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## Lesbian Veterans Experiences in the Military: A Case Study

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**LESBIAN VETERANS EXPERIENCES IN THE MILITARY:  
A CASE STUDY**

A Dissertation Presented

by

CAROLYN J. GUSTASON

Submitted to the Graduate School of the  
University of Massachusetts Amherst in partial fulfillment  
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2017

College of Nursing

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## DEDICATION

To my wife, Cora - at last!

All of this education and I still haven't the words to begin to convey what you mean to me. To my wife, my biggest supporter and believer, and my friend. This work would not have been possible without your constant and unflagging support, strength, patience, and humor. Your capacity to love astounds and inspires me; I am a better person because of you. Thank you for believing in me, cheering me on, and bringing me to the Border on Friday nights!

To my family, birth and choice. Thank you for your love and support. Nola and Alivia, thank you for reminding me that there is so much more to life than books. To Julie, Joanie and Bridget – more sisters than cousin and friends. I love you so very much.

To Kim, my work wife and my partner in crime. I'll hold hands, count to three, and jump anytime!

In loving memory of Gloria Desmarais

8/17/1940 - 7/27/1980

Beloved Aunt, Godmother

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Most importantly, my deepest appreciation and thanks to a group of women Veterans who not only sacrificed and served our country during times of war and peace, but who generously shared their time and experiences with us. I can only hope that my work begins to shine a light on your identity.

## **ABSTRACT**

### **LESBIAN VETERANS EXPERIENCES IN THE MILITARY: A CASE STUDY**

May 2017

CAROLYN J. GUSTASON B.S.N., FITCHBURG STATE COLLEGE

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Directed by: Professor Donna Zucker

Extant research suggests that lesbians, as a group, are a vulnerable population who engage in risky health behaviors and often do not receive regular care from healthcare providers, due to fears of discrimination and mistreatment. Recent research conducted with military Veterans suggests that some lesbian Veterans may engage in similar health behaviors, but may not choose to receive care from the VA. It is not well understood why lesbian Veterans choose to receive care elsewhere, but extant research suggests a trusting relationship between a lesbian and a healthcare provider may increase healthcare utilization. A person's sense of self, their identity, is key to informing expectations regarding the type of healthcare sought.

The purpose of this instrumental collective case study secondary analysis was to analyze qualitative interview data from a mixed-methods study to explore lesbian Veteran identity, and the significance of that identity for use of the VA Healthcare System, and relationships with VA healthcare providers. Twenty-four interviews were open coded and analyzed.

Lesbian Veteran identity was discovered to include the identities of hidden, hunted, and betrayed. These identities included themes such as secret societies, and

witch-hunts; as well as being policed, preyed upon, and betrayed by the military and colleagues. During the interviews, 10 of the 24 women spontaneously spoke about their experiences with military sexual trauma. These lesbian Veterans shared identities of women who were hidden, were hunted, and were betrayed in the contexts of military sexual trauma and institutional betrayal. The identities transcended sexual orientation.



## TABLE OF CONTENTS

|   | Page |
|---|------|
| ACKNOWLEDGMENTS .....   | v    |
| ABSTRACT .....  | vi   |
| CHAPTER   |      |
| 1. INTRODUCTION .....   | 1    |
| Purpose .....   | 5    |
| Research Questions .....                                      | 5    |
| Goals.....  | 6    |
| Aims .....  | 6    |
| Methodology .....   | 6    |
| Theoretical Framework .....                                   | 7    |
| Summary .....   | 7    |
| 2. FOUNDATION.....  | 9    |
| Lesbian and Bisexual Women .....                              | 10   |
| Sexual Orientation .....                                      | 10   |
| Prevalence.....   | 12   |
| Methodological Issues .....                                   | 12   |
| The Health of Lesbian/Bisexual Individuals .....              | 16   |
| Health and health behaviors. ....                             | 16   |
| Health Maintenance and Screening.....                         | 18   |
| Disclosure of Sexual Orientation to Healthcare Providers..... | 19   |
| Summary .....   | 19   |
| Health and Lesbian/Bisexual Women Veterans .....              | 20   |
| Don't Ask, Don't Tell.....                                    | 20   |
| Prevalence.....   | 22   |
| Health and Women Veterans .....                               | 24   |
| Physical health .....   | 24   |
| Mental Health.....  | 27   |
| Health of Lesbian/Bisexual Veterans .....                     | 28   |

|   |    |
|---|----|
| Summary .....   | 30 |
| Relationships Between Lesbian/Bisexual Women and RNs and MDs.....           | 30 |
| Relationships Between Lesbian/Bisexual Women and Registered<br>Nurses ..... | 30 |
| Summary .....   | 33 |
| Relationships Between Lesbians/Bisexual Women and Physicians .....          | 33 |
| Summary .....   | 36 |
| Identity and Self .....   | 36 |
| Identity .....  | 36 |
| Self .....  | 38 |
| The Relational Cultural Theory .....  | 39 |
| 3. METHODS .....  | 43 |
| Purpose .....   | 43 |
| Research Questions .....  | 43 |
| Goals.....  | 43 |
| Aims .....  | 43 |
| Methodology .....   | 43 |
| Qualitative Research .....  | 44 |
| Methods - Parent study.....   | 45 |
| Design.....   | 45 |
| Sample.....   | 45 |
| Setting.....  | 46 |
| Instruments .....   | 46 |
| Methodology .....   | 46 |
| Results From Parent Study.....  | 47 |
| Methods - Case Study.....   | 48 |
| Design.....   | 48 |
| Sample.....   | 48 |
| Risks.....  | 49 |
| Ethical Considerations .....  | 49 |

|  |    |
|--|----|
| Data Collection Protocol and Analysis Plan .....   | 49 |
| Data Collection.....   | 49 |
| Data Analysis .....  | 49 |
| Trustworthiness .....  | 50 |
| Dissemination .....  | 51 |
| Summary .....  | 51 |
| 4. FINDINGS .....  | 53 |
| Research Question One: What are Lesbian Veterans’ Experiences<br>of Identity? .....  | 53 |
| Lesbian Veteran Identity: Hidden, Hunted, and Betrayed .....   | 53 |
| A Hidden Identity .....  | 54 |
| An Identity of Hunted.....   | 58 |
| Betrayed by Colleagues .....   | 66 |
| Present Day .....  | 70 |
| Research Question Two: What Significance does Lesbian Veteran<br>Identity Have for Use of VA Healthcare? .....                                     | 70 |
| Significance of identity for use of VA healthcare .....  | 71 |
| Hidden From the VA .....   | 74 |
| Research Question Three: What Significance Does Lesbian<br>Veteran Identity Have for Subsequent Relationship With VA<br>Healthcare Providers?..... | 75 |
| Visible to healthcare providers.....   | 75 |
| Fully Visible .....  | 75 |
| Eventually participants disclosed.....   | 78 |
| Significance of Military Service .....   | 80 |
| Summary .....  | 84 |
| 5. DISCUSSION .....  | 87 |
| The Parent Study .....   | 87 |
| Theoretical Issues.....  | 87 |

|   |     |
|---|-----|
| The Relational-Cultural Theory.....   | 87  |
| Andersen Behavioral Model of Health Services Use.....   | 88  |
| Betrayal Trauma Theory.....   | 89  |
| Institutional Betrayal Trauma.....  | 89  |
| Methodological Issues.....  | 90  |
| The Researcher’s Lens.....  | 91  |
| Discussion of Research Questions.....   | 93  |
| Research Question One: What was the Lesbian Veteran<br>Experiences of Identity? .....   | 93  |
| Hidden, Hunted, and Betrayed .....  | 94  |
| Hidden Identity.....  | 95  |
| Hunted Identity.....  | 97  |
| Betrayed Identity.....  | 98  |
| Research Question Two: What significance does lesbian<br>Veteran identity have for use of the Veteran Health<br>Administration healthcare system? ..... | 100 |
| Research Question Three: What was the significance of<br>lesbian Veteran identity for the subsequent relationship<br>with VA healthcare providers?..... | 102 |
| Comparison of Study Findings with Extant Research.....  | 104 |
| Hidden: Secret Societies .....  | 104 |
| Hunted: Witch-Hunts .....   | 106 |
| Hunted: Preyed Upon.....  | 107 |
| Hidden, Hunted, and Betrayed in the Context of Military Sexual<br>Trauma and Institutional Betrayal.....  | 108 |
| Military Sexual Trauma.....   | 108 |
| Institutional Betrayal.....   | 110 |
| Betrayal Trauma.....  | 111 |
| Strengths and Weaknesses .....  | 113 |
| Future Directions.....  | 114 |
| Nursing Education.....  | 114 |

|                       |     |
|-----------------------|-----|
| Nursing Practice..... | 115 |
| Nursing Research..... | 115 |

APPENDICES

|                |     |
|----------------|-----|
| A. TABLES..... | 117 |
|----------------|-----|

|                    |     |
|--------------------|-----|
| B. WORKSHEETS..... | 119 |
|--------------------|-----|

|                   |     |
|-------------------|-----|
| BIBLIOGRAPHY..... | 121 |
|-------------------|-----|

## **CHAPTER 1**

### **INTRODUCTION**

Nearly one million Veterans identify as members of a sexual minority; the largest subpopulation of which are lesbian and bisexual women (Blosnich, Bossarte, Silver, & Silenzio, 2013; Gates, 2010; Roster, Hosek, & Vaiana, 2011). Many lesbian and/or bisexual (L/B) Veterans have access to healthcare provided by the Veterans Healthcare Administration (VA), yet, for reasons that are not well understood, not all lesbian or bisexual female Veterans utilize VA services (Blosnich et al., 2013; Simpson Balsam, Cochran, Lehavot, & Gold, 2013).

Research suggests that the sexual minority identity claimed by some Veterans influences their health care utilization in ways that are similar to civilian lesbian and bisexual female populations (Katz, 2010). Civilian sexual minority individuals report that fears or actual incidences of discrimination, maltreatment, and stigma act as barriers to disclosing their sexual orientation to healthcare providers (Facione & Facione, 2007; Lick, Durso, & Johnson, 2013; Neville & Henrickson, 2006; Simpson et al., 2013). Sexual minority Veterans may experience similar fears or incidents, however their experiences may be further complicated by discrimination, harassment, stigma and trauma associated with their service within the military's heteronormative, male-oriented milieu, and the military's recent Don't Ask Don't Tell (DADT) policy (Baltrushes & Karnik, 2013; Kauth et al., 2014).

Researchers have investigated the L/B Veteran experiences of care received from the VA and their satisfaction with that care (Mattocks, Sullivan, Bertrand, Sherman, & Gustason, 2015; Sherman, Kauth, Shipherd, & Street, 2014). A pilot study conducted by

Sherman et al., found that, when queried about deterrents to care, a majority of the sexual minority Veteran sample noted that lack of support of same-sex relationships and fears of poor treatment secondary to their sexual minority identity functioned as barriers to their use of the VA (2014). A fear of poor treatment and lack of recognition of significant others was also endorsed as barriers to VA care by the lesbian Veterans participating in the study led by Mattocks et al., (2015); however, those Veterans noted a welcoming VA atmosphere.

Research led by Kleinman (1975, 1980) suggests that one's cultural identity informs healthcare utilization. More specifically, cultural identity informed by one's family, friends, and larger society, teaches the individual the type of healthcare to seek and when healthcare should be sought. It is not well understood to what extent the L/B's identity, that is, her sense of self as a sexual minority and a military Veteran, may influence the healthcare sought. Additionally, it is not well understood how the identities of a sexual minority and female military Veteran may influence her decision to seek VA healthcare or the development of a therapeutic relationship with a VA healthcare provider.

It is important to understand L/B Veteran healthcare utilization because research with civilian SM individuals indicates that they often engage in risky health behaviors. For the purpose of this study, risky health behaviors engaged in by L/B civilians include behaviors known to lead to chronic and/or life-limiting illness. Examples of risky health behaviors associated with L/B women include tobacco use, (Boehmer, Miao, Linkletter & Clark, 2012; Gruskin, Greenwood, Matevia, Pollack, & Bye, 2007; Hatzenbuehler, McLaughlin, & Slopen, 2013), excessive alcohol use, (Bonvicini & Perlin, 2003; Condit,

Kitaji, Drabble, & Trocki, 2011; Hatzenbuehler, McLaughlin, & Slopen, 2013; Hughes, 2011; Wilsnack et al., 2008), over-weight or obesity (Dilley, Wynkoop Simmons, Boysun, Pizacani & Stark, 2010; Hatzenbuehler, McLaughlin, & Slopen, 2013), illegal substance use (Bonvicini & Perlin, 2003; Hequembourg & Dearing, 2013; Hughes, Szalacha & McNair, 2010), and lack of adequate physical activity (Rosario et al., 2014).

Researchers note civilian L/B women are less likely to seek regular healthcare (Boehmer et al., 2012; Seaver, Freund, Wright, Tjia, & Frayne, 2008). Furthermore, research suggests that the tenor of the relationship between a SM individual and the healthcare provider is significant and is noted to be key in establishing the degree of trust necessary to disclose one's sexual orientation (Klitzman & Greenberg, 2008; Seaver, et al., 2008; Steele, Timmouth & Lu, 2006). Non-disclosure of sexual orientation to one's healthcare provider has been associated with poorer health, less preventative health care, and fewer healthcare visits (Facione & Facione, 2007; Lick, Durso, & Johnson, 2013; Neville & Henrickson, 2006; Simpson et al., 2013).

The VA health care team is made up of physicians (MDs), registered nurses (RNs), and medical allied health personnel; each member is significant to the care of Veterans in the VA. Registered nurses (RNs) comprise the largest proportion of healthcare providers in the US (Benner, Sutphen, Leonard, & Day, 2010) and are the first point of contact for many patients. The VA employs over 50,000 RNs (US Department of Veterans Affairs, 2012). Central to the care provided by RNs is the unique, therapeutic, and trusting relationship the RN builds with the individual receiving care (Diamond Zolnierok, 2014; Halldorsdottir, 2008; Watson, 2010).



In the VA, MDs provide primary care for Veterans. The medical home model recently adopted by the VA has reinforced this role. Within each Patient Aligned Care Teams (PACTs), healthcare providers are grouped into “teamlets” consisting of “ 1 [MD] primary care provider, 1 RN care manager, 1 licensed practical nurse or medical assistant, and 1 administrative clerk” (Rosland et al., 2013, p. e264). The PACTs are designed to improve Veteran access to care, while enabling the Veteran to become an active and informed participant in his/her/zir healthcare (Patient Centered Primary Care Implementation Work Group, (PACT Work Group), 2009). The MD leads the teamlet in assuming responsibility for the healthcare of approximately 1,200 Veterans (PACT Work Group, 2009; Rosland et al., 2013).

The RN care manager is responsible for the overall coordination of care for this often chronically ill population; a task that may involve connecting with the Veteran during face-to-face appointments, or via telephone conversations (Rosland et al., 2013). The organization of healthcare providers into PACT teamlets allows the MD and the RN to foster a partnership with the Veteran toward the provision of meaningful, personalized care. It is unknown if L/B Veterans are able to take full advantage of the PACT model and enter into a therapeutic relationship with the RN care manager and/or the MD primary care provider, in which they are able to be fully authentic and disclose their SM identity.

de Munck, (2013), stated, “Identities are the means by which the self engages with the outside world” (p 182). An individual may have multiple non-mutually exclusive identities (Ryan & Deci, 2012; Stryker & Burke, 2000), all of which are influenced by the various contexts within the individual’s life (Mead, 1934; Stryker & Burke, 2000).

The culture one is surrounded and influenced by not only shapes the individual, but also the healthcare expected and sought (Kleinman, 1987). Therefore, it was reasonable to posit that an individual's sense of self, (also referred to as identity), would influence the healthcare sought, and expectations related to the manner in which healthcare interactions unfold. The experience of a SM Veteran's identity may influence care seeking in a manner different from that of an individual whose identity does not include status as a SM Veteran. A better understanding of L/B Veterans' identities would inform the creation of nursing interventions focused on meeting the unique cultural needs of L/B Veterans and thus improve the health of this very vulnerable population.

The capitalization of the word Veteran is a VA convention that conveys respect for those who served in the military and so will be utilized through-out this manuscript. Gender is no longer recognized as being binary in nature. Participants in this study identified as lesbian or human. Therefore, gender-neutral pronouns "zir, hir, hirs" used with he and she (Berkley, 2015; Massachusetts Institute of Technology, n.d.) will not be utilized within this manuscript.

### **Purpose**

The purpose of this exploratory, instrumental case study was to explore how L/B Veterans' identity influenced use of the VA for healthcare and relationships with VA healthcare providers.

### **Research Questions**

The research questions that informed the study are as follows: (1) What were L/B Veterans' experiences of identity? and (2) What significance did L/B Veterans' identity

have for their utilization of VA healthcare?; and (3) What significance did L/B Veterans' identity have for their relationships with VA healthcare providers?

### **Goals**

The long-term goal of this study was to extend the work of Mattocks et al., (2015), by exploring L/B Veterans' identities, and how those identities may have significance for later relationships with VA healthcare and VA healthcare providers.

### **Aims**

The aims of this exploratory, instrumental case study (Stake, 1995) were to (1) Describe the L/B Veteran identity; (2) Describe the significance of L/B Veterans' identity on their utilization of VA healthcare, and (3) Describe the significance the L/B Veterans' identity may have on their relationship with VA healthcare providers.

### **Methodology**

The instrumental, collective case study was guided by Stake's methodology (Stake, 1995, pp. 3-4) and was exploratory and descriptive in nature. An instrumental case study is utilized when the researcher is interested in the gestalt of a phenomenon rather than the individual case. Collective case studies are a type of instrumental case study that allows the researcher to utilize multiple cases towards gaining an understanding of the phenomenon (Stake, 1995). In this study, the phenomenon of interest - also referred to as the bounded unit of analysis, (Creswell, 2007), was L/B Veterans' identity. Therefore, in this study, L/B Veteran identity was the instrumental phenomenon of interest and the multiple extant L/B interviews were the collective components.

## **Theoretical Framework**

The relational-cultural theory (RCT) was proposed as a heuristic device for this study. Developed during the latter half of the 20<sup>th</sup> century (Stehn, 2014), RCT posits that women, in all facets of their lives, move toward relationships with others (Jordan, 2008a). If, however, that relationship is rejected, if “the more powerful person does not listen, responds with invalidation, humiliation or violence” (Jordan, 2008b, p. 2), the woman will learn to keep that part of herself hidden in order to remain safe and/or in the relationship. Keeping part of oneself hidden can negatively impact the development of a therapeutic, trusting relationship with one’s caregivers.

