veteran, they've got to be sort of up with the times as well. Because a lot of them think that a veteran is an older person, not a young person.

2.6.6 Reflections from stakeholders

Veteran health care provider A

I suppose in my own client load that I have at... have had since being here, I've had quite a few women, a number with deployment, some without who have been medically referred, but I've had a significant number who are identified as Veterans under our eligibility. Some of the biggest issues that I see are very much reconnecting with family... in terms of attachment and bonding, in terms of that reintegration into the family systems, that's a bit of a challenge for some of them as well as trying to deal with, like our male Veterans, not necessarily PTSD, but obviously the trauma of having been in a war zone, having been deployed, seeing what they've seen and then having to really repress it. So our male Veterans often, because it's a male thing not to seek help, "My doctor referred me, I had to come and see you, I've been told I've got PTSD and I need to deal with it or my wife's going to leave me blah, blah, blah", whereas women just kind of get to that point where everything kind of just falls in a heap. They phone us and by then it's to the point where often they're in the high risk category, or medium to high risk category of wanting to hurt themselves, or self-harming in some capacity, whether it's drinking or cutting or something, that's quite discrete that people don't necessarily know, but it's used as an outlet for their frustrations.

Veteran health care provider B

I think people lose sight of their core beliefs and values because they have become so regimented to a structure, such as Defence, and some of the women I've worked with have gotten out and been quite shell shocked, but also they've gone to look for other work and their... the way they've been, I don't know, restructured in a sense, doesn't fit with the civilian world either.

So it's finding... it's a sense of... and it does happen for men, I mean I've worked with men in exactly the same position, but I think for women, because they've had to sacrifice so much of what I would call their authentic self and their core beliefs and values because of their patriotic beliefs, or that part of the belief system that fits with the Military because they've sacrificed a lot of that, they leave the Military and they lose their self. They lose that authentic sense of self in "Who am I, what do I want to do?" and "Yes I might be a mum for now, but what other career options do I have?"

Sometimes too with childbirth comes issues around postnatal depression, and that's something that manifests itself. I've got two women at the moment who are at high risk of postnatal depression from their veteran status and being deployed, and just pushing everything down because they've decided "Yep it's time to become a mum, my biological clock's ticking" but the partner's still in, the partner's deployed and this woman has to keep a lid on absolutely everything.

Veteran health care provider C

I have a degree of I suppose a level as a practitioner of feeling quite uncomfortable saying to a female veteran "We've got a PTSD program but 90% of them are going to be males". That's doesn't... that's not necessarily conducive because the experience of war is very different, or can be very different, especially if you're not necessarily in a recognised combat role, but you're still deployed and you're still over there doing a job. It doesn't matter if you go over as a cook, you can still be having to pick up a weapon at some stage and protect yourself, or people around you.

PART B DEMOGRAPHICS

3. Demographics of female veteran participants

Of the 60 women interviewed, 33 were Army (including three Red Cross workers deployed with the Army during Vietnam), 19 RAAF, and eight Navy. Participants were located across all States and territories, in both rural and urban locations. A total of 27 women served during the Vietnam era and 33 were contemporary veterans (see Table 11).

The age of participants ranged from 26 to 72, with the majority of Vietnam veterans in the 60-69 age range and majority of contemporary veterans in the 40-49 age range. Nearly half of the interviewees had enlisted between the ages of 20-24.

Half of the participants were married or in a relationship at the time of interview, six were single and the remaining were divorced, separated or widowed. 41 had partners in the ADF or who were ex-ADF.

37 participants had children. 15 of these participants had been deployed while they had children (all under the age of 15), with the youngest being nine months old.

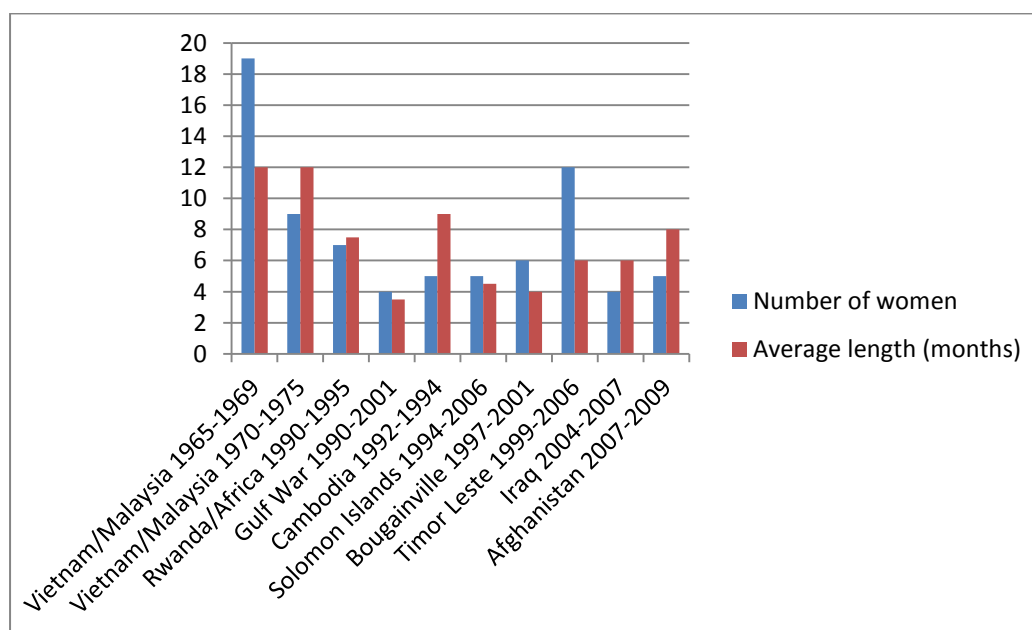
Because of the small sample size and need to protect participants' anonymity, a detailed breakdown of occupations has not been included in this report. Broadly, women in this study occupied the following roles: nurse, medic, Doctor (including surgeon, dentist, anaesthetist), Allied health (including dental nurse, psychologist and others), other medical (including Red Cross), other occupations (including clerical, transport, logistics, signals, mechanic, chef, communications, intelligence)