Barriers to the development of a therapeutic relationship between the L/B Veteran and the healthcare provider may prevent the provision of comprehensive, culturally appropriate health care, contribute to a decreased quality of life and an increase in health disparities experienced by SM individuals (Blosnich et al., 2013). Although researchers have examined how RNs and MDs, respectively, view patients who identify as a SM, (Yen et al., 2007), it was not well understood how L/B Veterans’ identity is significant for the care provided by VA healthcare providers within the VA.

## **Summary**

As an organization, the VA has an obligation to meet the healthcare needs of all Veterans. Nearly one million individuals who identify as members of a SM population are Veterans who have served in the US military. Of this group, L/B Veterans comprise the largest SM sub-group in Veteran population, but not all who are eligible utilize the VA. It is not understood if L/B Veterans’ identity was significant to their willingness to receive VA care, and if it was significant for their relationships with their VA RNs and

MDs and the tenor of those relationships. This study will build upon the work published by Mattocks et al., (2015), and was directly aligned with VHA's mission to provide Veterans with "personalized, proactive, patient-driven healthcare", (VHA, n.d., p. 7). If the VA is to provide culturally appropriate care for all Veterans, it is important to understand how the identity held by this group of L/B Veterans' impacts the care sought and received. The next chapter will review current knowledge of L/B civilians and Veterans, their respective healthcare needs, relationships established with healthcare providers, and identity. The RCT, as a heuristic tool for this study, will also be reviewed.

## **CHAPTER 2**

### **FOUNDATION**

The relationship between an individual and a healthcare provider is unique and key to the delivery of personalized, holistic, quality care (Felgen, 2004). Individuals may experience many emotions when presenting for an appointment with a healthcare provider, including discomfort secondary to illness, fear of the unknown, vulnerability, and perceived lack of power (Bøgelund Frederiksen, Kragstrup, & Dehlholm-Lambertsen, 2010; Lambda, 2010; Stein & Bonuck, 2001). The discomfort and vulnerability experienced by an individual seeking health care may be compounded if the individual believes their personal characteristics may be unacceptable to the healthcare provider.

Men and women who identify as a SM have reported discomfort with healthcare providers due to fears of and/or actual occurrences of interactions with providers who display heteronormativity, homophobia, and stigma. Their discomfort often translates into a lack of disclosure of their sexual orientation. A lack of disclosure is important because discomfort or lack of disclosure by SM individuals have been associated with fewer healthcare visits, lack of preventative care, and poorer health outcomes (Meyer, 2003). Most research regarding interactions between L/Bs and healthcare providers (HCPs) has been conducted in the civilian population.

Although researchers have investigated relationships between civilian SM individuals and their healthcare providers, much remains unknown about how a L/B Veteran's identity may impact utilization of VA healthcare services and the subsequent

relationship with VA HCPs. This secondary analysis of data gathered by Mattocks et al., (2015) aimed to expand their work and explore how L/B Veterans' identity impacted the relationship and utilization of the VA, and the relationship with VA HCPs. The purpose of the present chapter is to provide a foundation regarding (a) sexual orientation, (b) health of civilian and Veteran L/B individuals, (c) methodological issues in L/B research, (d) what is known regarding the relationship between civilian and/or Veteran L/Bs and healthcare providers, (e) the concept of identity, and (f) the relational-cultural theory (RCT).

## **Lesbian and Bisexual Women**

### **Sexual Orientation**

Sexual orientation is a complex paradigm consisting of sexual behavior, sexual attraction, and sexual identity (Bonvicini & Perlin, 2003; Eliason, Chinn, Dibble, & DeJoseph, 2013; Hatzenbuehler, McLaughlin, K.A., & Slopen, N. 2013; Herek & Garnets, 2007; Institute of Medicine (IOM), 2011; Kauth, Meier, & Latini, 2014; Thomeer, 2013). For the purpose of this study, the IOM's 2011 definitions of sexual orientation will be utilized. Conceptually,

.. *sexual orientation* [original italicized] refers to an enduring pattern of or disposition to experience sexual or romantic desires for, and relationships with, people of one's same sex, the other sex, or both sexes. As this definition makes clear, sexual orientation is inherently a relational construct. (p. 27)

When operationalized:

This working definition encompasses *attraction, behavior, and identity* [original italicized]...most researchers studying sexual orientation have defined it

operationally in terms of one or more of these three components. Defined in terms of *attraction* (or *desire*), sexual orientation is an enduring pattern of experiencing sexual or romantic feelings for men, women, transgender persons, or some combination of these groups. Defined in terms of *behavior*, sexual orientation refers to an enduring pattern of sexual or romantic activity with men, women, transgender persons, or some combination of these groups. Sexual orientation *identity* encompasses both *personal identity* and *social identity*. Defined in terms of *personal identity*, sexual orientation refers to a conception of the self based on one's enduring pattern of sexual and romantic attractions and behaviors toward men, women, or both sexes. Defined in terms of *social* (or *collective*) *identity*, it refers to a sense of membership in a social group based on a shared sexual orientation and a linkage of one's self-esteem to that group. (p.p. 27-28)

Therefore, a lesbian participant in this study is defined as a woman who meets one or more of the following criteria: (a) has identified herself as lesbian, (b) is sexually and/or romantically attracted to another woman, (c) who is currently in or wishes to physically act upon that attraction, and (d) who is currently in or wishes to be in a relationship with another woman. Similarly, for the purpose of this study, a bisexual woman is defined as a woman who meets the following criteria: (a) has identified herself as a bisexual woman, (b) is sexually and/or romantically attracted to both a woman and/or a man, (c) who is currently or wishes to physically act upon that attraction, and (d) who is currently in, was in, or wishes to be in a relationship with both a woman and/or a man. The parent study (Mattocks et al., 2015) utilized the labels of lesbian and bisexual. For consistency, those labels will be used in this secondary analysis.



## **Prevalence**

Lesbian and bisexual women are often noted to be part of a 'hidden' population (Aaron et al., 2001; Gates & Newport, 2012; Mattocks et al., 2015) and so it is difficult to determine exact population numbers. Researcher estimates range from as few as 2% to as many as 10% of the total adult population are members of a SM population, or more than 9 million US adults (Björkman & Malterud, 2007, p. 58; Bogart, Revenson, Whitfield, & France, 2014; Gates & Newport, 2012; Wilsnack et al., 2008).

Approximately 1 million SM individuals are Veterans (Blosnich, Bossarte, Silver, & Silenzio, 2013; Johnson & Federman, 2013; Kauth et al., 2014; Lehavot & Simpson, 2012; Ramirez et al., 2013; Simpson et al., 2013). It is believed that L/Bs have joined the armed services in greater numbers than gay or bisexual men, and in fact, their numbers in the military are believed to be greater than their numbers in the general adult population (Gates, 2010; Lehavot & Simpson, 2012). The larger proportion of L/B in comparison to other SM individuals and the civilian population would carry over from active duty into the Veteran population.

## **Methodological Issues**

Others cannot easily discern another's sexual orientation (Björkman & Malterud, 2007). Oftentimes, a SM individual must inform others of his or her sexual orientation; otherwise, it is assumed that the individual is heterosexual, (Bonvicini & Perlin, 2003), a phenomenon known as heteronormativity (Rondahl, Innala, & Carlson, 2006; Westerstahl & Björkeland, 2003). When one's identity is stigmatized and hidden, as is often the case with SM individuals, research and recruitment with that population proves problematic.

As a result, health research conducted with SM individuals is fraught with methodological issues.

Research with SM populations is characterized by small samples that may not be representative of the larger SM population (Thomeer, 2013). Research participants are frequently convenience samples, recruited via snowball sampling, or at SM-centric events such as gay pride festivals, bars, or community centers (Marques, Nogueira, & de Oliveira, 2014). As a result, research participants may exemplify only a small portion of the actual SM population of interest – for example, those who are publically ‘out’, those with self-confidence, and those that share traits similar to the original participant. Mereish & Poteat (2015) sought a representative SM sample for their study that utilized the tenets of RCT. Using the Internet, participants were recruited from SM listservs as well as from a commercial, online database.

Meanwhile, other SM members may be unaccounted for and under-represented in research because they did not have an opportunity or desire to participate in the research. Some members of the population may live in rural areas away from gay-oriented festivals or community centers or bars, may not feel safe in disclosing their sexual orientation or taking part in an anonymous study, may not have internet access or knowledge of SM-friendly websites, or may not know of opportunities to engage in research participation (Rothblum, Factor, & Aaron, 2002).

An additional methodological issue associated with L/B research is the lack of consistency in the definitions of L/Bs as utilized by researchers. Researchers have noted outcomes may be different when different time frames are used to document periods of sexual activity (Thomeer, 2013). For example, studies that examine L/Bs using

definitions that classify L/B status based upon the past one to two years of sexual activities may yield results different than studies that utilize a long-term view (for example, past five years) of sexual activity (Thomeer, 2013). An individual may have engaged in sexual activities seven years prior to participation in a study. If researchers limit their period of sexual activity to the most recent five-year period, an individual who may consider herself bisexual would not be counted as such. Examination of the L/B population may also be impacted by the manner in which individuals are identified by themselves or others.

Researchers have begun to recognize that sexual orientation may, in fact, be more complex than represented by the labels heterosexual, bisexual, and lesbian (Cochran, & Mays 2007; Gordon & Silva, 2014; Hughes, Szalacha, & McNair, 2010; Wilsnack et al., 2008). There may be levels of gradation between the three categories utilized to classify sexual orientation (i.e., attraction, behavior, identity) that are important to recognize due to health and wellness ramifications. For example Hughes et al., (2010), examined substance use in women from an Australian cohort and found increases in risky health behaviors in women who self-identified as “mainly heterosexual” and “bisexual” when compared with women who identified as exclusively heterosexual and lesbian (p. 825). Cochran & Mays (2007) placed women under the labels lesbian, bisexual, “homosexually experienced” heterosexual (p. 2049) and exclusively heterosexual. The results of their analysis found that women who identified as bisexual or homosexually experienced heterosexual women reported poorer health than women who reported being exclusively heterosexual (Cochran & Mays, 2007). The heterogeneous nature of the SM population contributes to the difficulty experienced when recruiting study participants. Identification

and recruitment of sufficient representative samples of SM individuals in order to identify differences in disease prevalence between members of the SM community and heterosexual men and women has been challenging (Meyer, 2003).

Women without any homosexual experiences were less likely to report problematic alcohol use than women who self-identified as lesbian; in this sample bisexual women were found to be at greatest risk for alcohol use and depression (Wilsnack et al., 2008). The differing behaviors encompassed by the definitions and consolidation of identities is problematic because it prevents an accurate examination of the L/B community. Women may be mislabeled and therefore their behaviors may not be accurately representative.

To summarize, extant research with SM populations suffers from methodological issues that may render it less reliable than research conducted with a more visible and less stigmatized population. Research participants were often recruited via snowball sampling, or at SM-friendly venues, and so may only be truly representative of members of the SM population who participate in events at public venues. Emerging research suggested there are health behavior differences between women who identify as heterosexual yet endorse homosexual experiences and bisexual women, lesbians, and exclusively heterosexual women. Additionally, the timing of homosexual experiences reported by women who identify as heterosexual may impact how they identify themselves and their reported behaviors.

## **The Health of Lesbian/Bisexual Individuals**

### **Health and Health Behaviors**

Little research addresses social-spiritual health and L/B women in the setting of healthcare. Therefore, the following will address only physical and emotional health behaviors of L/B women.

The above methodological issues and concealed nature of the population negatively affects the amount of reliable research that is available regarding the health of L/B women. While society has become, arguably, more accepting of SM individuals, (Hequembourg & Dearing, 2013; Irwin, 2007), others note a more covert discrimination or stigma that continues to be present. The discrimination, maltreatment and/or stigma continue to propagate hidden SM identities (Lick, Durso & Johnson, 2013; Marques et al., 2014). The stigma associated with one's SM identity may negatively affect one's health by limiting the number of visits to healthcare providers, inhibiting disclosure of sexual orientation, and receipt of preventive care/screenings (Meyer, 2003). Scientists have begun to incorporate questions concerning sexual orientation and behaviors into larger population-based studies; this inclusion has provided insight into SM health matters and behaviors (Cochran & Mays, 2007; Dilley, Wynkoop Simmons, Boysun, Pizacani, & Stark, 2010).

Research on the health behaviors of L/B individuals is becoming more prevalent and disparities in physical and mental health have been identified. Lesbian and bisexual women reported more physical complaints than heterosexual women, such as respiratory illnesses, gastrointestinal issues, back pain, and fatigue (Cochran & Mays, 2007; Dilley et al., 2010; McNair et al, 2011). Additionally, women who endorsed bisexuality and those

who identified as heterosexual but with homosexual behaviors have reported poorer health than exclusively heterosexual women. Such reports included higher rates of abnormalities in Papanicolaou (Pap) tests, sexually transmitted infections, urinary tract infections, and Hepatitis B and C (Cochran & Mays, 2007; Dilley et al., 2010; McNair et al., 2011).

Researchers examined the presence of mood, anxiety, and substance use disorders and found disparities in these mental health issues when L/B populations were examined in comparison to exclusively heterosexual populations (Bogart et al., 2014, p. 1; Dilley et al., 2010; McNair, Szalacha & Hughes, 2011). Researchers speculated the risky health behaviors detailed below, as well as mood and anxiety disorders suffered by L/Bs may be attributable to minority stress (Meyer, 2003).

Extant research suggested that L/Bs (including women who identified as heterosexual but with homosexual experiences) might have had a greater number of one or more risky health behaviors than their heterosexual counterparts. Researchers note that L/Bs reported tobacco use, (Boehmer, Miao, Linkletter & Clark, 2012; Gruskin, Greenwood, Matevia, Pollack, & Bye, 2007; Hatzenbuehler, McLaughlin, & Slopen, 2013), excessive alcohol use, (Bonvicini & Perlin, 2003; Condit, Kitaji, Drabble, & Trocki, 2011; Hatzenbuehler, McLaughlin, & Slopen, 2013; Hughes, 2011; Wilsnack et al., 2008), over-weight or obesity (Dilley, Wynkoop Simmons, Boysun, Pizacani & Stark, 2010; Hatzenbuehler, McLaughlin, & Slopen, 2013), illegal substance use (Bonvicini & Perlin, 2003; Hequembourg & Dearing, 2013; Hughes, Szalacha & McNair, 2010), and lack of adequate physical activity (Rosario et al., 2014). Emerging research suggests L/B women may have experienced a greater number of harmful experiences

when children that have influenced their adult health (Andersen & Blosnich, 2013; Zou & Andersen, 2015), with increased occurrences of chronic and life-limiting diseases including cardiovascular disease, and cancers.

Risky health behaviors may change as women age (Boehmer et al., 2012; Talley, Sher, & Littlefield, 2010). Boehmer and colleagues (2012) dichotomized health behaviors by age (above and below 50 years of age) and noted that L/B participants over the age of 50 reported more smoking behaviors than their heterosexual peers. Lesbian participants did not change smoking habits as they aged; however bisexual women over the age of 50 reported tobacco use similar to that of the heterosexual participants of the same age. More L/B over the age of 50 reported binge drinking, whereas older L/B women reported less binge drinking than older heterosexual women (Boehmer et al. 2012). Not all behaviors reported by participants were potentially harmful to health; participants in the research conducted by Boehmer et al., (2012), also endorsed health-promoting behaviors in the form of weight training and moderate levels of physical activity (p. 294).

### **Health Maintenance and Screening**

Research indicates that L/B women do not perform health maintenance and/or health screening such as Paps and/or mammography as often as heterosexual women (Aaron et al., 2001; Agenor, Krieger, Austin, Haneuse & Gottlieb, 2014; Boehmer et al., 2012; Bonvicini & Perlin, 2003; Dilley et al., 2010; McNair et al., 2011; Steele et al., 2006). They do not see healthcare providers at regular intervals (Boehmer et al., 2012; Seaver, Freund, Wright, Tjia, & Frayne, 2008). This lack of health maintenance and screening, combined with risky health behaviors places L/B women at increased risk for many acute and chronic diseases, including adult-onset diabetes mellitus, multiple

cancers, pulmonary disease, liver disease, and cardiovascular diseases (American Cancer Society, 2014; Bonvicini & Perlin, 2003; Cochran & Mays, 2007; Dilley et al., 2010; McNair et al., 2011).

### **Disclosure of Sexual Orientation to Healthcare Providers**

Lesbian and bisexual women have offered information regarding their decisions to disclose their sexual orientation to healthcare providers (Barbara, Quandt, & Anderson, 2001). As above, some are afraid of discriminatory treatment, having experienced such or having heard of others' experiences of discriminatory treatment. Other L/Bs report they did not disclose to their healthcare providers because they did not believe it to be pertinent to their healthcare and/or to their visit. Many L/Bs did, however, disclose their sexual orientation if the healthcare provider asked them outright (van Dam, Kob, & Dibble, 2001).

### **Summary**

Researchers have identified both physical and mental health disparities in L/B women. Overall, L/B women report more physical and emotional health complaints, as well as fewer health maintenance and/or screening activities. When parsed into sexual behavior categories, women who identify as bisexual or as heterosexual but with homosexual experiences appear to experience greater health disparities than lesbian and exclusively heterosexual women, respectively. Women may not have offered information regarding their sexual orientation, because of fear of negative repercussions or because they did not believe it was pertinent to their healthcare. Researchers posit disparities may be related to minority stress (Meyer, 2003). Research into the health behaviors and



subsequent morbidity and mortality would benefit from larger, population-based studies in which sexual orientation is clearly defined utilizing a consensus-based definition.

### **Health and Lesbian/Bisexual Women Veterans**

#### **Don't Ask, Don't Tell**

Although an in-depth examination of the policies regarding homosexuality held by the US military and/or the Department of Defense, (DoD), (McNeill Ransom, 2001), was beyond the scope of this study, it was important to understand the context in which many L/Bs performed their service to the US. The military has long proscribed homosexuality in service members; officially, homosexuality had been forbidden since the early 1900s (McNeill Ransom, 2001; Nagel, 2010). During his first term of office, President Clinton, in an attempt to halt the prohibition, established what came to be known as the Don't Ask, Don't Tell (DADT) policy. DADT became a DoD policy by 1994 and prohibited questioning service members regarding their sexual orientation unless there was a reason to launch an investigation (McNeill Ransom, 2001). DADT prohibited military personnel from discriminating against or harassing closeted homosexual or bisexual service members or applicants, while barring openly gay, lesbian, or bisexual persons from military service.

Persecution of SMs in the military did not abate with DADT; in fact, discharges secondary to suspected homosexuality increased, especially among women (Nagel, 2010). Although DADT did protect enlistees from questions regarding their sexuality, service members' sexual orientation was investigated if there was evidence or an accusation that the service member was a member of a SM. Service women reported that male service members would initiate such investigations in retribution for rebuffed sexual

advances (McNeill Ransom, 2001). Sexual harassment complaints lodged by female service members against male members were turned into an investigation into the sexual orientation of the female service member by way of a complaint filed by the male service member to his superior officer (McNeill Ransom, 2001). Records indicate that women, as a group, were unduly affected by the military's DADT policy; greater numbers of suspected L/B service members were discharged under DADT than suspected gay and bisexual men (Kauth et al., 2014; Lehavot & Simpson, 2012).

The Health Insurance Portability and Accountability Act, (HIPAA), limits and protects access to a civilian's medical record (US Department of Health and Human Services, n.d.); however, service members do not enjoy that same security. The DoD has access to service members' medical records to ensure suitability for duty (O'Reilly, 2009). Medical records may contain information that could be used in an investigation of a service member's sexual orientation (Katz, 2010; Nagel, 2010; O'Reilly, 2009; Smith, 2008).

The open medical records policy negatively affected the relationship between a service member and the military healthcare provider, as well as the delivery of comprehensive healthcare (Katz, 2010; Nagel, 2010; O'Reilly, 2009). Specifically, service members reported going without medical care or sought that care episodically at civilian clinics rather than to disclose their sexual orientation to military healthcare providers (Katz, 2010; Nagel, 2010; O'Reilly, 2009; Smith, 2008). DADT was repealed in September 2011.

After the repeal of DADT, service members and military Veterans who identified as a member of a SM population could then, arguably, serve without hiding their sexual

orientation and receive VA benefits without fear of persecution. However, change has not occurred easily or quickly, since the repeal. Anecdotally, Veterans who receive benefits while continuing to serve at times have not disclosed their sexual orientation for fear of their health records being privy to active duty personnel. A participant in this study, Yolanda, spoke of receiving care from VA healthcare providers prior to her separation from the military. As she was still an active member, she did not disclose her sexual orientation in fear her medical records were not private and disclosure would adversely affect her military career.

As a reaction to DADT and its subsequent repeal, SMs remained hesitant to disclose their status, and military providers hesitated to ask SM status questions due to the unintended negative consequences on the service member's career. Veterans reported fearing a loss of benefits, and/or rank. As above, this silence regarding sexual orientation negatively impacted the patient-provider relationship; a military provider's reluctance to ask questions regarding sexual behaviors for fear of 'outing' or disclosing a service member's sexual orientation meant infections or diseases associated with risky sexual behaviors often went undiagnosed or untreated (Katz, 2010).

### **Prevalence**

There are approximately 23 million military Veterans in the US; almost nine million Veterans were enrolled to receive VA health benefits during the 2013 fiscal year (National Center for Veterans Analysis and Statistics, 2014). Once separated from the armed services, military Veterans seeking access to VA benefits are evaluated and placed into one of eight Priority Groups. Not all Veterans are eligible for VA care. Placement into the groups is based upon the presence of a service-connected injury or exacerbation

of a pre-existing injury during service, events during service (such a Prisoner of War status), and income (United States Department of Veterans Affairs, n.d.). Sexual minority Veterans may be eligible for healthcare provided by the VA via this mechanism (Simpson, Balsam, Cochran, Lehavot, & Gold, 2013).

Nearly 2.3 million of Veterans above are women. As the largest integrated healthcare organization in the US (VA; Washington, Bean-Mayberry, Hamilton, Cordasco, & Yano, 2013, p. S571), the VA serves women Veterans who have served prior to World War II to the present. Women Veterans of the US armed forces are a large, heterogeneous population (National Center for Veterans Analysis and Statistics, 2011) with a wide range of ages, from young women who served in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND) to older adults who served prior to World War II. One third of women Veterans have only served during times of peace (National Center for Veterans Analysis and Statistics, 2011 p. 8; National Center for Veterans Analysis and Statistics, 2014).

When examined by age distribution, women Veterans created a tri-modal line. Peaks representing greater numbers of Veterans are evident at ages 27, 48, and 86 years, respectively (Frayne et al., 2012, p. 2). Nearly 10,000 women Veterans were 48 years of age during 2010, representing the highest peak. When examined by the percentage of the women Veteran population represented by an age group, nearly 90% of women served by the VA during the fiscal year 2010 were between the ages of 18-44 years (42%) and 45-64 years (45%), with the remainder of the population 65 years of age and older (13%) (Frayne et al., 2012, p. 8). As the number of women serving in the armed forces rose, so did the number of women enrolled in the VA. Between 2000 and 2009, the VA

experienced an 83% increase in the number of women served by the VA (National Center for Veterans Analysis and Statistics, 2011, p. 17).

## **Health and Women Veterans**

### **Physical Health**

The amount of literature regarding Veteran health echoes the influx of women into the service and into the VA, in that as the number of women Veterans has increased in the past ten years, so has the amount of research regarding women Veterans (Bean-Mayberry et al., 2010; Bean-Mayberry et al., 2011). Systematic reviews of literature have examined extant research on the health of women Veterans. Bean-Mayberry et al., (2010), recently updated an earlier systematic review of literature (Goldzweig, Balekian, Rolón, Yano & Shekelle, 2006) examining the state of the science on women Veteran's healthcare research. Studies covered such topics as genitourinary issues related to combat conditions, surgical outcomes, and quality of care studies that noted disparities in cancer screening and blood lipid levels. The preponderance of works found between 2004 and 2008 examined Veterans of the recent OEF/OIF/OND wars and centered on mental health issues (Bean-Mayberry et al., 2010).

In turn, Batuman and colleagues, (2011), updated extant research by examining research published after 2008 on two questions. The first question centered on reproductive health, genitourinary health, gynecologic oncology, and breast cancer, (p. 6). The authors identified studies that examined Veterans who served during the Vietnam War and the first Gulf War. No greater risk of gynecologic or breast cancers was identified in Vietnam Veterans. The occurrence of birth defects was higher in women Veterans who had served in Vietnam. Results from reproductive health studies in Gulf

War Veterans were not as clear and yielded mixed results. The authors noted that lack of large sample sizes negatively affected the reliability of the studies.

Researchers led by Washington, et al., (2013), reported on a cross-sectional survey of a large number of woman Veterans. Their sample included Veterans of World War II (and earlier), the Korean, Vietnam, and Gulf I Wars, through the OEF/OIF/OND wars. The mean ages of the Veterans from each war, in order from World War II to present, were 87 years, 77 years, 64 years, 46 years, and 38 years, respectively (Washington et al., 2013, p. S537). The older Veterans in this study, having served in World War II and Korea, respectively, endorsed the highest amount of multiple physical morbidities, not otherwise specified by the authors (Washington et al., 2013).

Women who receive VA care may do so for different reasons; some receive care due to a service-connected disability. A service-connected disability is one that was sustained or worsened due to military service (National Center for Veterans Analysis and Statistics, 2011). The most often reported disabilities include mental health disease/illness, musculoskeletal pain/injury, migraine headaches, and gynecologic surgery (p. 23). As compared to the women Veterans in Washington et al.'s study (2013) above, the National Center for Veterans Analysis and Statistics (2011) noted the highest number of service-related disabilities occurred in younger women Veterans (2011, p. 22; Frayne et al., 2012).

Finally, much research has been conducted on the health of OEF/OIF/OND Veterans. After separation from service, back, joint, and/or musculoskeletal disorders were among the most prevalent complaints in women Veterans (Haskell et al., 2011; Mattocks et al., 2010; National Center for Veterans Analysis and Statistics 2011). In

research reported by Haskell et al., (2011) the most frequently reported health conditions reported during the first 12 months home were back and joint disorders while musculoskeletal disorders were sixth most prevalent (p. 94). Additionally, further research noted the prevalence of musculoskeletal and joint disorders continued for seven years after deployment (Haskell et al., 2012).

Research is emerging that examines the presence and characteristics of multiple morbidities in the male and female Veteran population. Pugh et al., (2014) identified six clusters of physical and mental health diseases, both acute and chronic, in a cohort of OEF/OIF/OND Veterans. Membership in each one of the six groups differed by age, race/ethnicity, marital status, and military branch. The “Relatively Healthy” cluster, characterized by the fewest number of illnesses, had the largest membership, at 53% of the sample (Pugh et al., 2014, p. 176). Women Veterans were in the minority in each of the 6 clusters identified.

Reproductive disorders, including partial hysterectomies and other gynecologic surgical procedures, were among the top 10 service-connected disabilities reported in women Veterans (National Center for Veterans Analysis and Statistics (2011); disorders of the female reproductive system were reported by OEF/OIF/OND Veterans (Haskell et al., 2011; Mattocks et al., 2010). Gynecology and obstetrical care is noted to be a new need for the Veteran population, as 77% of returning women are 40 years of age or less and more likely to require gender-specific services (Department of Veterans Affairs, 2012; Mattocks et al., 2010; Mattocks et al., 2014).

## **Mental Health**

The wars in the Middle East, (OEF/OIF/OND), were notable not only for the increased number of women service members, but also for the lack of a defined front line. Thus, although not assigned to infantry positions, women were exposed to combat experiences as they served as military police, drivers within convoys, carrying personnel or supplies, (Mattocks et al., 2012; Fitzgerald, 2010). Mental health concerns appear most prevalent in the women OEF/OIF/OND Veteran population.

Batuman et al., (2011), in their update of prior reviews of literature, examined post-trauma sequelae in OEF/OIF/OND women Veterans. The research they reviewed suggested that women who deployed and experienced combat were more likely to develop depression and were at an increased risk for suicide when compared with civilian women. Researchers found a reported need for mental health care by women Veterans, and noted gender differences in care received; often OEF/OIF/OND women Veterans who were recently diagnosed with post-traumatic stress disorder (PTSD) received sub-standard treatment but utilized more healthcare services overall. Women Veterans were more likely to be evacuated from combat for mental health illnesses if they were under the age of 31 years and were a racial/ethnic minority, early into her deployment (Batuman et al., 2011, p. 2).

Bean-Mayberry et al., (2010) found PTSD was a prevalent topic of the research they examined, and when present, was associated with a poorer quality of life. Overall, researchers found greater prevalence of mental health illnesses in women Veterans. A history of military sexual trauma increased a woman's risk for PTSD, and in conjunction with deployment to combat situations, contributed to an even higher rate of mental



illness. Additionally, Veterans reported increased anxiety related to invasive medical procedures (Bean-Mayberry et al., 2010).

Additional research studies, not included in the previous systemic reviews, have also identified mental illness in women Veterans of OEF/OIF/OND. Psychosocial disorders reported by OEF/OIF/OND Veterans include adjustment disorders (Haskell et al., 2011; Maguen, Ren, Bosch, Marmar, & Seal, 2010), anxiety disorders (Blackstock Haskell, Brandt, & Desai, 2012; Maguen et al., 2010; Mattocks et al., 2010; Mattocks et al., 2013), and mood disorders (Blackstock et al., 2012; Cobb Scott et al., 2013; Haskell et al., 2010; Haskell et al., 2011; Mattocks et al., 2010; Mattocks et al., 2013). Also included are disorders associated with traumatic experiences, such as PTSD (Blackstock et al., 2012; Cobb Scott et al., 2013; Haskell et al., 2009; Maguen et al., 2010; Mattocks et al., 2010; Mattocks et al., 2013; Tsai, Harpaz-Rotem, Pietrzak, & Southwick, 2012), and military sexual trauma (MST) (Haskell et al., 2010; Mattocks et al., 2013). Experiencing such traumatic events may also be related to substance use disorders (SUDs) that included the use of risky health behaviors such as alcohol, tobacco, legal, and illegal drugs, or food (Blackstock et al., 2012; Cobb Scott et al., 2013; Maguen et al., 2010; Mattocks et al., 2010; Mattocks et al., 2012; Mattocks et al., 2013).

### **Health of Lesbian/Bisexual Veterans**

Much remains unknown about the health and healthcare needs of L/B Veterans (Blosnich, Bossarte, Silver, & Silenzio, 2013; Kauth et al., 2014; Lehavot & Simpson, 2012). Research with this sub-population of women Veterans has increased with the repeal of DADT, yet gaps in knowledge persist (Kauth et al., 2014). Methodological issues as detailed previously in civilian populations plague research with L/B Veterans;

additionally, L/B Veterans feared disclosure of sexual orientation may impact their eligibility for Veteran benefits or future career plans (Mattocks et al., 2015).

Recent reviews of extant research provide a baseline for what is known about L/B Veterans. Kauth et al., (2014), reviewed works that provided an exploration of the sexual health of SM Veterans. Regarding L/B Veterans, they noted the Veterans reported high rates of sexual violence experienced as children and when in the military. Mental health and SUDs were prevalent in this population of women (Kauth et al., 2014); Mattocks et al., (2015), noted similar findings. Researchers have conducted studies examining adverse childhood events with women, military Veterans, and lesbian women, but have not examined female lesbian military Veterans.

Simpson et al., (2013), examined VA utilization by SM Veterans and reported that approximately 34%-40% of L/B Veterans had utilized VA services in their lifetimes. Sexual minority Veterans who reported having been scrutinized for homosexuality were less likely to utilize VA healthcare services (p. 229), a finding that may be related to their trust in an organization that is perceived to be similar to the military.

Data suggests that L/B civilians and L/B Veterans may have similar risk factors and experiences. However, researchers do not understand how known disparities associated with military Veterans status and L/B status may combine and together impact the health, health behaviors, and wellbeing of L/B Veterans (Kauth, Meier, & Latini, 2014; Lehavot & Simpson, 2012; Mattocks et al., 2015). This is important information as the combination of stigmatized identities may be additive or synergistic in action, magnifying negative sequelae associated with sexual orientation and military service.

## **Summary**

Healthcare needs for women Veterans are many, reflecting the heterogeneous nature of the population, the burgeoning number of women Veterans, injuries sustained during service, and health concerns and/or illnesses that are characteristic of the specific age groups represented (i.e. pregnancy or other reproductive health issues in young adult women). Trauma-related diagnoses, such as MST and PTSD, are especially prevalent in the OEF/OIF/OND cohort. The number and types of healthcare concerns shared by women Veterans reinforces their need for culturally appropriate VA care. Disparities have been identified in the mental health care received by women Veterans. More importantly, women who identify as L/B may have additional concerns regarding healthcare access in that theirs is a hidden population secondary to the stigma and discrimination experienced by the SM community when seeking healthcare. The next section will discuss relationships between L/B women and RNs and MDs.

### **Relationships Between Lesbian/Bisexual Women and RNs and MDs**

#### **Relationships Between Lesbian/Bisexual Women and Registered Nurses**

The US Department of Health and Human Services estimated that there were nearly 3 million RNs in the US during 2010 (Health Resources and Services Administration (HRSA), 2013). Nurses comprise the largest population of healthcare providers in the US (Benner, Sutphen, Leonard, & Day, 2010); the VA employs approximately 50,000 RNs (VA). When surveyed, the general public consistently rates nurses as the most ethical and trustworthy of professions (Gallup Poll, 2013; 2014). This is particularly important because researchers note that during healthcare encounters,

individuals spend the majority of their time with nurses (Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007; Felgen, 2004).

Nurses conceptualize persons as holistic, biopsychosocial human beings, consisting of biological and psychosocial components that are interconnected and indivisible (Watson, 2010). The care planned and executed by the RN reflects the perception that a person is more than a sum of her parts. Integral to that nursing care is the unique, therapeutic relationship built with the person and/or persons receiving the care (Diamond Zolnierek, 2014; Felgen, 2004; Halldorsdottir, 2008; Watson, 2010). However, discrimination, heteronormativity, homophobia, and stigma displayed by RNs may prevent the development of the therapeutic RN-patient relationship and contribute to the development of health disparities (Eliason, Dibble, & DeJoseph, 2010; Giddings & Smith, 2001; Goldberg, Harbin, & Campbell, 2001; Richmond & McKenna, 1998; Røndahl et al., 2006; Røndahl, Bruhner, & Lindhe, 2009; Weisz, 2009).

If, as Diamond Zolnierek (2014) posits, “nursing care is delivered within the context of the relationship with the patient” (p. 4), then anything that hinders that relationship has the potential to negatively affect the health of those individuals. Lesbian and bisexual women who are at-risk or suffer from acute and chronic diseases may suffer from health disparities and may be reluctant to pursue healthcare because of discriminatory treatment.

Heteronormativity is a type of discrimination and is described as: “the assumption that heterosexuality is the only sexuality of individuals and society...The invisibility of the social lives...functions as a mechanism of social exclusion, which leads to out-group status” (Røndahl et al., 2006, p. 374). Heteronormative assumptions were often reported

as a mechanism by which SM individuals experienced discrimination and invisibility (Goldberg et al., 2011; Gray et al., 1996; Irwin, 2007; Røndahl et al., 2006; Røndahl, 2009; Røndahl et al., 2009; Russell, 2009; Seaver et al., 2008; Weisz, 2009). For example, Goldberg et al., (2011) and Røndahl et al., (2009) found that heteronormativity in the setting of maternity care adversely affect the care received by women.

Homophobia was also found as an etiologic agent towards discriminatory care, fewer healthcare interactions, and health disparities (Goldberg et al., 2011; Irwin, 2007; Weisz, 2009). Richmond and McKenna, (1998), defined homophobia as “a dislike or distrust of homosexuals’ life-style based upon personal, social, or cultural beliefs” (p 367). Irwin, (2007), noted homophobia on the part of healthcare providers could contribute to patients’ feelings of segregation and separation. Weisz, (2009), presented homophobia and heterosexism as social justice issues in women’s health and reminded nurses of their roles as patient advocates.