Women in the Vietnam cohort were mostly nurses whilst contemporary veterans comprised a range of roles. Women had careers that spanned 2 years to 20+ years. 22 women interviewed had discharged less than five years prior to interview, and older veterans up to 30 years since separating from the ADF. More than a third of participants had served in the Reserves.

Age on deployment ranged from 18 through to 40 years of age.

Further details of demographics can be found in Appendix 5.

Table 11. Number of women by deployment and average length of deployment



*This table includes women who deployed multiple times giving a total 76 deployments

PART C FINDINGS AND RECOMMENDATIONS

4. FINDINGS

4.1 Introduction

The findings from this study have been categorised into three broad areas:

- 1. *Barriers to accessing existing services for female veterans***
- 2. *Significant gaps in available and appropriate information, resources and DVA policies for female veterans***
- 3. *Gaps in knowledge of female veterans that impact health and wellbeing and service provision***

Each finding is numbered and is followed by a synopsis of evidence and implications. Participants in this study described and attributed a range of physical, mental and reproductive health issues to their service (see table 16). Those listed represent those most commonly described by age group.

When undiagnosed or belatedly treated, both physical and reproductive health issues contributed to poor mental health outcomes. Reproductive health issues were rarely, if ever, described as forming the basis of seeking assistance from DVA, although many women expressed a desire to.

A large proportion of women in the study had mental health issues that were undiagnosed and/or untreated. Many of these women were at a crisis point, and expressed isolation, vulnerability and an uncertainty about who they could turn to.

There were a large number of women in this study who had experienced significant, repeated exposure to trauma, for example on one or multiple deployments. In various ways women expressed needing to have these experiences validated. There was a need to be listened to, understood, and helped to make sense of their experiences and their reactions to them. Although many veterans expressed similar struggles in dealing with issues relating to trauma stemming from deployment, discharge, maternal separation, or abuse or harassment, and subsequent impaired mental health issues, they all felt alone in needing help. Women in this study who displayed significant trauma associated with service overwhelmingly had not received any help or support since leaving the military.

The message from participants in this study was that there were no services that existed that could help them address their needs. There was both limited knowledge of what services did exist, and an assumption that support, such as that offered by VVCS, was inappropriate and inaccessible (i.e. developed for males).

These findings indicate that female veterans are not receiving appropriate and necessary treatment and support, potentially leading to worsening health outcomes.

Validation

The method of validation of the issues female veterans raised, namely interviews with health care workers and other DVA personnel, legitimated these findings as pervasive rather than isolated.

Table 16: Overview of common health issues attributable to service by age group and deployment

Age group	Mental health	Physical health	Reproductive health
20 - 29 PEACEKEEPING, MIDDLE EAST	Agoraphobia Depression PTSD Sexual trauma (rape) Sexual trauma (relating to harassment) Trauma from bullying	Anorexia Back injury Chronic fatigue Syndrome Glandular fever Hip problems Knee problems Severe arthritis	Nil
30-39 PEACEKEEPING; MIDDLE EAST	Attempted suicide Depression Nervous breakdown PTSD Sexual trauma	Back injury Chronic headaches Fibromyalgia Hearing loss Irritable Bowel Syndrome Knee Injury	Nil
40-49 AFRICA; MIDDLE EAST; PEACEKEEPING	Anxiety Depression PTSD	Back injury Hearing loss Hip problems Irritable Bowel Syndrome Knee problems	Birth and labour complications Miscarriage
50-59 VIETNAM; MIDDLE EAST; PEACEKEEPING	Anxiety PTSD Sexual trauma (rape) Stress	Back injury Knee problems Stroke	Birth defects Infertility Multiple miscarriages Stillbirth
60-69 VIETNAM	Anxiety Depression Isolation Nervousness Nightmares PTSD Stress	Alcoholism Arthritis Back injury Cardiac arrhythmia Chronic Urinary Tract Infections Crohn's disease Dermatitis Diverticular disease Glaucoma Haemorrhoids Hearing loss Knee injury/ replacement Multiple cancers Renal nephropathy Severe Bowel problems Thyroid cancer Tumor Ulcers	Birth defects Endometriosis Multiple miscarriages Multiple specified and unspecified gynaecological problems
70+ VIETNAM	Depression Flashbacks and nightmares PTSD	Arthritis Back injury Bowel problems Breast Cancer Diabetes Hearing Loss Knee problems Leukemia Pelvic inflammatory disease Shoulder reconstruction Skin cancer Ulcer	Birth defects Endometriosis Fibroid Cysts Hysterectomy at early age Infertility Multiple miscarriages