Several studies examined the experience of RNs who identify as L/Bs within nursing education, and in the workplace (Eliason et al., 2011; Dinkel et al., 2007; Giddings & Smith, 2001; Gray et al., 1996). An online survey of SM RNs noted that within a single institution, the degree of ‘friendliness’ to SM RNs changed from unit to unit and that ‘friendliness’ meant nothing more than lack of outright aggression to a SM staff member (Eliason et al., 2011). Giddings and Smith (2001) found differing levels of support for RNs who disclosed their SM status at their workplace and a continuation of the invisibility of SMs in nursing. Røndahl (2009) noted an overwhelming need for education regarding SM in both nursing school and medical school; the majority of 124

nursing and medical students who completed a test of knowledge about SM individuals failed.

### **Summary**

In conclusion, RNs represent the largest population of healthcare providers in the US. Ethical standards demand RNs care for individuals in ways that respect their individuality and potential differences. Unfortunately, RNs are also products of the society from which they develop. Therefore, the nursing care provided to SMs is often marked by heteronormativity, homophobia, and stigma. Such discrimination negatively affects the care provided to SMs, who may hide their sexual orientation from healthcare providers or not seek healthcare at all. This may be dangerous to a population known to experience health disparities and engage in risky health behaviors. For Veterans served by the VA, the above barriers to therapeutic relationships with RNs may negatively impact the relationship between the L/B Veteran, an RN Case Manager, and the care offered by the PACT team. Nursing education regarding care of SMs has been lacking in nursing programs as well as continuing education programs. The next section will speak to relationships between SMs and an integral member of the healthcare team, MDs.

### **Relationships Between Lesbians/Bisexual Women and Physicians**

Physicians are highly educated health care providers who practice in multiple settings and within many specialties, ranging from primary care physicians to gynecologists-obstetrics, oncologists, general surgeons, and psychiatrists, to name but a few areas of expertise. Often, MDs will specialize in internal medicine or primary/family care and in those roles function as primary care providers. Only 30% of US MDs practice primary care. Primary care providers are often gatekeepers; providing general physical

and emotional care and referring patients to specialists on an as-needed basis. To provide appropriate, caring, culturally competent healthcare, the MD, in whichever specialty he or she chooses, must establish a trusting relationship with the patient.

The MD-patient relationship has evolved over time. During the past 50 years or so, the expected relationship between MD and patient has transformed into a more “patient-centered” model, in which the MD and patient are partners in the patient’s care (Kaba & Sooriakumaran, 2007). A holistic understanding of the patient and the ability to form a working relationship with the patient, one in which the patient is comfortable and is able to share intimate details, is a necessary key to quality healthcare. Barriers to the MD-patient relationship may adversely affect the health of the patient.

A barrier to the relationship between MD and patient may occur if either the patient or the provider feels uncomfortable speaking about a topic such as sexual health, including sexual orientation (Bonvicini & Perlin, 2003; Klitzman & Greenberg, 2002; McNair, Hegarty, & Taft, 2012; Politi, Clark, Armstrong, McGarry, & Sciamanna, 2009). Lesbian and bisexual patients report discomfort broaching the topic of their sexual orientation with MDs, for fear of a negative or discriminatory reaction from the MD (Bonvicini & Perlin, 2003; Facione & Facione, 2007; Marques, Nogueira, de Oliveira, 2014; McNair et al., 2012; Neville & Henrikson, 2006; Politi et al., 2009; Stein & Bonuck, 2001). In turn, MDs report discomfort when questioning patients about sexual orientation for fear they will embarrass the patient, or will not know how to react if she discloses her identity as a L/B (Bjorkman & Malterud, 2007; Hinchliff, Gott & Galena, 2005; Westerståhl & Björkeland, 2003).

This discomfort often inhibits an MD from asking a patient about her sexual orientation (Hinchliff et al., 2005; McNair et al., 2012; Stein & Bonuck, 2001).

Discomfort in addressing a patient's sexuality may be accompanied by heteronormativity, an action that renders L/B patients invisible (Neville & Henrikson, 2006). As with RNs, MDs are products of their environment and they will mirror society's perspectives (Bonvicini & Perlin, 2003).

Researchers have explored reasons behind the lack of assessment of sexual orientation by MDs (Dahan, Feldman, & Hermoni, 2008). Explanations offered included, in no particular order: (a) they are not in the practice of asking any patients about sexual orientation, (b) they do not understand how to react to a disclosure of SM status, (c) the patient's sexual orientation was irrelevant to her healthcare, (d) embarrassment, (e) not knowing the correct language to use, (f) homophobia, (g) lack of medical education, and (h) heteronormativity (Bonvicini & Perlin, 2003; Dahan et al., 2008; Hinchliff et al., 2005; Klitzman & Greenberg, 2002; McNair et al., 2012; Neville & Henrikson, 2006; Stein & Bonuck, 2001).

In the setting of a healthcare visit, inquiring into a patient's sexual orientation is important. As detailed above, while L/Bs may not freely disclose their sexual orientation, many will when asked directly (McNair, Hegarty, & Taft, 2012). An MD's incomplete assessment during an encounter may have negative ramifications for the L/B patient. Data suggests that L/B patients may suffer from acute and chronic physical and psychological morbidity secondary to their risky health behaviors. Physicians who assume their female patients are heterosexual may not conduct key assessments, and focus on health care needs less pertinent to L/B (Labig & Peterson, 2006; Sherman,



Kauth, Shipherd, & Street Jr., 2014). They may spend time during the encounter providing counseling on birth control for an assumed heterosexual women, for example. Additionally, providers may not adequately screen for risky health behaviors. Thus within the VA primary care system, an MD may fail to provide appropriate referrals.

### **Summary**

The primary reasons given by MDs for not assessing their patient's sexual orientation include heteronormativity, the belief that a patient's sexual orientation is not pertinent to their healthcare, a knowledge deficit regarding the presence of SM patients, and the appropriate language to use. This may negatively impact the relationship between a L/B patient and MD, and negatively affect the L/B's health.

There is a paucity of data regarding relationships between L/B Veterans and VA RNs and MDs. It is not known if L/B Veterans have similar considerations as civilian L/Bs regarding disclosure of sexual orientation to healthcare providers. Is it not known if or how the repeal of DADT has affected L/B Veteran decision-making regarding disclosure of their SM identity to their healthcare providers. The next section in this chapter will discuss identity. The final section in Chapter Two will detail the relational cultural theory that was used as a heuristic device for the study.

### **Identity and Self**

#### **Identity**

Identity (ID) is a common, yet difficult concept to describe. Scholars have struggled to offer a definition that adequately describes identity for more than two millenia (Leary & Tangney, 2012). In a general sense, identity can be defined as “the qualities, and beliefs, that make a particular person or group different from others”

(Merriam Webster Online Dictionary, 2015; Taylor, 2003). An ID is dynamic, (de Munck, 2013; Gibson & Macleod, 2012; Oyserman, Elmore, & Smith, 2012), multifaceted, complex (Shroff & Fordham, 2010; Taylor & Littleton, 2006), and unique (Stets & Burke, 2000). It is both given to and constructed by the self and others (Dunlop & Walker, 2013; Taylor, 2006), and is how one identifies himself or herself, and how one perceives or defines other individuals (Shroff & Fordham, 2010). Identities assist the self in negotiating cultures (de Munck, 2013) and understanding one's position in a social hierarchy (Griffith, 2011). Through the use of identities, an individual can be characterized in many different ways (Oyserman et al., 2012).

How an ID develops is not agreed upon by scholars. Some note IDs develop over time as the individual matures and becomes self-aware (Ryan & Deci, 2012), whereas others suggest one's ID may already be in place prior to one's birth and remains after one's death (Baumeister, 2011). Individuals suffering from memory loss, (Jetten, Haslam, Pugliese, Tonks, & Haslam, 2010), episodic or otherwise, may lose a sense of their identity, as the 'what where when of an event' is key for an intact ID (Klein & Nichols, 2012, p. 679).

Two theories that were developed in order to explicate the concept of ID are identity theory (IT) and social identity theory (SIT) (Griffith, 2011; Hogg, Terry & White, 1995; Stets & Burke, 2000; Stryker & Burke, 2000; Swann, Jetten, Gomez, Whitehouse, & Bastian, 2012; Teuscher, 2010; Willets & Clarke, 2014). Social identity theory, as the name would suggest, privileges the importance of society in the development of one's ID or sense of self (Hogg et al., 1995; Stets & Burke, 2000; Willets & Clarke, 2014). Society-driven identification pre-exists in this theory and an

individual fits into the pre-existing society by assuming a role, with its pre-existing rules for behavior. A role that is esteemed within society would increase the chance that an individual would strongly identify with that role (Teuscher, 2010).

Stryker & Burke (2000) attribute the development of IT to G.H. Mead and noted his contribution in the pattern of influence, in that “society shapes self shapes social behavior” (p. 285). Identity theory suggests that the self is cognizant and able to identify itself as belonging in some social categories while not in others, based upon the role(s) it assumed (Griffith, 2011; Hogg et al., 1995; Stets & Burke, 2000; Stryker & Burke, 2000). The individual compares himself or herself to the “identity standard”, or how they believe a person in the role should personify that role (Stets & Burke, 2000). One’s perception or understanding of one’s own ID is the ‘self’ (Oyserman et al., 2012).

### **Self**

The concept of ‘self’ is closely related to ID. In fact, Oyserman et al., (2012) described self, self-concept, and ID as “nested elements” (p. 74) and noted IDs create the self (Oyserman et al., 2012). Self is defined as “a particular part of your personality or character that is shown in a particular situation; the combination of emotions, thoughts, feelings, etc., that make a person different from others” (Merriam Webster Dictionary, 2015). Leary and Tangney (2012) noted self could be perceived as something an individual possesses. Self is also conceptualized as an active part of an individual’s consciousness.

Baumeister, (2011), suggested that the self is a three part phenomenon. In one part, the self is a storage vessel for ID characteristics, whereas the two other parts are components that have active roles in the individual’s day to day life: one interacting with

others on a daily basis, and one that engages in decision making. Similarly, de Munck (2013) theorized that the self is functional, in that “The primary function of the ‘self’ is to bestow self-consciousness on an ID” (p. 182). Leary and Tangney (2012) implied that a self is sentient in nature; “the capacity for self-reflection lies at the heart of what it means to have a self” (p. 1).

Identity and self share definitions that are similar in that both highlight the differences between individuals that serve to distinguish between one individual and another. Both constructs are created within interactions between self and others, and both words are often used interchangeably (Oyserman et al., 2012). Identity and self both inform how we interact within society and how society views the individual, including behavioral expectations. Because of these similarities, for the purposes of this manuscript, the terms ID and self will be used interchangeably.

### **The Relational Cultural Theory**

The relational-cultural theory (RCT) is a feminist developmental theory that emerged during the 1970s (Miller 1976; Miller, 1986; Vogel, 2006/2007) when a group of female therapists, during discussions with peers, noted commonalities in their clients. The therapists, whose practices were informed by male-oriented, European schools of psychiatric theory (Jordan, 2001), were seeing many women in their practices who were unhappy in their lives and relationships; some women were told they were ill. During discussions, the women therapists noted that their clients weren’t actually ill. They desired a closer relationship with others and the lack of close relationships in the clients’ lives led to unhappiness. This flew in the face of extant theory, that taught that as one developed, in order to be healthy, one needed to separate oneself from close ties with

others (Head & Hammer, 2013; Ruiz, 2005). The women's experiences were misinterpreted (Jordan, 2001) and the pathologizing of the women's emotions led them into counseling.

The group of women, (Jean Baker Miller, Judith Jordan, Irene Stiver, and Janet Surrey), began to develop a theory based upon what they were noting in their practices (Vogel, 2006/2007). The theory, also known as the self-in-relation theory or the Stone Center relational model, (Ruiz, 2005) was later expanded upon by Miller and others (Frey, 2013; West, 2005), and was renamed the RCT. The development of the theory is ongoing. Originally meant to inform the emotional health and treatment of women, the scope of RCT has since been expanded to include all persons, including men, persons of color, SM individuals and refugees (Jordan, 2001; Mereish & Poteat, 2015; Ruiz, 2005; Stein, 2010; Thomas & Matusitz, 2016). The RCT has roots in relativism and phenomenology, in that the individual's perception of reality and how the individual experiences that reality are privileged in this theory (Stein, 2010, p. 145).

The premise of the RCT is that people, in order to be healthy, need to be in mutually empathic and empowering relationships with others in which they can be their authentic selves, (Freedberg, 2007; Miller, 1976, 1986; Portman & Garrett, 2005; West, 2005). Individuals will alter or hide parts of their authentic selves in order to 'fit' into a relationship with an important other. When in a relationship where it is safe to be authentic, the individual (as well as the 'other') will experience growth, and experience the "five good things" (Ruiz, 2005):

Five good things:

1. Zest (vitality or energy)

2. Empowerment and Change
3. Knowledge of self and others
4. Improved sense of self-worth
5. Desire for more connections with others (Head & Hammer, 2013; Ruiz, 2005)

However, if a person is not able to be in a mutually empathetic and empowering relationship with an important other, growth will not occur. For example, if a relationship with an important other proves to be non-empathetic, or if the individual fears hostility and/or rejection secondary to a trait or characteristic, the individual will attempt to remain within the relationship by concealing that trait, characteristic, or portions of themselves (Comstock et al., 2008; Freedberg 2007; Miller 1976, 1986; Portman & Garrett 2005; West 2005).

The need to be in relationship while fearing the consequences of authenticity is referred to as the “paradox of connection” (Jordan, 2001, p. 96). The work an individual will undertake to conceal the unwanted parts of self leads to isolation and disconnections from others. Referred to as “strategies of disconnection”, Jordan typifies these strategies as “strategies for survival” (2001, p. 96). The psychological cost of such actions may include feelings of “shame, unworthiness, and self-blame” (Stein, 2010, p. 140).

Individuals are able to work past the disconnections with empathetic others, professionals or friends and family members. Professionals have utilized the RCT as a therapeutic device with a wide range of clients (Head & Hammer, 2013; Jordan, 2001; Mereish & Poteat, 2015; Ruiz, 2005; Thomas & Matusitz, 2016; Vogel, 2006/2007), especially with clients who have, at the center of their illness, loss of or inability to be in relationship with important persons in their lives. The therapist will work to build a

trusting and accepting therapeutic relationship in which the client can feel their full self is seen and appreciated (Stehn, 2014; Thomas & Matusitz, 2016).

This theory could partially explain the dynamics of the relationship between L/B and the VA and VA healthcare providers in which, due to remnants of DADT, homophobia, heterosexism, invisibility, and the male-oriented milieu of the VA, the woman does not feel safe in disclosing her authentic self and so may not seek to enroll at the VA or may not receive appropriate healthcare from VA HCPs.

The next chapter will describe the parent study (Mattocks et al., 2015) and the plan for the secondary analysis of the qualitative data.

## **Chapter 3**

### **METHODS**

#### **Purpose**

The purpose of this exploratory, instrumental case study was to understand if and how L/B Veteran identities influenced the use of the VA for healthcare and relationships with VA healthcare providers.

#### **Research Questions**

(a) What were L/B Veterans' experiences of identity? (b) What significance did L/B Veterans' identity have for use of VA healthcare; and (c) What significance did L/B Veterans' identity have for relationships with VA healthcare providers?

#### **Goals**

The long-term goal of this study is to extend the work of Mattocks et al., (2015), by exploring L/B Veterans' self-identity, and how that identity may have impacted relationships with VA healthcare system and VA healthcare providers.

#### **Aims**

The aims of this exploratory, instrumental case study (Stake, 1995) were to (a) describe the L/B Veteran identity; and (b) describe how the identity may have impacted the relationship with VA healthcare and VA healthcare providers.

#### **Methodology**

The instrumental, collective case study was guided by Stake's methodology (Stake, 1995, pp. 3-4) and was exploratory and descriptive in nature. An instrumental case study is utilized when the researcher is interested in the gestalt of a phenomenon rather than the individual case. In this study, the phenomenon of interest, (Creswell,



2007), was L/B Veterans' identity. Collective case studies are a type of instrumental case study that allows the researcher to utilize multiple cases towards gaining an understanding of the phenomenon (Stake, 1995). Therefore, in this manuscript, L/B Veterans' identity was the instrumental phenomenon of interest and the multiple extant L/B interviews were the collective components. The purpose of this chapter is to detail the methodology to be used in this qualitative study.

### **Qualitative Research**

This exploration was guided by tenets of qualitative research. Qualitative methodologies are appropriate for use when the researcher seeks to understand the meaning behind a phenomenon from the point of view of those directly engaged in or with the phenomenon (Lincoln & Guba, 1985; Miles & Huberman, 1994; Munhall, 2007). A qualitative study is best when it's important to understand the individual's experiences as they perceive them. Qualitative research privileges the experience of the participants as expressed in their own words. This research methodology yields results that invite the researcher and reader to enter into the participant's lifeworld and understand their experiences from their unique point of view (Lincoln & Guba, 1985; Miles & Huberman, 1994; Munhall, 2007).

The secondary analysis of the interview data collected by Mattocks et al., (2015), sought to fill a gap in the extant research by revealing descriptive data on L/B Veterans' identity. The descriptive results would inform the practice of healthcare providers by helping them understand the care needs of this very vulnerable population. Additionally, case study is noted to be a methodology that promotes rapid translation of research findings, and so it was expected that results from this research would facilitate the

development of nursing interventions meant to improve the delivery of culturally appropriate healthcare to L/B Veteran populations.

## **Methods - Parent study**

### **Design**

The multiple site parent study was titled “*Understanding lesbian and bisexual women Veterans’ experiences and satisfaction with VA care*”. “Parent Study” will be used in place of the title from here forward. Participants were recruited from multiple geographical areas of the US, as well as US territories. Recruitment was accomplished through the use of flyers posted at VA medical centers, medical center staff referrals, and word of mouth (Mattocks et al., 2015).

### **Sample**

The sample consisted of a racially diverse group of adult women who were military Veterans, received care through the VA, and self-identified as L/Bs or reported a history of having female sexual partners. Participants represented Veterans who served in the US military during Vietnam, during the Cold War, during times of peace, the military activity in Somalia, and Operation Iraqi Freedom, Operation Enduring Freedom and Operation New Dawn (OIF/OEF/OND). Non-eligible participants did not identify as L/B or report having female sexual partners. Women unable to understand, speak, or read English were not eligible for participation. A total of 24 participants were enrolled. Participant demographics are found in Appendix A1; pseudonyms, years of service, and branch of service are found in Appendix A2.

## **Setting**

Participants for this study were recruited via VA healthcare centers, and through participants who told their friends of the study. Participants passed information about the study around their social and social networking groups without prompting; anecdotally, Veterans encouraged others to participate to “get the word out” about what they had experienced (personal communication, May 2014). Permission to utilize the qualitative data has been obtained from the Principal Investigator of the original study (private communication, March, 2014).

## **Instruments**

A VA Institutional Review Board (IRB) approved the study. An investigator-developed, semi-structured interview guide was utilized for the participant interviews. Interviews were conducted in-person or over the telephone. All interviews were audio-recorded, and lasted between 15 and 90 minutes in length. The audiotapes were redacted to remove identifying information and were transcribed verbatim. Participants were asked to complete a survey form and demographic information at the conclusion of the interview. Eighteen of the 24 participants completed the survey document.

## **Methodology**

The majority of participants were screened over the phone and appointments made for face-to-face interviews or phone interviews. At least one participant was a ‘walk-in’ – informed of the study by facility staff and screened, then interviewed, by a researcher. At the time of the interviews IRB-approved informed consent was reviewed and permission to proceed obtained from the women. To further protect the

confidentiality of the participants, a Waiver of Written Informed Consent was obtained from the IRB.

The informed consent was reviewed prior to the start of the interviews and the women were given that copy of the informed consent to take home. The data analysis plan included the use of an a-priori codebook based on the interview guide and the theoretical framework. The codebook was elaborated upon based on emergent themes and adjusted as interviews were conducted. Data was compared across facilities. Demographic and survey data was analyzed utilizing Excel<sup>®</sup> statistical software for analysis.

### **Results From Parent Study**

The parent study was a mixed methods investigation of L/B Veterans' experiences while receiving healthcare within the VA, as well as their satisfaction with the received healthcare. Results suggested that although participants reported fear of harassment secondary to their sexual orientation, only 10% of the 18 participant sample who completed the survey reported actually experiencing harassment from healthcare providers; 30% reported fear that they would be harassed and 40% noted harassment from other Veterans (Mattocks et al., 2015). A large percentage of participants believed that VA healthcare providers should not ask patients about their sexual orientation. Quality women's healthcare, regardless of sexual orientation, was important to respondents. Official recognition in the form of a patient's bill of rights, including LGBT-friendly verbiage, was a suggestion made by some by participants (Mattocks et al., p. 5, 2015).

This secondary analysis was planned to extend the work of Mattocks et al., (2015) with the goal to add additional breadth and depth to healthcare providers' understanding of care received by L/B Veterans, through an understanding of the impact of identity on relationships with the VA healthcare system and VA healthcare providers.

## **Methods - Case Study**

### **Design**

This study was an instrumental collective case study of extant L/B Veteran interviews. The use of qualitative methodology allowed the researcher to explore the significance of L/B Veterans' identity on the development of relationships with VA healthcare and VA healthcare providers. This was accomplished via the secondary analysis of the parent study; i.e., the qualitative interviews gathered by Mattocks et al., (2015). The demographic survey data from the Parent Study was utilized with permission of the primary investigator (private communication).

### **Sample**

The sample for this study was sufficient to answer the study questions as posed and consisted of the L/B Veterans as detailed above as well as demographic/survey instruments, audio-recordings, and transcripts of L/B Veterans from the Parent Study (Mattocks et al., 2015). The phenomenon of interest was L/B Veteran identity. In order to extend the work of Mattocks et al., (2015), the experiences of multiple L/B Veterans were examined. The researcher sought to develop an understanding of the significance of L/B Veteran identity, how it may have influenced the experience of being cared for within the VA system, and in a healthcare relationship with VA providers.

## **Risks**

There were no physical and/or emotional risks to L/B Veteran participants associated with this secondary analysis; similarly, risk to participant confidentiality was minimal. The researcher had no access to participants' protected health information. The researcher performed the secondary analysis with pre-gathered data that has been redacted by the primary researchers several months prior to analysis (Mattocks et al., 2015).

## **Ethical Considerations**

The ethical treatment of individuals should be at the forefront of any research. The University of Massachusetts, Amherst approved the plan for the research study.

## **Data Collection Protocol and Analysis Plan**

### **Data Collection**

The extant data was encrypted on a VA computer/server. Once the study had been approved, the researcher obtained the redacted data from the Parent Study's Principal Investigator (Private Communication, 2014). The demographic/survey tools did not contain any identifying information that would tie a participant to a completed form. Therefore, the plan was to utilize the demographic/survey tools from the Parent Study in aggregate (personal communication, 2014).

### **Data Analysis**

Data analysis was iterative in nature and began immediately upon receipt of the data. The researcher utilized journaling and methodological memos as part of the data analysis (Lincoln & Guba, 1985; Miles & Huberman, 1994; Strauss & Corbin, 1998). Researcher thoughts, beliefs, and assumptions were documented within the theoretical

memos in order to more fully recognize their presence and potential impact during data analysis (Lincoln & Guba, 1985; Miles & Huberman, 1994; Strauss & Corbin, 1998).

Ongoing analytic decisions were written and kept in the form of theoretical memos (Lincoln & Guba, 1985; Miles & Huberman, 1994; Strauss & Corbin, 1998).

Open coding techniques (Strauss & Corbin, 1998) were utilized to facilitate an inductive analysis of data. Coding memos that detailed the inductive codes were placed into a table for use during the iterative analysis. Additional codes were added on an as needed basis to reflect emerging codes, concepts, and themes (Miles & Huberman, 1994; Strauss & Corbin, 1998). Data was examined for the presence of codes, concepts and themes (Strauss & Corbin, 1998). The researcher utilized a qualitative data analysis computer program, Atlas.ti®, during coding and analysis. Stake's (2006) worksheets, (Appendix B) were completed during the analysis.

### **Trustworthiness**

The trustworthiness of this study was ensured by following Lincoln and Guba's (1985) criteria (Amankwaa, 2016; Connelly, 2016; Polit & Beck, 2010). Peer debriefing with registered nurse colleagues and a licensed independent social worker was utilized to lend credibility to the findings and to validate emotions associated with engagement with the Veterans' difficult experiences. Thick descriptions allowed participants' words to draw the reader into their world as they experienced it. The researcher's use of journaling added rigor to the study. Additionally, the researcher dwelled with the data for an extended period of time.

The utilization of Stake's (2006) worksheets added rigor to the study. The use allowed the researcher to ensure that the same questions were used to analyze each of the

24 interviews. Worksheets 3 and 4 allowed the researcher to keep detailed notes on each case. The researcher referred to these worksheets often during analyses; the worksheets became an integral part of the data analysis.

### **Dissemination**

The results of this analysis will be disseminated via academic journals, and professional presentations.

### **Summary**

This instrumental case study employed a secondary analysis of qualitative data gathered by Mattocks et al., (2015). This study was conducted in order to expand the breadth and depth of understanding of the role of L/B Veterans' identity in the relationship between L/B Veterans, the VA healthcare system, and VA healthcare providers, in the context of healthcare delivery. The data from the parent study "*Understanding lesbian and bisexual women Veterans' experiences and satisfaction with VA care*" (Mattocks et al., 2015) was used for this study; original audio-recordings, transcripts, and a demographic/survey instrument were analyzed during this study. Data analysis utilizing open coding techniques was iterative in nature and follow methods advocated by Lincoln & Guba, (1985) Miles & Huberman, (1994) and Strauss & Corbin (1998). Additional analysis tools include computer software, and the use of theoretical and coding memos.

This study met the intent and the spirit of VA directives towards providing culturally appropriate care for all individuals who served in the US military, regardless of sexual orientation. An understanding of how an identity may influence the healthcare



sought and received will inform the development of nursing interventions aimed at meeting the healthcare needs of this vulnerable population.

## **Chapter 4**

### **FINDINGS**

Although the parent study from which this data was drawn was open to lesbian and bisexual women, the 24 participants self-identified as lesbian or human. Several women noted relationships with men, however none of the participants identified as bisexual women. Therefore, moving forward, reference will only be made to lesbian Veterans.

#### **Research Question One: What are Lesbian Veterans' Experiences of Identity?**

The study participants were a diverse group of women. Eighteen of the 24 women completed the survey and demographic instrument. Of those participants, a preponderance (15/18) were 41 years of age and older. The predominant branch of service was the Army (14/18), followed by the Air Force (6/18). None of the women reported service as a Marine. Years of service ranged from one year to 29 years. In this sample, the majority of lesbian Veterans (18/24) served in the military prior to 09/11/2001.

#### **Lesbian Veteran Identity: Hidden, Hunted, and Betrayed**

The phenomenon of interest in this analysis was the lesbian Veterans' identity. The identity of lesbian Veterans during their time in the military can be best described as lesbian women who were hidden, were hunted, and who were both betrayed and who perpetrated betrayal.

## **A Hidden Identity**

Seventeen participants (17/24) identified as lesbian during their military service and hid that sexual orientation from most others while in the military. Four (4/24) became aware of their lesbian identity after they had separated from the service. One participant spoke of questioning her SO while in the service.

A hidden identity was conceptualized on a continuum, representing the differing levels of concealment reported by the women. On one end, some participants spoke of not being out while in the military. For example, “I was a medic for four years...and I never ever ever ever brought that up. So, I mean, I tried everything that I could do to make people think I was straight” (Sandra). For both Sandra and Izzy, a strategy to hide their lesbian identity included dating men.

Some of the things I had to do to keep my cover were disgusting to me, you know? I had to date men. I had to, once in a while, to sleep with men. And it just never, not ever something I would do under normal circumstances. You know, it’s not who I am. (Izzy)

Others managed to have same-sex relationships during their time in the service, but never overtly disclosed a lesbian identity to colleagues:

But we, you know, became so tight, that on those days when there’s nothing to do, you know, no casualties coming in, it would just be her and I walking and talking and spending time together. And eventually, people figured it out...We didn’t really have to reveal it because the people that figured it out were very cool about this. They, they knew what was going on. (Beverly)

Still other participants spoke of a conscious choice to change herself to remain hidden:

I had to change your whole personality just to cope with my assignments and to be able to be treated equal. I had to be tougher, some times I had to be aggressive, aggressive in a good way, for make me be respected by men. Because, being, you know, a homosexual, I didn't want them to know. I was really, you know, my private life, I had it very hidden and I just, I didn't want to lie and say oh, that's my boyfriend. So I never went and I never tried to be what I wasn't. And that's how I change my personality because then...I used to be you know, just relaxes, happy and everything. And my life turned around to be hidden. Being someone I wasn't. (Madelaine)

On the other end of the continuum, participants spoke of being out regardless of the consequences. For example, one woman described her experience of nearly 30 years in the military, "I never covered it. And from the beginning I said, "I'm gay". Because it's better I don't lie to people and say, "No I'm not gay, I'm straight". (Queenie)

Near the center of the continuum were those participants who spoke of dual identities:

I still tell my friends to this day when I talk about my experiences in the military. You know, my lifestyle led for me to develop, develop a process in which I would put my uniform on and I would become a different person. So I would take my uniform off and I was a different person. It was kind of like I lived two separate lives. And so when I was in uniform I was very military and very much about my job. And where people could discuss their personal lives freely, I was not able to. (Wanda)

Similarly, Anna notes, “I was living in my private life, my civilian life, a very out lifestyle, but in my uniform I was not. So that was interesting you know, to kind of walk that two lives kind of thing.” Nancy noted that she never disclosed her sexual orientation to others, but often associated with other lesbians. She offered a simple, pragmatic explanation for her need to pretend, to be someone else: “It was a survival thing”.

### *The development of secret societies*

Participants spoke of the presence of secret societies in the military. The dictionary defined a secret society as follows: “Any of various oath-bound societies often devoted to brotherhood, moral discipline, and mutual assistance” (Merriam Webster n.d.). For the purpose of this study, secret societies were defined as groups of individuals, who share characteristics, offer mutual assistance, and who keep their association private. In this study, secret societies of interest included L service members who formed close-knit, family-type units in which they were free to be Ls; group members gave and received social support from colleagues.

Kagami stated, “I was friends with the secret society of the lesbians...there were definitely women that, they knew they were lesbians...they were clear about that. But were they identifying that to anyone? No. It was a secret society for sure”.

Odetta, a service member who served eight years in the Army, provided an example of the family-type atmosphere present within a secret society but also the need to hide one’s affiliations to remain safe:

We go to somebody’s house and meet there and like cookout, barbeque. Just trying to stay away from the base. And we’d get together in the base. We had to

like be, not touch hands, not show that we're lesbians. We're just friends with each other; that's it.

Wanda used the word "family" in explaining her group of close-knit friends, "They were my surrogate family. Six months after I got overseas, maybe, I had a tightknit group of friends that I spent all my off time with. A few of them in my same unit."

Yolanda talked about the use of code words to maintain secrecy, as did Tabitha: I mean we had code words for everything we talked about. We actually had numbers for everybody who was [lesbian]. So we would go well, number four, number three are really interested in each other and they're going to meet up at so-and-so. Or, you know, well I don't understand what's going on with number five. But we had a numbering system. We also had protection systems. And that was that, if somebody got into a conflict with somebody else, everybody was there standing up for them. It was like a very close-knit family. Except nobody else outside our family knew. Well, at that point in time to come out would definitely do 2 things. Either would either get you put into the military jail, or it would get you kicked out faster than you could say anything. It was, you know, you try to protect each other best you can.

Colinda noted the assistance members of the 'secret society' could offer during investigations. However, the offer of assistance was not without its own danger to others in the secret society.

We did have some issues where you had other females within that attachment that really had, not really liked us because we were pretty much leading the way for the rest of the females. So they would try to bring up stories, trying to get us

kicked out. We had to write statements saying that no, this person did not do X, Y, or Z. By pretty much standing up for the person and because of the don't ask don't tell policy, we were...scared that it was going to get us in trouble and get us kicked out, you know.

### **An Identity of Hunted**

The identity of hunted was another piece important to the understanding of the lesbian Veteran identity. This theme was related to a hidden lesbian identity in that being hunted was a consequence of lesbian service members' need to be concealed. Three categories associated with hunted were: (a) witch hunts, (b) policed, and (c) preyed upon. Additionally, participants spoke of the concept of being a 'good soldier' as a protective mechanism against the witch hunts.

#### ***Target of witch hunts***

A witch-hunt was defined as "the act of unfairly looking for and punishing people who are accused of having opinions that are believed to be dangerous or evil" (Merriam-Webster Dictionary, n.d.). For the purpose of this study, this definition included not just opinions, but identity and actions. It was a term used by several women as they described their service in a military in which identification as a lesbian was illegal. Witch hunt presented as an in vivo code. Participants were not always able to tell what sparked the witch-hunt.

Anna was investigated twice during her time in the Army, although she noted she was not dating anyone during those time periods. The investigations did not yield charges. In the statement that follows, Anna provided clues as to why she was targeted

for investigations. Furthermore, her words were indicative of the general atmosphere during that time in the service:

Just, you know, rumors and innuendos. I was hanging out with people that were gay, so you know, that were known to be gay. And back in the 80's, there were these witch-hunts going on. And you know, if you were seen with somebody, you know, you were tagged as somebody who was suspicious.

As a way of coping with the fear and vulnerability associated with their lesbian identity, participants would take care not to associate with others who had been victims of the witch-hunts so as to avoid the guilt-by-association experienced by Anna.

Odetta witnessed similar activity and noted the isolation that could occur secondary to the witch-hunts, in that others attempted to avoid the guilt by association.

There was a friend of mine, she got kicked out. Yes. She was a good soldier, a nice person. She did her PT, physical test, everything good, and still she got kicked out. Because of that, none of us, were a lot more careful in whatever we do. We got scared. Anybody get close to her – got...it was bad.

Elaine was not a subject of a witch-hunt, but witnessed witch-hunts aimed at her colleagues. Her passage spoke to the surreptitious nature of the witch-hunts.

Yeah, I mean, they um...well they had witch-hunts, you know? They would go after people...I mean, what's weird is that you never really know what happened. You know, like people would just, like, get transferred or get discharged. They would disappear...you know, like, they would just be gone. There would be no explanation...I mean, I know I have been in touch with people...I found out later



on. They were very very hurt by being kicked out...It was scary as hell to get caught, you know.

In the above passage, Anna also notes the expected protection implied when considered a 'good soldier', and how that protection was not always present. This is echoed by other participants.

*The good soldier identity as protective*

Ten of the 24 participants spoke of the concept of a "good soldier". For these women, one's identification as a "good soldier" brought with it an expectation of protection from witch-hunts. In Odetta's passage above, she noted her friend was a good soldier; suggesting that being a good soldier should have provided immunity or protection from the witch-hunts. In the following passage, Queenie did not hide her SO while in the service; instead she relied upon the 'good soldier' protection. Interviewer: Were you worried about getting kicked out of the military? Queenie: "No, because I did my job. I went to all the schools. All my jobs, I do a great job."

Wanda also offered additional insight regarding who was chosen for a witch-hunt and why:

The military is very strange because it depends on who your commander or your first sergeant is, those key leaders. And from there it depends on you. Now, are you a good soldier; do you come to work every day; do you do your job, go above and beyond, and do you, are you I guess flamboyant about it, your lifestyle? I mean, there's a lot of factors that go in, I think, into what they refer to as witch-hunts. As far as I know, I was never a target. But then again, I never gave them a reason to target me, I guess. So I excelled at what I did in the military.

Anna noted her reputation for being a 'good soldier' was protective for her.

...in the Coast Guard it seemed to be a lot more accepting as long as you did your job...And a lot of my coworkers, I found out eventually, knew that I was gay, but you know. And out of respect they weren't going to talk about it. And so I did my job and I did it well and they left it alone.

Similarly, Colinda noted "And for me, I was lucky enough to be, everybody be okay with it. I guess it works with my personality; how I present myself, more so than anything else."

Yolanda echoed the importance of the individual's relationship with superiors. "But see, it all depends on who your platoon sergeant was and what relationship you have with that person."

Jalisa was the only participant to seek discharge under DADT. Below, she explained her decision in the context of her friend who was a good soldier but still discharged:

I was actually identifying and I actually took preemptive measures so that it would be under my control because I watched someone else be identified and kicked out when she really really really wanted to stay in. And she was, she was supporting her mother who was disabled. And she got all these honors and everything and then they just kicked her out and she was gone within two weeks."