4.1.1 OVERVIEW OF KEY FINDINGS

Barriers to accessing existing services for female veterans

1. Lack of an authentic veteran identity
2. Lack of trust in confidentiality of DVA/ADF funded services
3. Stigma associated with mental health issues and treatment seeking
4. Lack of trust in the DVA 'system' of claims processing
5. Disconnect between information given at time of transition and perceived/actual time of needing this information
6. Perceived and/or experienced lack of understanding from others about issues related to discharge or deployment
7. Perceived and/or experienced lack of understanding from others about issues related to maternal separation and parenting

Significant gaps in available and appropriate information, resources and DVA policies for female veterans

8. Perceived lack of support services developed for or targeted at female veterans
9. Lack of resources for facilitating continuity of learned coping strategies
10. No resources, information or DVA policies relating to military sexual trauma
11. Lack of appropriate or available information on female specific issues, including: *maternal separation, reproductive and gynaecological health, domestic violence, lesbian, transgender and same sex attracted women, and military sexual trauma*

Gaps in knowledge of female veterans that impact health and wellbeing and service provision

12. Perceived limited understanding of trauma exposure experienced by their civilian and DVA service providers
13. Significant gaps in evaluation and best practice guidelines of health care provision for female veterans in Australia

4.2 Barriers to accessing existing services for female veterans

4.2.1 Finding 1: Lack of an authentic veteran identity

Synopsis of evidence

Despite active service, multiple deployments, and combat like roles invariably women did not identify themselves as being veterans. An *authentic* veteran was male, older and likely to have served in Vietnam or a combat role. Findings from this study suggest that this is a barrier to women accessing appropriate health and support services aimed at ‘veterans’.

The women who did identify as veterans were more like to have pursued a successful claim through DVA. Being ‘accepted’ by DVA brings with it not only financial and medical benefits, but legitimate status as someone who has served their country. It can become a significant factor in legitimising the experiences of the veteran. In the absence of this legitimisation women often describe feeling devalued, rejected, isolated, and displaced.

This was an issue for women across all ages and deployment cohorts and regardless of occupational group or service type.

Retirement was a time when some women began to feel more like a veteran. Retirement often brought with it more opportunities to associate with the local RSL or become a DVA advocate – assisting others to get their DVA claims written up and processed. These kinds of activities appear to facilitate status as a veteran in the veteran community.

Perceptions women had included:

- DVA as ‘geared toward’ men
- VVCS as a service for their partner (if their partner was a veteran)
- The DVA claims process as devaluing, and deeply symbolic of their inauthentic veteran status.

Women described a lack of authentic veteran identity being reinforced through:

- Repeated questioning by civilian (often medical admin) and/or DVA staff over ownership of their gold/white card.
- DVA legislation that didn’t accommodate a range of women’s health issues
- Lack of understanding by Veteran’s Access Network (VAN) staff about health issues for female veterans, particularly
 - veterans as mothers
 - issue concerning sexual health/violence
- Lack of knowledge of issues for female veterans by DVA advocates
- Lack of VVCS support focused at women in particular
- Lack of acknowledgment or understanding in the broader community of the existence and experiences of female veterans

Implications

- Reluctance of female veterans to access DVA services, including VVCS
- Limited motivation to look at DVA website or resources that might be available
- Reluctance to make a DVA claim for fear that the process will be degrading and humiliating
- Worsening mental and physical health due to delayed treatment seeking
- Feelings of isolation that lead to negative mental health outcomes

4.2.2 Finding 2. Lack of trust in the confidentiality of DVA/ADF funded support services

Synopsis of evidence

A tradition of associating ill health disclosure with potentially compromising deployability has led to some veterans being suspicious of lines of reporting from DVA/VVCS back to the ADF. Similarly there was a level of suspicion of the relationship between VVCS and DVA and the potential for future eligibility for entitlements to be compromised.

Although there is a high level of confidentiality at VVCS this was not well known within the participants of this study, across both Vietnam and contemporary veterans.

Some women felt 'burnt' by breaches of confidentiality while serving and this informed a mistrust of ADF/DVA health care providers. Many younger veterans for example described widespread knowledge and gossip about their own and their peers contraceptive use, pregnancy, abortion, STDs, and attempts to access civilian GPs while serving.

There was a commonly held perception that there is an agenda by DVA to *not* pay compensation, and that a doctor or psychologist who was employed/paid by DVA would share this agenda.

A large number of women in this study described a tension in accessing either Defence-related or civilian health care and support services. Some women felt strongly that they did not want any association with any military related support, namely VVCS, however at the same time were distressed that civilian health care providers had limited understanding of the Defence Force and issues for female veterans. This created a perceived gap in service provision.

During data collection for this project the researcher was alerted to one group that had formed to attempt to fill this gap. In 2011 this group ran a 'retreat' for victims of military sexual and other trauma. It was facilitated by 'professionals' with dubious qualifications and as far as the researcher is aware there was no follow up for participants. This service signals a potential risk for female veterans who are vulnerable and searching for alternatives for what is currently offered. There was risk that such services could be more damaging than they are helpful and signal an alarming need for development of appropriate, professional and adequately evaluated services⁴².

Implications

- Women reluctant to access DVA/ADF services
- Delayed treatment seeking
- Deteriorating mental health in already vulnerable women
- Participation in potentially damaging 'alternative' therapies

4.2.3 Finding 3. Stigma associated with mental health issues and treatment seeking

Synopsis of evidence

It is commonly understood that there is a stigma attached to mental illness in the ADF⁴³. Whilst still serving, disclosure of mental health issues can have a very real impact on future deployment opportunities, tantamount to stalling or ending ones military career. Within the military mental illness is perceived to be a symptom of weakness and individual agency. Women in this study

⁴² At the invitation of the group convener the researcher was invited to attend this retreat. 8 self selected women attended, who had varying degrees of mild to severe trauma related to childhood and military sexual and other abuse. The retreat was facilitated by a 'visionary life coach' and a hypnotist and was run over 5 days. This was an alarming example of alternatives to professional and appropriately designed and funded services for women veterans.

⁴³ See Dunt, D (2009) Review of Mental Health Care in the ADF and Transition to Discharge: p 93.
<http://www.defence.gov.au/health/DMH/Review.htm>

described being conditioned to ignore and ‘get on with it’. Amongst study participants there was particular stigma associated with PTSD, which is commonly constructed as a label signifying inability to cope.

For other women going to DVA for help goes against the resilient ‘hardened’ self they worked so hard to achieve while in the Defence Force. As a result they do not wish to access DVA and their services as it signifies ‘not coping’.

The majority of older veterans in this study were nurses. These women identified strongly with their profession and the identity of a nurse as resilient, stoic and looking after others before themselves. Many described being consumed by their work as a mechanism of coping. Retirement was either a response to, or catalyst for, poor mental health in some of the women in the Vietnam cohort. For a number of the women who were married to Vietnam veterans, PTSD was a diagnosis they associated with their partner. Many women in this group had also been diagnosed with PTSD related to their time in Vietnam, however much later than their partners - for some up to 40 years after deployment.

Overwhelmingly women did not know what services were available to them regarding mental health support, or what they might need in the future. This was further complicated if mental health issues stemmed from sexual harassment or abuse or bullying.

Women in this study described mental health issues (including PTSD) manifesting in

- Substance abuse
- Self harm
- Suicidal thoughts/attempts
- Depression
- Anxiety
- Unexplained anger
- Nightmares and sleep disturbance

For some women this further resulted in:

- Relationship breakdown
- Unemployment
- Social isolation
- Difficulty with parenting responsibilities
- Homelessness

Implications

- Reluctance to access VVCS or civilian support services
- Limited ability to recognise mental health issues and seek help
- Significant trauma not addressed, leading to deteriorating mental health
- Severely delayed treatment seeking, often until they are at crisis point (for example suicidal thoughts/attempts, relationship breakdown, self harm)

4.2.4 Finding 4. Lack of trust in the DVA ‘system’ of claims processing

Synopsis of evidence

For a number of women in this study the experience of DVA assessment of a claim is a lengthy, exhausting process most commonly described as a ‘fight’ for recognition. It is characterised as having a lack of transparency, being geared toward male health issues, sexist, and lacking understanding of military culture.

The ‘fight’ for DVA benefits goes beyond financial and medical entitlements. The findings from this study suggest that the process of being recognised by DVA is also about being granted legitimate status as ‘veteran’; and has a significant impact on a veteran’s sense of self and therefore wellbeing. When a claim is ‘knocked back’ it can mean feeling devalued, isolated, rejected, and can lead to questioning the commitment they gave to the ADF.

There is widespread perpetuation of myths and stories of DVA claims processes that emphasise them as gendered: ‘geared towards men’. In addition there was widespread concern of embarrassment and humiliation if female specific issues, for example gynaecological or sexual health, were mentioned.

Women described a lack of resources as they waited up to two years or more for assessments to be finalised by DVA, during which time they struggled financially and with ill health. This was a particular struggle for those who were unemployed, single or had young children. This was a time in which many women described their life being ‘on hold’ because of the lengthy DVA processes.

There was perceived and experienced re-traumatisation through the DVA system of assessment. For many women whose health and wellbeing was already compromised the potential trauma associated with collating ‘evidence’ for mental issues, particularly related to sexual harassment, abuse or bullying, was expressed as ‘not worth the risk’.

Many participants in this study described attempting to claim a pension or acquire a white card for issues that they perceived would ‘get through’ the DVA claims process rather than presenting the actual cause of their suffering. This was most common with mental health issues related to sexual trauma or bullying, or gynaecological or reproductive health. Women felt DVA advocates were ill equipped to give them the guidance they needed on these issues.

Implications

- Lack of reliable data on the issues women are experiencing rather than what they are presenting to DVA with
- Failed claims applications potentially leading to poor and worsening mental health
- Risk of retraumatising the victim through DVA assessment process
- Gap in support from time of application until actual outcome of assessment.

4.2.5 Finding 5. Disconnect between information given at time of transition and perceived/actual time of needing this information

Synopsis of evidence

The findings from this study indicate that there are several barriers to women accessing appropriate health and support services in a timely way, if at all. Lack of knowledge about what is available, lack of trust in the confidentiality of services accessed while they are still in the ADF, lack of trust of DVA appointed or approved medical practitioners, and difficulties with DVA assessment processes and claims decisions mean that at present there are significant gaps in service provision for female veterans.