Finally, Lacey witnessed harassment by others in the military and spoke of it in terms of anti-gay culture intersecting with the ramifications of not fitting into the 'good soldier' category:

“...and there were some individuals who were from areas where it was okay to be that way; to be very hateful toward homosexuals. And they did not hide their feelings. So, you know, I mean it became difficult for some folks who were, but these are individuals who weren’t successful in other areas as well. Not to say that’s an excuse. But, you know, they were also really not good at their jobs, or were also always jacked up in the way that they appeared; like their stuff was always way out of whack or they were always doing the wrong things, making the wrong decisions, and that was just another thing to add on to the verbal and you know, cutting you down that happens when you’re trying to get somebody to fix themselves, you know? But for the most part many of the people who I knew who were family were very successful at their jobs, you know. And I think that lends to how people who are higher up really didn’t care about that because you would lose so many good people. They cared about it, you know, but yeah...

### ***Policed by military sexual trauma***

The next theme was an important piece of Hunted. The women felt the need to hide in order to remain safe because of being policed. Policed is defined as “to control (something) by making sure that rules and regulations are being followed” (Merriam-Webster, n.d.). Participants in this study were policed or controlled by the threat of MST and physical and/or verbal harassment and/or assault. Both service men and service women were perpetrators of this method of control.

Beverly, a Navy Veteran, provided an example of the way lesbians were policed by male service members, “Even back in boot camp, there was a girl I knew of. She was obviously a very masculine lesbian. She wound up getting gang raped, you know. The

threat was there, that's why everyone tried to keep quiet". Odetta shared her experience of MST and being unable to report it due to fears of retribution, "And if I reported it, they would do something to you. [Slapping noises] You're a lesbian, you're getting out". Similarly, Vicki also noted the policing that occurred after MST. Women who reported MST were labeled as scarlet women and/or discharged from the service.

Threats to lesbian service members did not only come in the guise of MST or from men. Colinda reported being targeted by other women for harassment because of her lesbian identity. Anna witnessed two women bullied while in the service; she attributed the harassment to their appearance as they "were very masculine and they were kind of affectionate". Similarly, Raeanne attributed the near weekly disciplinary write-ups she experienced to her appearance – including her short hair.

I think it was because I was gay. I was wrote up twice for having short hair, when it was perfectly within regulations...I kept telling them that...people would just try to come up with random things just to dock me, to get me in trouble and make me do extra duty. Or whatever. Because they didn't like me. And especially my boss in Iraq. And so yeah, she would write me up. I got wrote up almost every week that I was in Iraq. I was also being harassed by a lieutenant while I was over there for being gay, because it's obvious by my appearance that I am gay.

### ***Preyed upon by male colleagues***

For the purpose of this analysis, "preyed upon" was defined as "To exert a harmful or injurious effect on something or someone...[or] "to hunt or kill something for food" (The American Heritage Dictionary, 2005). The term was used to describe the manner in which others treated some of the lesbian Veterans during their military service.

Colinda spoke of she and her lesbian friends being singled out for harassment by others. Debra talked about surviving constant sexual harassment, MST as well as being forced to have an abortion while in Vietnam. Izzy denied personally knowing colleagues who were sought after, (i.e. hunted), and discharged secondary to their SO. However, she knew hunters:

I knew of investigators, that it was their job to weed them [LGBT service members] out. It was their job to follow them at night, on a weekend. It was their job to take pictures, it was their job you know, to show Judge Advocate General (JAG), this is the information we got.

Jalisa, an Air Force Veteran, was the only participant who was voluntarily discharged secondary to DADT. She herself felt preyed upon and was at risk for disclosure by others and she wanted control over events leading to her discharge. She was fully aware of the subsequent investigation. Jalisa was able to put plans in place for an eventual discharge on her own terms.

Nancy related a particularly difficult four years of service in the Navy. Deployed on a naval vessel, she speaks of being immediately, and constantly, preyed upon by male service members. The MST took the form of verbal abuse, pornography left in sight of the sailor, unwanted physical conduct such as rubbing against the sailor within the halls of the ship, and a gang-rape leading to a pregnancy. The lack of privacy and/or distance from the perpetrators contributed to the nightmarish experience of feeling preyed upon, trapped, and hunted.

I thought I was going crazy. But my immediate comrades were just not, I mean for the majority of them, were just horrible. It was awful...I know everyone was

so, the women, we were so stressed. And I mean, you couldn't talk about anything because you felt the walls could listen. And they probably could. I mean people; men found things out that women were saying in our quarters just by standing in the doorway...we had separate quarters, but they could pretty much go when and if they wanted to. ...I felt like I was running away, constantly. From people, from pornography, from just a whole environment. I mean, looking back, I could see it; it's like a movie that never goes away.

Debra also spoke of the constancy of the MST she survived at the hands of her fellow soldiers.

I mean there was so much unwanted sexual attention. I mean it was just constant, constant, constant. And I was raped in Vietnam. And I got pregnant and then had the military force me into an abortion. Which they did on XXX's ward. They stuck a rag in my mouth, no anesthesia, and threatened to court martial me if I ever told anybody.

Padma spoke of being hunted, leading to a subsequent assault suffered at the hands of a colleague during the late 1970's. After an assaultive altercation at a softball game, the assailant later presented at her door during early morning hours, ostensibly to apologize. Instead, he violently assaulted her, stopping only when another officer interceded and threatened him with a gun. Padma was stripped, badly beaten, and required hospitalization with a broken jaw.

Lastly, Beverly gave an example of how the fears associated with being hidden, hunted, and betrayed impacted the available identities one could claim.

Being a female who went to a combat zone was bad enough. There's no way that women would talk about being lesbians on top of that. Just because, you know, like I said, that one girl in boot camp in the mid-80s was gang-raped only because she looked dyke-y.

### **Betrayed by colleagues**

Betrayed was defined as “to hurt (someone who trusts you, such as a friend or relative) by not giving help or by doing something morally wrong” (Merriam-Webster, n.d.). In this sample, participants reported feeling betrayed by their superior officers and the military regarding MST. Elaine reported suffering MST during basic training and was betrayed by her superiors when she reported it. “All of these big colonels and all these people...They covered it up.”

Izzy, however, described a different, non-MST experience. A self-identified lesbian since the age of five years, she sought legal assistance during her time in the military when an incriminating letter, addressed to her, was opened and read by someone else.

“I’m sitting in front of the JAG office, asking an officer, a lawyer, you know, what do I do? And basically he’s sitting there telling me “you’re fucked! There’s nothing I can do for you. You’re gay. You’re in the military. You don’t belong here, you’re fucked. You’re gay and you’re not supposed to be here. I don’t know what I can do for you.” So, I’m a soldier in the military and you can’t advocate for me? You know, it was very betraying, and I was scared for a while that I was going to be dishonorably discharged based on my sexuality.

Nancy conveyed the betrayal she felt secondary to the constant sexual harassment and the failure of her supervisor to stop the abuse. In fact her supervisor also began to sexually harass her. "I reported it to my supervisor; well my supervisor eventually started doing it. The people in the countries were great! But my immediate comrades were just not; I mean for the majority of them, were just horrible."

Raeanne's narrative of surviving harassment associated with her lesbian identity included feelings of betrayal. She felt betrayed by individuals in her National Guard unit, in that she worked above her grade yet was never recognized nor reimbursed for that work. Her difficulties with superiors followed her when she was deployed to Iraq.

I got wrote up almost every week that I was in Iraq and, I think a lot of my PTSD honestly came from her and the continued, continually being belittled and you know told that I wasn't good enough. And she told me multiple times that I wasn't gonna get any awards for my deployment because I didn't have a passing PT score. Because I was injured. And I was like, you can't do that! Like you're overseas, you automatically get at least an Army commendation medal. And that's what I ended up with getting. I didn't get anything above that. And others did. And I worked my butt off. And I did a lot of things that other people couldn't do. And I went above and beyond my job. But it didn't matter.

Feelings of betrayal were also associated with the MST she survived. Raeanne attempted to press charges, but stated, "The Army covered it up". No charges were brought against her attacker until he assaulted other service members. At that time the military asked her to testify, to which she agreed. However, prior to the court date the



attacker made a plea bargain and she did not have the opportunity to testify against him, “It was just one more thing that didn’t have closure”.

Sandra’s four years in the Air Force were marked by four different episodes of MST. Her responses to condolences indicate a feeling of betrayal, and of hopelessness. “Well, that’s the military. That’s what women, especially back then, had to deal with. And they’re still dealing with it today, so I’m not alone”.

Ursula experienced betrayal while deployed to the African continent. A male colleague convinced her to accompany him to an abandoned, bomb-out airport as dusk was falling, to “show me something”. She recounts that after a long walk, she noted another male hiding behind a corner. She became frightened and left the area. The same male service member who took her to the airport in this episode eventually raped her at another time.

Padma experienced the betrayal of MST from a fellow officer, as above. Additionally, she experienced betrayal at the hands of her superiors on base. The colonel and lieutenant colonel, when appraised of the assault she had endured, failed to offer protection and justice.

“And they tried to put the blame on me. After that I’m not going any more times to the chaplain. Because he, I remember that he said to me, oh you’ve got to understand, that females today, they will join the Army. Well, you’re out to get a good husband or to have a good lay. A lieutenant colonel said that to me! And then Colonel XXX said to me, well, you know, XXX, you’re too beautiful to be in the military. He said it to me. And I said what? He said you’re too beautiful. You, you just, you’re Barbie to be in the military”.

Finally, Vicki presented a clear description of the betrayal she felt:

“This is the problem I’m having. They don’t want to hear it because then they have to admit that we weren’t protected. They didn’t take care of us. And they *didn’t* take care of us...And all they want to do is whitewash. And that’s not right. You know? Let’s call a spade a spade, people, you know? Identify it. But then if they have to identify it, that throws all their numbers out of whack. Oh my God we might have to admit to something that happened 30 some odd years ago...but so you know, there’s more of us out there than our government wants to admit to. We’re the dirty little secret they don’t want to fess up to ”

Jalisa was the only participant who instigated her discharge under DADT. She was in danger of being betrayed by her friends, who threatened to ‘out’ her if she testified during their drug trial. Her decision to be discharged under DADT resulted.

### ***Betrayer of colleagues***

Participants spoke of not only having been betrayed, but of also betraying others. Some described feeling that they had betrayed their military colleagues, because they were not honest about an integral part of their identity. Izzy shared her difficulty in lying in order to meet the military’s heterosexual requirement: “You feel guilty, you know? You have to lie in order to serve your country.” Sandra felt like she had betrayed her colleagues. “It’s kind of like lying to your peers, you know. And, after a while it just sort of eats away at you. And I always kind of felt like, more of an outsider.”

Similarly, Tabitha noted the strain associated with keeping her true identity concealed, “You try to protect each other as best you can; but you can’t when you have a

whole bunch of people that you can't even open up to. So, a lot of it just kinds of eats at you.”

### **Present Day**

Between three to 46 years passed between the Veterans' separation from military service and their participation in the interviews conducted by Mattocks et al., (2015). During that period of time, the women lived across the US and its territories, were employed in private and government sectors, and received healthcare from the VA, as well as from private, community-based healthcare providers. They were caregivers for family members, and engaged in relationships; a minority of participants had children (Mattocks et al., 2015). Six of the 24 participants reported questioning their sexual orientation or did not identify as a lesbian until after their military service.

The following sections explicate the significance of lesbian Veteran identity for the subsequent relationships with VA Healthcare System pertaining to their use of VA Healthcare and their relationships with VA healthcare providers.

### **Research Question Two: What Significance does Lesbian Veteran Identity Have for Use of VA Healthcare?**

In order to be eligible to participate in the study conducted by Mattocks et al., (2015), women had to be enrolled in the VA Healthcare System (VA). However, the women did not all enroll in the VA within the same time frame. Nine of the 24 participants enrolled in the VA immediately after separation from the military. Fourteen women waited a period of time after their separation from the military and prior to their enrollment in the VA. One participant did not address the length of time between the end

of her military service and enrollment in the VA. Below, the significance of the lesbian Veteran identity for the use of the VA is discussed.

### **Significance of identity for use of VA healthcare**

As identified above, the identity of the lesbian Veteran represented by this sample is one that is hidden, hunted, and betrayed. However, the most relevant identity (i.e., the identity most often utilized) for the lesbian Veteran who sought VA care was hidden. The significance of this lesbian Veteran identity for the use of the VA is complex and began with the decision to enroll in that system. The decision to enroll and use VA care was pragmatic and at times informed by preconceptions regarding VA care.

The lesbian Veterans who enrolled immediately into the VA after separation from the military did so for various reasons. Veterans Colinda, Gabby, and Wanda, respectively, did not indicate a need for care; however, they chose to immediately enroll as it was offered, each was entitled to it.

Several women needed care for injuries or illnesses diagnosed prior to their discharge from the military. For example, Hannah continued the oncology care she had received prior to her retirement from the service. Both Tabitha and Yolanda sought care for a musculoskeletal injuries sustained during their service. Queenie and Raeanne needed mental health care that they attributed to their time in the service.

The 14 lesbian Veterans who enrolled at a later point after their military separation were also pragmatic in their decision-making; but that pragmatism was informed by their preconceptions regarding the VA. For example, Beverly, Jalisa, Madelaine, Nancy, Sandra, Ursula, and Vicki enrolled in the VA Healthcare System

when (a) their health deteriorated, (b) they lost their private insurance, (c) they lost the employment that led to private insurance.

Not all participants spoke to the reasons they decided to enroll in the VA when they did. However, some lesbian Veterans may have lost their employment secondary to experiences in the military. For instance, Nancy experienced MST, including gang rape and a resultant pregnancy, while in the Navy. After separation from the military, she described rages and nervous breakdowns that would lead to job loss, “I would hide behind my job until I would have a nervous breakdown”. She would lose her job, and then switch professions in order to hide her mental illness. She enrolled in the VA after being unable to get or hold a job that would provide health insurance.

Vicki, also an MST survivor, related how a work injury led to her treatment for MST sustained during her time in the service:

“...I’d had an accident at work. A 600-pound door hit me on the head. Took me back to all that...hopelessness and helplessness that I felt when I was over in Europe, with nobody to talk to, you know...And when that door hit me, it brought a lot of, I started having nightmares...”

The preconceptions held by Debra, Izzy, Jalisa, Nancy, Sandra, and Vicki included noting the similarities between the military and the VA, and fearing the environment would be the same. In the following passage, Sandy spoke to the similarities between the VA and military service, her reluctance to enroll in the VA directly when she separated from the military, as well as the events leading up to her enrollment in the VA.

I didn’t want anything to do with them. I, my mind, especially at that time, why would I want to go from one military branch into another one? Which is very,

very, very much like the military? And so basically when I got out I went alone. I just, you know. I worked so I got benefits through them. But at one point I got older and you know, I couldn't keep a job anymore due to some of the issues that I had from the military. I couldn't afford medical care. So I've been in the VA system since then.

Some participants shared misconceptions regarding VA care. Beverly noted that while the VA meets her needs, women Veterans are not completely accepted by the "old guard". Gabby had heard uncomplimentary details about the VA. However, when she enrolled and utilized the care offered, she noted she liked the care; and believed women were treated well. Queenie was pleased with the VA care she received.

Lesbian Veterans sometimes feared that the VA would have a non-welcoming atmosphere due to the preponderance of men who relied on the VA for care. This may have been particularly off-putting to lesbian Veterans who experienced MST. In passages above, Vicki spoke of trust issues with the VA and VA health care providers that she attributed to the MST she experienced while in the military and the lack of recognition by the VA of the assaults. Additionally, she, like others, conflated the Department of Defense and the VA. She noted that while some VAs gave good care, others did not.

Other commonalities existed in the reasons lesbian Veterans chose to enroll in the VA at a later time. Anna, Kagami, and Vicki endorsed altruistic reasons for deferring their enrollment. Each believed there were a specific number of available patient spots and that other Veterans needed the care more than they. They didn't want to take another's spot. As Kagami noted:

There was a part of me that thought, you know, if you have insurance, you should leave space for the people that don't at the VA, you know? I don't wanna, I don't wanna take away from a Veteran that can't get healthcare, you know?

### **Hidden from the VA**

Lesbian Veteran identity as hidden meant those who utilized the VA might have chosen to 'pass' and not correct the heteronormative assumptions they were faced with when accessing the VA. Women were hidden, in that they appeared absent in some VAs. Per Beverly, "I never saw any female Vets. Never." Some remained hidden and did not correct staffs' assumption that the women themselves were heterosexual. Participants reported that they were assumed to be a Veteran's spouse rather than the Veteran; or that the Veteran population the staff served was exclusively male. In order to receive treatment, however, that misconception needed to be clarified. For example, Madelaine stated, "They – most of the time they in the beginning or even now they asked me if they don't know me if I'm a wife! No, no I fight for this country! I'm here because I deserve it!"

Jalisa connected her military service to her enrollment into the VA.

Because of the way that I left the military, I was really hesitant to go, to go there. And that still carries over even to this day, somewhat. You know, my my, the whole second half of my military. I was really bitter about a lot of things. It was not a very good experience and I was really hesitant to go to the VA because I knew it would be mostly men. One of the other things, while I was in the military, I was raped. So, so you know, a little...very hesitant because I knew that mostly men would be there.

Sandra, who served during the 1980s, noted that similarities between the military and the VA caused her to remain closeted, hidden, when first accessing VA healthcare.

And, that's pretty much, in some places that's how it is. You grin and bear it because you need the care. And you know for the most part, it was definitely like that in the military. And you know, I was always worried especially when I first started in the VA system with care. I was with XXXX at that time, and like, don't say anything about what we are together, because I was so afraid that if it was exactly like the military. I was probably like that for about five years? Before I even mentioned that I had a partner.

**Research Question Three: What Significance Does Lesbian Veteran Identity Have for Subsequent Relationship With VA Healthcare Providers?**

**Visible to healthcare providers**

Most, but not all participants reported remaining hidden during their military service. However, once separated from the military and enrolled into the VA for healthcare, a majority of participants reported disclosing their lesbian identity to at least one of their HCPs. The term 'visible' represented the participants' decision to disclose their sexual orientation, to no longer remain hidden, but to be visible. Participants could be placed into one of three degrees of visibility; a) fully, b) some, and c) eventual.

**Fully Visible**

Once enrolled in the VA, half of the participants (12/24) fully disclosed their SO to their HCPs. A shared rationale offered by the participants for disclosing their SO was that an open and honest relationship with the HCP meant better care for them. Anna



noted the importance of disclosure to her HCP:

When I get Pap smears, they need to know you're sexual, how active you are to understand what they're looking at when they go in there, I guess. So, yeah, I have been very open and telling them that I'm in a gay sexual relationship...I'm very open about that with my doctor...Yeah, I don't think that they could have a true understanding of what's going on with you physically, especially if you have something going wrong if you're not truthful and open.