Whilst information about services are routinely given to veterans at discharge there was a disconnect between time it is received and actual time at which it is perceived or actually needed. There was a widespread mistaken assumption that DVA would ‘reach out’ to veterans at some time after they exited the military.

During interviews for this study younger veterans were commonly surprised to learn that DVA did not have their details.

Post-discharge DVA do not provide direct services, with the exception of VVCS, since responsibility for Repatriation Hospitals has been transferred to state public hospital systems⁴⁴. DVA is rather the funder of a range of services and benefits. DVA does not therefore initiate contact with former members but waits for them to do this.

Women often felt they were unique in not being contacted by DVA and that this reinforced that they perhaps weren't 'really a veteran'.

In addition mothers in particular described the VVCS run 'Stepping out' program as having nothing that addressed issues for them.

Implications

- Delayed information and treatment seeking
- Risk that women may 'fall through the gaps' as they mistakenly wait for DVA to make contact

4.2.6 Finding 6. Perceived and/or experienced lack of understanding from others about gender issues related to transitions (discharge or deployment)

Synopsis of evidence

There are two key transition phases that women, like all veterans, experience. Firstly transitioning home after deployment and secondly transitioning out of the military.

Challenges for women when transitioning related to deployment included:

- Lack of support for husband/partner at home
- Lack of preparation for deployment regarding leaving children
- Difficulty knowing how to deal with children's separation anxiety
- Difficulty reasserting place as a mother in the family environment on return from deployment
- Difficulty reconnecting emotionally with their children on return from deployment

Women in this study also described challenges resulting from

- Perception that there was a lack of understanding from ADF/DVA about caring for a partner with PTSD
- Perception that there is no knowledge of the roles of women in the ADF or what they are exposed to (for example trauma).
- Perception that there is no understanding from ADF/DVA that women may have a dual parenting/professional role
- Difficulties with career structure and inflexible work arrangements

These stressors posed challenges for women long after they had returned home from deployment, and were often only fully realised after military discharge. At this time women often felt unsure of their role in the family, felt isolated, and found it difficult to make sense of the sacrifices they had made for their military career. Out of the military context women described 'coming undone' as they tried to juggle the demands of a family and adjustment to civilian life.

These issues commonly manifested in:

- Feelings of isolation; not belonging to either military or civilian worlds
- Feeling disconnected from network of still serving friends

⁴⁴ For a comprehensive description and further information see Dunt, D (2009) Review of Mental Health Care in the ADF and Transition to Discharge: p 117. <http://www.defence.gov.au/health/DMH/Review.htm>

- Dealing with emotional and psychological issues that surface once out of the defence context
- Challenges to feelings of self worth
- Anger that DVA wasn't 'looking out' for them following discharge (even though the individual hadn't made any contact with DVA)
- Relationship and family breakdown

Implications

- Deteriorating mental health as women try to cope with family responsibilities and new civilian life
- Confusion about role of DVA support
- Feelings of isolation and abandonment by ADF and DVA leading to poor mental health

4.2.7 Finding 7. Perceived and/or experienced lack of understanding from others about issues related to maternal separation and parenting

Synopsis of evidence

Changes in the 1960s and 1970s to restrictions on women having to exit the military when they got married or fell pregnant means that for contemporary veterans it is not unusual to be deployed leaving a young family at home.

Women in this study spoke about this as a particular challenge. Some of the issues raised included difficulties dealing with sick, starving, injured or neglected children while on deployment. In addition the logistics of organising care for children, particularly for single mothers, was a feat in itself, and women described little support or assistance from the ADF. Communicating regularly with their children while deployed was frequently mentioned as a way to cope. Many mothers were unsure how to prepare themselves or their children prior to deployment or integrate back in to the family on return.

Women in the study who did not have children were aware of some of the difficulties that mothers face. For some it was cited as a reason for leaving their military career earlier than they would have liked in order to start a family. This then led to resentment and challenges to their professional and personal identity. A combined military career and family was described as not compatible with military culture, evidenced in the lack of flexible employment models, and experienced as a significant barrier to career progression.

Women commonly mentioned:

- A lack of understanding from DVA or ADF regarding the pressures of children starting school, and lack of understanding that some women may have the multiple roles of mother, veteran and carer to a veteran partner.
- That women's role within the family system was not acknowledged or incorporated into DVA and VVCS policy and practices.
- A lack of knowledge and resources about issues for single parents.
- A lack of information and resources available on how to cope with separation anxiety in children (an issue that can extend beyond the length of deployment).
- Civilian healthcare providers had limited understanding of military or deployment experiences of women, particularly mothers
- A lack of resources on parenting skills
- A lack of accessible and affordable childcare

Implications

- Lack of childcare is a significant barrier to accessing support services, for example VVCS programs.
- Lack of family friendly spaces is a barrier to accessing services
- Lack of preparedness for deployment can negatively impact mental health of mothers and children beyond deployment time.
- Limited skills in parenting or readjusting to parenting role post deployment or discharge impacts mental health
- Perceptions of a ‘forced’ discharge due to family responsibilities can lead resentment and isolation, which in turn leads to poor mental health.

4.3 Significant gaps in available and appropriate information, resources and DVA policies for female veterans

4.3.1 Finding 8: Perceived lack of support services developed for or targeted at female veterans

Synopsis of evidence

There was overwhelming consensus amongst research participants that DVA was an organisation that only accommodated the needs of males, in particular older males.