Frannie noted that she was comfortable with the VA HCPs knowing her SO and did not fear discriminatory treatment from VA staff.

Oh my God, it's like, no; they're like old friends. They don't discriminate. They do what they do. They're friendly and it just comes natural for them. And I have never had an experience with a mean person there, as long as I've been going there. Male or female. Sometimes I flirt with both male and female and you should see their faces! Maybe, I don't know, maybe they had a bad day that day and I just get all in their face, and they go ohhh, here comes Miss XXX. No, not in a bad way, that...this is one of their good patients, you know? And they do seem to care. Like if my pressure is up or something like that, they will call the next day and they will find out whether or not, you know, did I get my pressure down or something like that.

Kagami echoed satisfaction with VA HCPs regarding care and how comfortable she feels as a L Veteran.

You know, I got her completely by mistake like that, you know? And now actually, I mean, she's a great doctor so I must admit I've used the VA a little bit

more now because she's helped me. I mean even like her nurses; she's had a couple of different nurses since I started seeing her. I mean, to tell you the truth, I just went for my appointment a couple of weeks ago, it was a new nurse, and um, she asked me my marital status which had changed since my last appointment and there's not a, not only not a negative reaction, but there's a you know, she congratulated me...It was extremely comfortable and that's just how it is. Like, they don't act like, I mean. When I was in the VA back in the 1980/81 kind of time frame, umm, no one asked me, they assumed I was straight. I wasn't volunteering it and no one was asking it. And it was hugely different.

These participants found the HCPs to be positive and welcoming. Some did not. Participants who felt they were not being treated with respect were sometimes able to arrange a different provider. Others did not have that option; participants like Sandra spoke to just getting through the appointment because they needed the care, "grin and bear it".

### **Some participants disclosed to some healthcare providers**

Eight of the 24 women were out to some, but not all, HCPs. A common thread in the explanations these participants gave for choosing whom to disclose to was the lack of pertinence of their SO for their current treatment. For example, Beverly disclosed her SO to her psychiatrist, but not her gynecologist. She explains

Well I'm going into the mental health system I knew, there was nothing there was no way I was going to get help if I wasn't completely open and honest... The guy that does their GYN, he's a warrant officer and he is visibly uncomfortable doing female exams. And I think I would just blow his mind if I told him that I was also

a lesbian. He just goes by the fact that he knows I have a son and so he made assumptions...

Shortly after, the interviewer continues to clarify the participant's decision-making process regarding disclosure of her SO.

Interviewer: Have any providers ever outright asked you about your SO or your sexual activity in any sort of way?

Beverly: Well, yeah. Whether it's primary care or gyn, they want to know are you on birth control? What method do you use? Yada yada. Like, I don't. I just abstain from that.

Interviewer: You're not saying no, I don't need that because I'm lesbian?

Beverly: I just answer the question

Interviewer: You just answer it, no, I don't. Okay. Is it lack of comfort for you?

No. Is it because they are not asking it or is it because you don't really see that as important?

Beverly: It's not pertinent to all of my care.

Interviewer: So it's just not necessary for...

Beverly: If it was, I'd mention it.

### **Eventually participants disclosed**

Three participants eventually disclosed their SO to their HCPs, however, the women noted it took time to develop a level of comfort and trust that allowed them to disclose. When asked if she had disclosed, Vicki replied, "Not initially, not initially; didn't feel comfortable. It was long before don't ask don't tell. I think that was in '91?" As the conversation progressed, she stated, "I didn't come out to them, except for one

time after my wife hit me. She gave me a black eye.” When later asked what she would want registered nurses to know about taking care of her, she replied “Taking care of me as a woman. And if I feel comfortable enough to disclose to you that I’m a lesbian, then I will do that.”

Lacey shared the following. In her reply to the interviewer’s questions, she provided a glimpse into her fears:

I think more than the provider or the system I think, the biggest hurdle was for me, myself. To kind of come back to the way of being okay with it. I think for me the hurdle was getting over that. Where I could have the conversation with my provider. And, and my current provider is as gay as blazes. I, it took me a while to come out to her and she is apparently family...I think most of it was my own processing of it, in getting to the point where I wasn’t nervous about these things. And it’s in the record, you know? She was going to write in the chart! And that was going to be a permanent thing and I couldn’t take that back! I couldn’t say well she misheard me or something like that, you know what I mean?

Finally, Jalisa spoke to the decision-making regarding whether to disclose her SO to HCPs; nearly 20 years after her service she had to make a conscious decision to disclose she was lesbian:

I’m...always have my guard up first, and then I need to feel them out. Sometimes I won’t tell them at all, which I think is a disservice because it doesn’t really make me feel comfortable and seen. If I’m there for my hearing and it doesn’t come up, I don’t feel like that I’m not being seen, that I’m not a whole person at all. But if I’m there for my ear and my family comes up, and you know, we’re talking about

my son and a husband comes up, and you know, then I have to make the decision of whether I'm going to say, well, I'm going to correct the person or not.

### **Significance of Military Service**

Eight of the 24 participants in this study spoke to the significance their experiences during their military service had for subsequent care by VA HCPs. Colinda's choice of phrases during her interview could be related to the lesbian Veteran identity of hidden, hunted, and betrayed. Colinda spoke of a mental health provider who asked about her SO:

The only one was for my psychology appointment, but that was just for treatment purposes. Not necessarily for personal gain or anything like that. I knew where she was trying to go with that, in the reasons for it wasn't like she was trying to get it for her own personal gain, to try to use it against me or anything like that.

So I was fine with it.

Interviewer: That fear, or that concern, that worry about being outed, did that carry over at all while you were at the VA?

Just very slightly...I find it kind of interesting trying to explain that to them. I don't have an issue being what I am or anything like that. It's just more, why do you need to know type of thing.

During Izzy's interview, she was asked if the fear associated with being a lesbian in the military carried over to VA healthcare. She replied:

Well, I've always been comfortable in my own skin. But when it came to the military, always. Well, yeah. I mean, you know, because people, I mean people judge. I know and that's part of being human and they judged me, you know?

And in the military you know, you've got these people and all they know is that you can't be gay, you can't be in the military, you know? And here you are as a Veteran, and you are a gay veteran, you know, and why are you even here? How is that possible?

For Odetta, it was difficult to be in an environment where there were a lot of men and reminders of the military. "It was hard. They didn't want to understand. It's like right now, it's more, you open the computer and they see MST. They treat you a little bit different...they know that they have to give you a female nurse."

Jalisa also spoke to the MST she experienced while in the service and how it and the preponderance of men served by the VA colored her perceptions of VA HCPs

Because of the way that I left the military, I was really hesitant to go, to go there. And that still carries over even to this day, somewhat. You know, my, my, the whole second half of my military...it was just not a very good experience and I was really hesitant to go to the VA because I knew it would be mostly men. One of the other things, while I was in the military, I was raped. So, so you know, a little...very hesitant because I knew that mostly men would be there.

While not echoed by all participants, some preferred that women physicians were their caregivers. Unfortunately, the preferred gender was not always available. Elaine noted that she preferred a female HCP but she will not request one, fearful of whom she may be assigned. To receive necessary healthcare she noted she would "kind of blank out and go ahead and I do what I gotta do".

The final four participants (17%) who noted connections between their military services with their relationship with VA HCPs are Lacey, Nancy, Odetta, and Sandra.

Lacey noted similarities between the military and the VA as well as fears that may have prevented she and others from accessing VA and the HCPs earlier:

Letting the guard down about it and not being spooked about the fact that it's the VA and the military are somewhat connected; but I don't really understand how this would affect my service connection, and will this affect anything? Will they yank things? Will I get thrown in the jail? What will happen? I think a lot of people who were in before don't ask don't tell was repealed, especially before it was initiated, have a lot of paranoia about that...

Nancy noted she did not immediately enroll in the VA and spoke of a friend, also a Veteran, who encouraged her to enroll in the VA.

And I said I don't want to go there. And she said why? I said I don't want to say why. I said I'm afraid to go there...I lost contact with her and then, I found her again...and she basically picked me up and dragged me over there. Well, not drag me but took me, and she stayed with me, because I didn't want to go by myself, and I would not let her leave my sight. I just felt like I was going to go to be back on that ship. I just thought it was going to be the same. I couldn't even comprehend that it would have to do with my healthcare.

Finally, Sandra offers a reason regarding the delay in seeking VA care once separated from the military, "No, I didn't want anything to do with them. In my mind, especially at that time, why would I want to go from one military branch into another one? Which is very, very, very much like the military?"

Further conversation with Sandra demonstrated that while some staff were open and accepting, others displayed homophobic and dismissive behaviors:

So I put XXXX, my partner, on as my next of kin, which has, it's been a different experience since then.

Interviewer: Do the nurses and doctors notice that? And acknowledge it?

Well, some of them do and some of them don't. And a lot of times when I've brought it up, you know, that XXXX needs to be included in this for whatever reason, and they're like what do you need her for? And I'm like she...that's my partner and she should know what's going on. And they're like, well, is she your, you know, spouse? So I said yeah, you can consider it that. And they're like, well if it's not your husband and not your family, she can't come in.

Interviewer: So your relationship is totally not recognized. Is that the physicians or the nurses or both?

On occasion it's both. But generally, a lot of times it's the nurse. I have had that happen with a couple of physicians. But for the most part, they really don't care. As far as that goes they don't deal with the paperwork, you know, and all the VA stuff. As far as filling out paperwork, general things. You know, I'm pretty open about that stuff you know. I'm 50 years old and I'm like, things aren't gonna change, I mean you can always tell by the expression on their face when you tell them that,

Interviewer: You can tell how they feel about it.

Yeah. You know a lot of times it's, they sort of pull away. And then they find it really hard not to make comments. Well, it's almost like they're not sure, or it's almost like they don't want to lose their jobs, so they try to be nice. But it's not genuine; I guess there's a lot of implied messages, especially in the South. I



would say that it was super bad in Alabama. They were pretty outwardly, you know, verbal about it. I did have some discrimination in the Florida system. But that was mainly at the main hospital. There was once physician there. She was actually the gynecologist in the women's care. And she had made several comments about; you know that, one of the comments she made was that, that wasn't natural. So, I'm like, what's not natural? Because I wasn't really paying attention at the time she was talking about. So I asked her, what did you say because I didn't hear her, I was doing something else. Getting dressed or whatever. And she told me word for word; I guess what she had just said. And I said, really? Okay, I'll ummm, I'll just change that for you.

### **Summary**

Findings suggest that lesbian Veteran identity can be best described as hidden, hunted, and betrayed. Concepts or consequences associated with the themes of hidden, hunted, and betrayed were as follows: (a) hidden had secret societies; (b) hunted had witch-hunts and the good soldier, policed, and preyed upon; and (c) betrayal of participants by their colleagues and the military, and participant betrayal of their colleagues.

Most participants spoke about the need to hide their identity while in the armed forces. Hidden lesbian identities could be conceptualized as existing on a continuum, representing the degree to which the participants hid their lesbian identity. Several Veterans were fully open about their sexual orientation while in the military, several did not identify as lesbian until out of the military, and others were completely hidden. Gabby remained hidden at the time of the interview; to her, sexual orientation was a

privacy issue. Some participants spoke to having two identities; one specific to when they were in uniform and a different one when they were out of uniform.

Secret societies developed organically within the troops to provide lesbian service members with a community. The women used the term witch-hunts in their narratives to represent the ways in which the military attempted to ferret out lesbian soldiers. One's label as a "good soldier" was expected to provide protection from the witch-hunts.

The concept of policed represented the ways in which MST was utilized as method of ensuring lesbians remained hidden and quiet. Preyed upon symbolized the ways in which lesbian service members were singled out and pursued during their time in the military. The final theme, betrayal, was characterized the lack of protection felt by participants, as well as the regret experienced by some participants because of their inability to show their authentic selves to their colleagues.

The events experienced by these lesbian Veterans affected their lives at the time of the events and may continue to impact the lives of many of the participants in the present day. Some participants were diagnosed with post-traumatic stress disorder (PTSD) after separation from military service; still others believed they should have carried that diagnosis but were not diagnosed with PTSD. Several continued to deal with the biopsychosocial sequelae of the MST they endured.

A majority of participants enrolled in the VA at some point after their separation from the military. Reasons given included not wanting to take another's place, conflation of the Department of Defense and the VA, and preconceptions of the VA being very much like the military. The participants were pragmatic in their decisions to utilize the

VA for care. Care at VAs across the country was variable in that participants noted geographic location influenced whether a VA facility was welcoming.

Of the three pieces of lesbian Veteran identity, the most salient piece of identity to describe participant relationship with VA HCPs was hidden. Participants had to decide the level of disclosure related to their sexual orientation and the VA caregiver. Most relevant for these women was the care they were receiving and if the knowledge of their SO was pertinent to that care. Participants noted that when VA HCPs asked about their SO, they would disclose if they felt comfortable with their SO; if they were not comfortable, they would continue to hide their SO. Ancillary staff and nursing staff were noted to be least welcoming to lesbian Veterans.

Table A1, with participant demographics from the parent study, and Table A2, detailing pseudonyms, and information regarding military service are located in Appendix A. Analysis of the findings above will be discussed in chapter five.

## **CHAPTER 5**

### **DISCUSSION**

The results of this study are significant and important because they speak to how the experiences that lesbian Veterans had while service members continue to affect them years later. As such, findings from this research offer new insight and lead to a better understanding of lesbian Veteran identity. This data also has major implications for the care of an aging, vulnerable population of women Veterans.

#### **The Parent Study**

The participants in this study were an ethnically diverse group of 24 lesbian Veterans who participated in the research study conducted by Mattocks et al., (2015), in 2014. The DADT law had been repealed less than five years prior when researchers conducted a mixed-methods study to explore lesbian Veterans perceptions of the quality of care from VA healthcare practitioners as well as the atmosphere within VA Healthcare Systems. The analysis conducted noted that overall, the participants were satisfied with the care they received from VA healthcare, and while they were afraid of maltreatment and discrimination, most did not experience it. This study extends the work of Mattocks et al., (2015).

#### **Theoretical Issues**

##### **The Relational-Cultural Theory**

The RCT was chosen as the heuristic theory for this study, as it speaks to the primacy of relationships and the ways in which individuals will hide portions of their identity if it is believed to be objectionable to the other person. It was reasonable to posit that this paradox of connection could explain why lesbian Veterans might have chosen to

hide their sexual orientation from the VA and VA healthcare providers. As the analysis proceeded, however, it became clear that the interview data was not sufficiently detailed; the data did not demonstrate a movement of the women toward finding relationships with HCPs. The women did not speak to a need to establish a relationship with their healthcare providers; nor did they speak to hiding their sexual orientation from VA staff in order to be in a relationship with the healthcare provider. The women were pragmatic; they needed healthcare and utilization of the VA was a way to get it. The transcripts did not contain sufficient in-depth data to allow for the utilization of the RCT for analysis.

#### **Andersen Behavioral Model of Health Services Use**

Other theories that may have been useful as heuristic devices were examined. Andersen's behavioral model of health services use (1995) was examined; the model suggested the presence of intra-and extra-personal factors that acted as barriers or facilitators of healthcare use (Aday & Andersen, 1974; Babitsch, Gohl, & von Lengerke, 2012). A derivative, the Gelberg-Andersen behavioral model for vulnerable populations (Oser, Bunting, Pullen, and Stevens-Watkins, 2016) was also examined, as lesbian Veterans met criteria as a vulnerable population (Lehavot, & Simpson, 2012).

Both theories examine healthcare utilization through a holistic lens, suggesting healthcare utilization is a multifactorial process. Because the theories are holistic, they would appear to be congruent with nursing theory that conceptualizes individuals holistically. Future research examining lesbian Veteran healthcare utilization through the lens of the behavioral models would be informative to the development of nursing and policy interventions that could positively impact the use of the VA for lesbian Veterans.

### **Betrayal Trauma Theory**

To inform the ongoing analysis, extant literature was examined regarding MST. Ten of the 24 participants in this study reported experiencing MST. While not a majority of participants, it was striking in that the women spontaneously reported the assaults to the researchers. A theory that is relevant to the lesbian Veteran participants, their experiences, and MST was discovered.

In 1996, Freyd published a text in which she detailed a new theory associated with experiences of childhood sexual abuse; betrayal trauma theory. The betrayal trauma theory explicated the process by which children who have been abused were able to ‘forget’ the experience, or to not ‘see’ it, and therefore carry on in a relationship with their abusive parent or caregiver. Researchers suggest that institutions also play a role in betrayal trauma.

### **Institutional Betrayal Trauma**

In ways similar to family units, institutions such as universities and the military have as part of their ongoing mission, responsibility for the care and well being of individuals that have joined their organization. For example, when individuals join the armed services, the military replaces their former world. The military provides uniforms, shelter, food, and camaraderie. Individuals are encouraged to consider their unit as their new family (Haaken & Palmer, 2012; Northcut & Kienow, 2014). Recruits sign contracts when enlisting in the military that state terms of service. It is extremely difficult to resign. Additionally, a soldier’s failure to abide by the signed military contract carries with it legal penalties.

Betrayal trauma theory and institutional betrayal theory posit that the betrayal of a child or a service member via physical, emotional, or sexual abuse, is extremely damaging because it ruptures the bond or relationship the individual has had with the caregiver or institution whom the individual depended upon for safety, food, and shelter (Freyd, 1996). Physical and emotional sequela of abuse is intensified by both interpersonal and institutional betrayal (Tamaian, Klest, & Mutschler, p. 38, 2017). When abused, oftentimes, the child is trapped, unable to avoid or to stop the abuse; the service member may similarly be trapped in a unit or on board a naval vessel. Institutional betrayal trauma theory may be important in understanding how experiences of MST were significant for lesbian Veterans and will be discussed in further detail later in this chapter.

### **Methodological Issues**

This study is distinctive as it utilized extant data and Stake's (1995; 2006) instrumental case study methodology to explore lesbian Veteran identity. The utilization of instrumental case study methodology (Stake, 2006) allowed the researcher to combine the data from the 24 participants and refine it to represent the gestalt of the lesbian Veteran identity, and the significance of that identity for interactions with the VA and VA healthcare providers.