According to women in this study, this was evidenced by:

- A lack of female DVA advocates
- Male advocates with little or no knowledge of issues for female veterans.
- A perception that support for women was targeted at war widows. Overwhelmingly, female veterans indicated not wanting to be ‘lumped together’ with war widows.
- DVA policies that did not accommodate women’s health issues

It is important to note that it was widely acknowledged that gender was not necessarily unifying variable amongst women veterans. Women may have more in common with their campaign, service, occupational group, or corps, rather than simply their gender. However a desire for the option of female support groups was repeatedly explicitly expressed.

Ageing

Older veterans described there being no support or information available for coping with retirement, death of a partner, or major surgery. Also that there was no link with DVA provided at these critical life stages.

The Vietnam cohort suggested in particular:

- The need for cancer support groups for military women
- More support for single or widowed older women, either individually or group based.

Younger female veterans

Younger veterans commonly described feeling that DVA provided ‘nothing for me’. They described needing services that were tailored to females on issues such as:

- Mothering
- Sexual trauma
- Sleep problems
- PTSD

They also described a need for younger advocates who understood their experiences.

It was also acknowledged that issues for women of all ages who were classed as Totally and Permanently Incapacitated (TPI) were not well understood or catered for.

Implications:

- A lack of services targeted at women reinforced a sense of not belonging to the veteran community.
- There was a reluctance to participate in male dominated support groups
- Perception that DVA and VVCS were for male veterans only

4.3.2 Finding 9: Lack of resources for facilitating continuity of learned coping strategies

Synopsis of evidence

The women interviewed in this study used various notions of resilience to characterise how they coped during deployment and in their military career more broadly. For nurses, it is the stoicism instilled in them by their profession that they credit for enabling them to cope with their work.

Women in other occupations highlighted the need to have ‘thick skin’ and commonly used the term ‘harden up’ to describe how to adapt and succeed in an intense deployment environment and in the ADF more generally.

How one ‘copes’ is often difficult to articulate, and according to many ‘it just happens’. Being resilient - characterised as showing little emotion and being able to ‘get on with it’ - are all characteristics that women prided themselves in. These signified being a ‘good’ nurse or a ‘good’ soldier/officer.

Strategies for coping and perceptions of resilience are developed during a military career and are often challenged when the veteran transitions out of the ADF. This occurs in two ways

- Lack of continuity in learned methods of coping
- Reluctance to access mental health care services and support

For Vietnam era women it was nurse training and experience, the support of colleagues, sharing the experiences with others, and their upbringing that enabled them to ‘get on with it’ and do their job. Also drinking, informal chatting, smoking, using black humour and, for some women, their faith. However there was often an acknowledgment that at some point in time some of the challenges they had been confronted with would need to be addressed, for example through counselling.

For women more recently in the ADF coping was achieved in one dominant way: exercise. Nearly all contemporary veterans interviewed emphasise the importance of exercise for them being able to cope. This was a way to alleviate boredom, blow off steam, and keep fit.

Many women spoke of being in their peak physical fitness during their military career and exercise as a key learned strategy of coping in intense and stressful times. For many women, transitioning out of the military often meant opportunity to do regular exercise was significantly diminished.

While VVCS offer exercise programs these are geared towards heart health and older veterans.

Capacity to do exercise was restricted by:

- Taking on a more full time carer/parenting role
- Juggling full time work and parenting
- Being unable to afford a gym membership
- Difficulty getting child care
- Finding it hard to prioritise with other competing demands

Implications:

- Weight gain and poor self esteem
- Feelings of not coping and negative impact on mental health
- Poorer physical health
- Increasing pressure to ‘cope’ yet limited resources to do it.

4.3.3 Finding 10: No resources, information, or DVA policies relating to military sexual trauma⁴⁵

Synopsis of evidence

Like other organisations in Australia, and like other male dominated professions, sexual harassment and sexual abuse occur in the Australian Defence Force. Recent figures show that there are approximately 75 cases reported each year⁴⁶.

A small number of women in this study had experienced sexual abuse (rape or assault), a larger number of women mentioned regular harassment and the majority of younger veterans mentioned experiencing occasional harassment (name calling, derogatory remarks about their sexuality or body image). A number of stakeholders interviewed mentioned having a client base that included victims of sexual abuse and or/assault and harassment.

A small number of women in this study were severely traumatised by sexual harassment and abuse during their ADF career. None of them had sought professional counselling or treatment.

Impacts of sexual harassment or abuse included:

- Sexual dysfunction
- Social isolation
- Anxiety
- Depression
- PTSD
- Relationship breakdown
- Premature end to their military career

Issues relating to service provision for military sexual trauma included:

- Rigid DVA assessment processes that risked retraumatising the victim
- VVCS not well supported to provide appropriate services
- Dependence on local sexual assault services that didn’t necessarily understand the context of ADF and had inappropriate models of practice for still serving women
- No availability of support groups, information or resources for military sexual trauma
- No mention of military sexual trauma on the DVA website which sent a message to victims that it was not a legitimate issue

A number of women had attempted to get ‘genderless’ issues assessed by DVA that they perceived to be ‘acceptable’ in the hope that they would then use this compensation/benefits to address the

⁴⁵ ‘Military sexual trauma’ is a term used by the US Department of Veterans Affairs to refer to sexual assault of repeated, threatening sexual harassment that occurred while the veteran was in the military. It is an appropriate term to use in the context of this report as it relates to abuse and harassment women experienced during an ADF career For more information about the definition see <http://www.mentalhealth.va.gov/msthome.asp>.

⁴⁶ Review of the Management of Incidents and Complaints in Defence including Civil and Military Jurisdiction: p29

‘real’ issues that were affecting them. In this way sexual abuse and harassment *remain hidden and* DVA is perceived to be accommodating this invisibility.

Implications:

- Women accessing poor quality and potentially damaging support services (c/f Finding 4.2.2)
- Continued negative impact on mental health
- Evidence process for claiming for sexual assault/harassment could be potentially retraumatising the victim leading to further negative impact on mental health

4.3.4 Finding 11: Lack of appropriate or available information on female specific issues, including maternal separation, reproductive and gynaecological health, domestic violence, lesbian, transgender and same sex attracted women, and military sexual trauma

Synopsis of evidence

Findings from this study indicate a significant gap in information available to female veterans about issues for female veterans. Participants noted both a lack of information, or noted the poor quality of information that existed. This included:

- Knowledge of VAN staff
- Knowledge of advocates
- DVA website pages regarding women’s health issues
- Lack of DVA policies accommodating women’s health issues

The areas that women described needing information about included:

- Maternal separation
- Reproductive and gynaecological health issues (for example possible effects of long term menstrual suppression)
- Domestic violence
- Lesbian, transgender and same sex attracted women
- Military sexual trauma

Another area of limited appropriate resources was women and PTSD. This was positioned as important as it acknowledged and validated that women who were not in front line combat could be exposed to and affected by trauma.

Women described a need for a combination of resources available from both civilian and military settings, but civilian providers needed to have knowledge of the ADF context. It was important for there to be confidential and self-directed resources.

Implications

- Women had a sometimes limited understanding of why they weren’t coping
- Women felt that their experiences were unique to them and that there was therefore unlikely to be appropriate resources
- Women were unsure of where to go for advice or support or if their issue was ‘legitimate’

4.4 Gaps in knowledge of female veterans that impact health and wellbeing and service provision

4.4.1 Finding 12: Perceived limited understanding of trauma exposure experienced by veterans by their civilian and DVA service providers

Synopsis of evidence

The current debates about women in front line combat have rendered the considerable trauma and combat-like work that women have done, particular health personnel, invisible. The exposure to trauma evidenced in this study's interviews reveals acute, often repeated, exposure to trauma related to death and wounded in war, and the lack of support available to women on return and when they discharge from the military.

Deployment stress is not just about exposure to trauma, it is also the stress of being confined to a compound and living in close quarters with your colleagues for a long period of time.

The deployment experiences described by interviewees commonly included:

- The excitement and privilege to be selected for deployment
- The 'normalisation' of trauma
- Having to 'harden up' to survive and do your job
- The stress of living in a compound
- Frontline combat like experiences
- Grief and loss following leaving a deployment early

These experiences challenge some popular perceptions of women's roles in the ADF and provide an understanding for why deployment is such an important component of their ADF career.

Implications:

- Women felt that service providers did not understand their unique needs (for example assumed that their deployment experiences were 'benign')
- Women were reluctant to seek help or support
- Delayed treatment seeking leading to worse physical and mental health outcomes

4.4.2 Finding 13. Significant gaps in evaluation and best practice guidelines of health care provision for female veterans in Australia

Synopsis of evidence

To date there have been no evaluations of health service provision for female veterans, or evaluations of the impact DVA systems of assessment may have on women. Similarly there have been no evaluations of the effectiveness of the ADF's major psychological screening tool: POPS (Post Operation Psychological Screening). POPS is designed to be done at the end of deployment and three months later. Many women said they had never done the one at three months as it was never followed up. This seemed to be a common experience.

For Vietnam era women debriefing was an informal process that involved chatting with peers over cups of tea or alcohol. For more recent veterans debriefing is seen in the context of POPS and is perceived to be ineffective, not confidential, and as potentially having a negative impact on future deployment or career opportunities.

For some women the interview for the study was the first time they had spoken to anybody in depth about their experiences and the impact it has had on them.

Women often described there being no continuity of care between their military and civilian health care providers.

There are currently no best practice guidelines for treating female veterans, or assessing female veterans by DVA.

Implications:

- Health care for female veterans is sub optimal
- Assessment of women could be damaging and leading to poorer mental and physical health outcomes
- No continuity of care between military and civilian health care providers
- Lack of appropriate models of care is limiting women's access to services and support

5. RECOMMENDATIONS

Overview of recommendations

1. **Develop targeted support and resources for female veterans**
2. **Increase the visibility of services for and experiences of female veterans**
3. **Facilitate continuity of learned coping strategies post-discharge from the ADF**
4. **Implement and evaluate family friendly practices**
5. **Provide training to civilian health care providers on issues for female veterans**
6. **Develop best practice guidelines for the treatment of female veterans**
7. **Set a strategic research agenda on female veterans health**

5.1 Develop targeted support and resources for female veterans

Suggestions for achieving this:

- Set up an advisory committee to determine priority areas of need. This committee could consist of representatives from DVA, VVCS, state based women's health centres, domestic violence centres, Centacare, Relationships Australia, DCO, ADF Joint Health Command, and other key stakeholders.
- Develop a partnership model to provide integrated care to female veterans. This could be done for example through building partnerships with local women's health centres
- Develop self-directed care through updating DVA website resources.
- Provide a number of access points for information for women – DVA website, VVCS and VAN offices, women's health centres, GPs.
- Facilitate parenting workshops through VVCS (with childcare available).
- Develop text and web based resources specifically targeted at women, on issues including: mothers, TPI, PTSD, sexual trauma, retirement.
- Pilot a program promoting all female VVCS support groups.
- Develop exercise programs aimed at younger veterans.

5.2 Increase the visibility of services for and experiences of female veterans

Suggestions for achieving this:

- Appoint women's officers at Veteran's Access Network sites.
- Develop a number of targeted publications highlighting experiences and needs of women veterans, for example.
 - Develop a pamphlet titled 'Female veterans', similar to those currently addressing a number of other veteran sub groups, for VVCS and VAN offices for example.
 - Publications targeted at the broader community about the roles and experiences of female veterans.

- Special editions of DVA publications that feature services and support aimed at female veterans.
- Prioritise training female and younger advocates.
- Advocate for the inclusion of female veterans as a sub group on future women’s health policies and in national women’s health agendas.
- Promotion of VVCS/DVA support and resources as *male and female veterans*, not simply ‘veterans’.

5.3 Facilitate continuity of learned coping strategies post discharge

Suggestions for achieving this:

- Develop exercise programs aimed at younger veterans.
- Develop exercise programs aimed at mothers, for example where children can be involved.
- DVA to consider a partnership with gyms/sporting groups to incentivise membership and fitness assessment.
- Improve accessibility of childcare.

5.4 Implement and evaluate family friendly practices

Suggestions for achieving this:

- Evaluate adequacy of current family friendly spaces at VVCS and DVA locations.
- Consider accessible and affordable childcare options so that women can attend programs or counselling.

5.5 Provide training to civilian health service providers on issues for female veterans

Suggestions for achieving this:

- Develop a GP training module that focuses on the health and care of female veterans.
- Develop information and resources aimed at civilian health care providers regarding the needs of female veterans. This could be given to Relationships Australia, Centacare, Victims Support, women’s health centres, and domestic violence support centres.

5.6 Develop best practice guidelines for the treatment and care of female veterans

Suggestions for achieving this:

- Evaluate current models of care for female veterans.
- Evaluate impact and appropriateness of DVA assessment processes for female veterans.
- Set up a committee to develop best practice guidelines.

5.7 Set a strategic research agenda on female veterans health

Suggestions for achieving this:

- Facilitate a research agenda setting workshop with stakeholders.
- Develop a program of research into targeted mental, physical, sexual and reproductive health needs.

6. CONCLUSION

This project sought to mobilise the experiences of Australian female veterans and inform gaps in current DVA policy. Women highly value their careers in the ADF and are empowered by the skills and opportunity it affords them. In contrast women are disempowered by a sub optimal health care delivery model that does not adequately take into account the needs of female veterans.

There is a consistently and strongly held view among the veterans interviewed that DVA as an organisation is geared to meet the needs and service a traditional male veteran. Opportunities exist to refresh their current resources and practices to enable a wellness approach for women consistent with their broader policy framework.

The key findings from the study evidence:

1. Significant barriers to accessing existing support services for female veterans
2. Significant gaps in available and appropriate information, resources and DVA policies for female veterans
3. Gaps in knowledge of female veterans that impact health and wellbeing and service provision

The implications of addressing the above barriers and gaps include empowering women with targeted support and resources that they can access with ease. In this way self directed strategies for seeking support are consistent with the empowered self developed in their ADF career.

This project relied on a small sample size of 90 interview participants to develop its findings and recommendations. The 60 veterans who participated comprise a very small percentage of the overall female veteran treatment population. The findings are thus limited to the experiences this group described and cannot be generalised to the entire treatment population.

However, the validation by various stakeholders, including experienced VVCS and DCO staff, of key themes emergent in these interviews creates a powerful argument for broader application of the study's conclusions. In addition the ethnographic methodology over three years, including a comprehensive international review of the literature and the Principal Investigators participation in other DVA and Department of Defence funded research, framed a deep understanding and respect for ADF culture and values and impact of service on all military personnel.

Further research to better understand details of specific challenges for women will be critical in developing appropriate resources for female veterans. This research must be situated in a strategic research agenda that delivers timely, policy relevant outcomes.

Findings from this research are grounded in complex accounts from female veterans of the duality of empowerment/disempowerment: a positive, rewarding ADF career with inherent challenges, superimposed on limited mental, physical and reproductive health and wellbeing support and resources to meet their needs as veterans. These findings have been translated into evidence for action for improving the health and wellbeing of all female veterans.

Underlying this study's recommendations is the need for women to have access to self-directed strategies for both preventing and/or recovering from physical and mental health issues. These findings go to far more than issues of readjustment post-discharge, rather they highlight a critical need to adjust the health care delivery and support model for female veterans. In doing so the empowerment/disempowerment paradox may be reconciled, ultimately improving female veteran's health and wellbeing.

This research presents an attainable future state for female veterans that includes equitable access to professional, appropriate, well evaluated, evidence based care.