As the study was a secondary analysis, the semi-structured research questions that guided this analysis were not the research questions utilized by the parent study to inform the interviews. For example, participants were never asked to describe their identities; interviews began by researchers asking the women to speak about their time in the military. This broad question gave participants the opportunity to control the start of the interview as well as the initial direction in which the conversational interview went.

An additional distinction in this study was the researcher's role in the parent study. As part of the research team, the researcher conducted and transcribed interviews for the parent study. In order to avoid writing a study tailored to a priori knowledge, every effort was made to develop the research questions without utilizing prior knowledge regarding the interview contents.

The results of the analysis were also distinctive. The study was developed to explore lesbian Veteran identity in the context of military service and potential significance to later relationships with healthcare entities and providers. During analysis, however, themes that transcended sexuality appeared and new, important concepts emerged. Military sexual trauma and institutional betrayal developed as the major themes in this study.

### **The Researcher's Lens**

In order to recognize, account for, and minimize bias, it was important for the researcher to examine the lens through which she analyzed the data (Lincoln & Guba, 1985). The lens, or viewpoint, the researcher brought to the analysis was one informed by her life as a middle-aged lesbian who is often able to easily 'pass' as a heterosexual woman. She had a history of experiencing sexual harassment in the workplace, but had not experienced sexual or physical assault. She had loving family, friends, and coworkers. She had minimal familiarity with the armed services or female Veterans as a group when the analysis began. Therefore, elements of both emic and etic perspectives were noted and every effort was made to strike a balance between the perspectives (Olive, 2014).



The themes that emerged from the qualitative analysis were substantially different from the quantitative results found by Mattocks et al., (2015); indeed, still other researchers may have come to different understandings of the data (Yin, p. 12, 2010; as quoted by Olive, 2014). The difference in data analysis is characteristic of qualitative research, where the researcher and participants together are an integral part of the research process and the researcher is ultimately an analytic tool.

On reflection, the researcher noted that she tends to be pessimistic in her view of the world; she was encouraged to memo on that subject by a committee member, so as to be better aware of any unconscious discrimination stemming from that her normal less-than-positive world-view. Essentially, the question was, did the researcher's pessimism account for the findings of MST and betrayal?

After writing memos, the researcher came to the conclusion that researcher subjectivity did not color her viewpoint to such a degree so as to lead to inauthentic findings. While hidden, hunted, and betrayed were indeed harsh themes, two of these themes were *in vivo*. All themes were informed by the words and experiences of this sample of lesbian Veterans. The women provided thick descriptions of their experiences while in the military, contributing to the authenticity of the findings (Olive, 2014).

An additional question that may arise concerns the gender of the research team conducting the interviews. The participants, as well as the researchers, were women. Did gender influence participants' responses? Would they have spoken about MST unprompted if the interviewer had been male? One's first instinct may be to answer 'no', as some of the women who had experienced MST spoke to their discomfort with male individuals.

However, that may not have been the case for all participants. For example, James Olive (2014) noted that although he was a male researcher, three female research participants spontaneously spoke about sexual assaults they had experienced as college students. Gender did not appear to inhibit their disclosure. Clearly they felt comfortable with him, to trust him with such an intimate, violent experience (Olive, 2014). Therefore, there is no way to accurately answer the question if interviewer gender influenced participant responses.

An analysis of the research study questions and findings follows. The research questions, subsequent themes and a comparison of the findings with extant research will be offered. Next, a discussion of the core themes of MST and institutional betrayal trauma in the context of the study will be presented. The significance of the findings for health care delivery, recommendations for future study, and implications for nursing practice, science and education will be discussed.

### **Discussion of Research Questions**

#### **Research Question One: What was the Lesbian Veteran Experiences of Identity?**

As individuals, participants in this study came to the knowledge of their sexual orientation at different times. The variations in ages during which participants became aware of their sexual orientation identity is congruent with what is understood about sexual identity development (Institutes of Medicine, (IOM), 2011). The IOM noted (2011) that the age during which one recognizes and identifies oneself as lesbian has changed along with changes in societal mores related to homosexuality. During the past 50 years, females were more likely to endorse a lesbian sexual orientation in her mid-

twenties, as opposed to females closer to the present time, many of who report recognizing same-sex attraction during mid-adolescence (IOM, 2011).

Homosexuality was unlawful in the military since the early 1900s (Nagel, 2010). Intended as a compromise to offer some protection to sexual minorities serving in the military, DADT was signed into law in 1993, enacted in 1994, and was repealed in 2011. Trivette (2010) noted that the advent of DADT did little to ameliorate the harassment experienced by sexual minority service members; in fact research suggests more lesbian service members were discharged due to this law (Nagel, 2010). The long-standing proscription against homosexuals in the military, prior to DADT, is important to remember as 20 of the 24 participants performed at least part of their military service prior to 1993.

### **Hidden, Hunted, and Betrayed**

Lesbian Veteran identity was multifaceted, focused on maintaining safety, and centered on experiences that took place while the women performed their military service. Remaining safe was an overall goal of the lesbian Veterans; themes that emerged from the data were of identities that developed as women attempted to remain safe in what was an unsafe environment. The identities were of a: (a) hidden lesbian, (b) a hunted lesbian, and (c) a betrayed lesbian.

The identities of hidden, hunted and betrayed focused on fears of discharge from the military secondary to serving as a lesbian, occurrences of physical or sexual violence at the hands of military colleagues, threats of such violence, and the sense of betrayal experienced by participants as they found the military offered them no protection, as women or lesbians.

## **Hidden Identity**

Lesbian Veterans felt compelled to hide and remain hidden during military service due to the proscription enforced by the military against homosexual members. The majority of lesbian Veterans who participated in this study shared an identity of hidden; they kept their lesbian identity or same sex attraction hidden. Many could not or did not disclose their sexual orientation to others, due to concerns of sexual assault, sexual harassment, physical assault, verbal assault, and/or being forcibly discharged from the service. As Nancy noted, “It was a survival thing”.

“Hidden” took several forms. Some simply didn’t talk about personal lives while serving in the military. Other participants, (Izzy and Sandra, for example), entered into physical relationships with men in order to conceal their sexual minority status. Still other participants, such as Anna and Wanda, spoke of being two distinct people; while in uniform, one was a soldier, assumed to be a heterosexual. Out of uniform and off the military base, one was able to be more herself. The level of comfort felt by the participants was dependent, of course, upon her bond with her friends.

Additionally, disclosure of one’s lesbian identity could bring with it a vulnerability to betrayal (Trivette, 2010). In Trivette’s work (2010), gay Veterans noted the gamble that was implied by disclosing one’s sexual minority status to a colleague. Disclosure of sexual minority status could bring with it a loss of benefits, as it was not legal to serve in the military as a sexual minority at that time. Said Harry, a participant in Trivette’s study, “Who do you trust with your million-and-a-half dollar secret?” (p. 219, 2010). The betrayal by colleagues was illustrated in Jalisa’s experiences. Jalisa initiated her discharge under the DADT statute because friends who knew of her sexual

orientation were blackmailing her. They threatened to “out” her if she testified against them during their drug trials.

Several other participants, however, noted that they were ‘out’, or openly lesbian, when in the military. It was important to them to be honest about who they were, regardless of the consequences. They did not speak of experiencing adverse events as a consequence of their honesty. Some did note that their safety, once they disclosed their SO, depended upon a good relationship with their commander and a reputation of being a good soldier. Relationships continued to be of great importance to these participants, despite the fit with the RCT.

### *Secret Societies*

As a consequence of being hidden, and to manage the paradox of connections, lesbian Veterans developed secret societies. Secret societies grew organically. Seemingly only open to lesbian service members, spread by word of mouth, and by invitation only, the secret societies gave the women a place to be authentic with similar, empathetic others.

Women spoke of these secret societies as being close-knit, family-like, and protective. Odetta noted circumscribed behavior was sometimes still required within the group she belonged to, even when off base, lest others learn they were lesbians. Yolanda and Tabitha spoke to using code words when referring to ‘family members’ as another way to keep everyone safe. Women spoke of defending members against others who may have wished them harm.

## **Hunted Identity**

The second identity that emerged reflected the ways in which lesbian Veterans were pursued when in the military. Fellow service members, while performing their military service, hunted Lesbian Veterans for purposes of sexual harassment, sexual assault, and violence and as a means of maintaining power and control over female service members.

## ***Witch-Hunts***

Lesbian Veterans were the subject of “witch-hunts” during their military service. Several participants used the term “witch-hunts” to describe how they and others were hunted by other service members during their military service. An in-vivo code, witch-hunt in this sense was used to represent being hunted without cause, accused of wrongdoing, in an effort to control another.

Guilt by association was a tactic utilized in witch-hunts. For example, Anna had noted that she was the target of two witch-hunts during her time in the service. She commented that during these periods of time, she was not in relationships with other women. However, Anna was a friend with a group of people known to be gay, and therefore she was suspicious for homosexual activity by association. And that warranted the witch-hunts she experienced.

## ***Policed***

Lesbian Veterans were policed, or controlled, by threats of physical or sexual violence. Violence perpetrated on others stood as examples of what could happen if one did not keep one’s lesbian identity hidden. Beverly spoke of the masculine lesbian in boot camp who was gang-raped; her assault stood as an unspoken threat to Beverly of what

could happen if she did not ‘keep quiet’. This form of intimidation was also utilized to prevent victims of MST from reporting the crime. For example, Odetta did not report the MST she suffered due to fears of vengeance.

### ***Being Preyed Upon***

Lesbian Veterans were preyed upon during their military service. Preyed upon represents the ways in which male soldiers pursued some female service members. Physical and/or sexual assault were often the goal of the pursuit. Padma reported pursuit by a fellow officer who, when he caught her, physically and sexually assaulted her, leading to her hospitalization. Nancy related a nightmarish account of constant pursuit, sexual harassment and sexual assault by naval service men while serving onboard a ship. Her experiences of sexual harassment began immediately on the ship and were perpetrated by multiple men, including Nancy’s superior officer. She suffered a gang rape while on board, which led to a pregnancy. At one point, in an effort to escape the nightmare, Nancy went away without leave (AWOL). She did not discuss the ramifications of that action, just her need to escape.

Debra also reported perpetual pursuit by male colleagues while she was stationed in Vietnam during that war. She was raped and then, pregnant from the assault, was forced to have an abortion “...which they did on XXXX’s ward. They stuck a rag in my mouth, no anesthesia, and threatened to court-martial me if I ever told anybody.”

### **Betrayed Identity**

Lesbian Veterans described betrayal by military personnel as well as the military as an institution. Several sources of betrayal are noted in participants’ passages.

Interpersonal betrayal was evident in Padma’s interactions with her commanding officer

and chaplain. Following hospitalization for injuries suffered in a sexual assault, Padma reported the assault to her commanding officer and to her chaplain. The commanding officer was loath to report the incident. He placed the blame for the assault on Padma; told her that she was too beautiful, “too Barbie” ...to be in the military.” The chaplain also placed the blame for the assault on Padma, as she (as well as other women) was only there for sex or to find a husband.

Izzy spoke to feeling betrayed when a military lawyer refused to help her regarding a possible invasion of privacy, because she was a lesbian. Several women spoke about betrayal at the supervisor level associated with experiences of MST. Participants who experienced MST often went to their superior officers expecting protection and legal consequences for the person who assaulted them, only to discover that the assault was swept under the rug. Superior officers were noted to ignore reports of MST, to counsel victims to not report the assault, and /or to join in the sexual harassments and assaults taking place.

The military was noted to be the major source of institutional betrayal. Vicki, who experienced sexual assault while serving overseas, perhaps best verbalized the sense of betrayal felt by some: “They don’t want to hear it because then they have to admit that we weren’t protected. They didn’t take care of us. And they *didn’t* take care of us...We’re the dirty little secret they don’t want to fess up to.” The institutional betrayal she experienced adversely affected the relationship Vicki was able to have with her VA healthcare providers years later. Her words clearly evoked institutional betrayal by the military and the VA, as Vicki believed the two institutions were the same governmental entity. She noted she wasn’t able to trust her VA psychiatrist; this may have negatively



impacted her response to therapy, as well as the therapeutic bond with her HCP.

### ***Betrayers***

Conversely, several participants spoke of feeling as if they had betrayed their colleagues by keeping their sexual identity a secret. Sandra, Tabitha, and Yolanda talked about the discomfort they experienced while lying to their peers; the dishonesty “eats at you”. Izzy felt she had betrayed the military by enrolling when she knew she was a sexual minority at a time when homosexuality in the military was illegal.

Per the RCT, people are drawn to be in relationship with others and experience discomfort when that need is not met because they have to hide an important part of their self (Vogel, 2006/2007). Some participants felt that the hiding of their sexual orientation had a negative effect on their relationships with important others, as well as on their own emotions, as they stated their betrayal “ate away at them”. The armed services create a tight bond between members in a group, an intended group unity that is supposed to mimic that of a family unit (Northcut & Kienow, 2014). Hiding one’s sexual orientation from a group of people who are supposed to be ‘family’ may also feel like a betrayal of the group’s trust.

### **Research Question Two: What significance does lesbian Veteran identity have for use of the Veteran Health Administration healthcare system?**

The identities discussed above are salient for the utilization of the VA for healthcare. The lesbian Veteran was pragmatic in her decision to utilize the VA for healthcare. Access to healthcare was necessary, and many who enrolled in the VA lacked private insurance. The decision to utilize the VA was particularly difficult for participants who had suffered MST, and may have led to a delay in accessing VA care.

Several participants believed the VA would be like the military they had left, or that the preponderance of men receiving and providing treatment would create an uncomfortable atmosphere. The number of male staff members at VAs may have been particularly off-putting to women who had experienced MST. Participants reported promises that they would have female healthcare providers and staff because of their history of MST, yet such services were not always provided.

Anecdotally, it was not unusual for lesbian Veterans, such as Vicki, to mistakenly believe that the military was connected with the VA (Mattocks et al., 2015). This may have contributed to delays in seeking care and may have been particularly troubling for lesbian Veterans who felt betrayed by the military's failure to protect from MST and provide care in the aftermath. The consequences of the conflation of the two separate branches of government are noted to result in a lack of trust and feelings of betrayal in the VA, VA healthcare providers, and the military.

Other participants experienced institutional betrayal perpetrated by the VA. While most participants were satisfied overall with the care they received at the VA (Mattocks et al., 2015), some also noted it was difficult to get appointments, they were treated differently by staff such as cafeteria workers and schedulers, often mistaken for spouses rather than Veterans, and their same-sex partnerships were not recognized for healthcare purposes. Participants believed the above treatment was secondary to their sexual orientation.

**Research Question Three: What was the significance of lesbian Veteran identity for the subsequent relationship with VA healthcare providers?**

Lesbian Veteran identities of hidden, hunted, and betrayed were salient to the relationship the Veteran established with VA healthcare providers after separation from the military. Analysis of the transcripts suggests that once separated from the military, many women who had been hidden became more visible by disclosing their sexual orientation to healthcare providers. Military separation may have been transformative for many participants. Being hunted by colleagues was no longer the immediate threat it had been.

However, a different threat existed. Some lesbian Veterans were cognizant that they had participated in an illegal event by remaining in the armed services as a lesbian. Some spoke of fears that they could be expected to recompense the government for the pay and benefits they received during their military service. At least one participant refused to disclose when she had become aware of her identity as a member of a sexual minority. Most participants did not appear to have considered the ramifications of being a sexual minority when it was illegal to be so in the service of one's country.

Many lesbian Veterans who had been hidden during their military service reported disclosing their sexual orientation to a VA healthcare provider. Some disclosed to all their providers, some disclosed only to a select few. Lesbian Veterans were more likely to disclose their sexual orientation if they felt it was pertinent to their healthcare needs. What met the criteria of pertinent was very individual to lesbian Veterans; for example, Beverly felt her sexual orientation was pertinent to her psychiatrist, but not to

her gynecologist. Another participant believed her identity as a lesbian was pertinent if, during an appointment, the subject of her family or significant other was raised.

Matters of trust and betrayal were evident in some narratives. During her interviews, Colinda often used the phrase “for personal gain” – she would judge the intent behind healthcare-related questions by deciding if the question was legitimate, i.e. not for personal gain. Her repeated use of the phrase “for personal gain” suggested she was wary of being hunted or betrayed by this information being used against her in some manner. She noted that fears of being ‘outed’ continued, “just very slightly” once separated from the military; “I don’t have an issue being what I am or anything like that. It’s just more, why do you need to know?” Her reluctance to disclose her sexual orientation to healthcare providers may have signaled that she remained fearful of repercussions.

Differences in tone during interpersonal conversations and changes in body language once a participant’s sexual orientation was known are ways in which participants experienced betrayal by VA healthcare providers. A participant told of instances when staff did not honor a Veteran’s need for additional personnel in an exam room, or for female personnel only because she has experienced MST. Some participants noted different areas of the country had different reactions to their sexual orientation, some welcoming, some not. Sandra said that when she experienced a homophobic reaction secondary to her sexual orientation, it was usually by a nurse, although she also spoke of a gynecologist who told her after an exam that her homosexuality wasn’t normal.

Nevertheless, the women were pragmatic in their use of the VA for healthcare, as well as how they interacted with their healthcare providers. Veteran Administration healthcare providers did not always demonstrate acceptance of homosexuality when lesbian Veterans disclosed their sexual orientation. Participants required healthcare and many did not have the option to utilize private healthcare. Lesbian Veterans who noted discriminatory behaviors would change healthcare providers if they were able. However, some participants who did not like the healthcare provider did not have the option to choose another provider. Some noted that the physician caring for them had been the only practitioner available and they would have to receive care from a discriminatory provider to receive the healthcare they needed. Elaine noted she dealt with that circumstance by ‘blank[ing] out’ while Sandra said she would just “grin and bear it”. Putting in a request for a different provider may have entailed a delay in care secondary to provider availability.

### **Comparison of Study Findings with Extant Research**

The themes resultant from this analysis transcended sexuality and gender. Although this study was limited to lesbian Veterans, extant literature suggests the themes would also apply to bisexual and heterosexual women and men.

#### **Hidden: Secret Societies**

Lesbian military members were not alone in their desire to protect their ‘own’, nor were heterosexual women free from worries of sexual and physical assault. A study led by Cheney et al., (2015), noted women in the military could be in danger simply due to their gender and inexperience. Participants in that study spoke of the more experienced, higher-ranking female military personnel mentoring younger female service members in

ways to remain safe in the male-oriented environment, "...servicewomen sought to work together to protect each other" (Cheney et al., p 10, 2015). Interestingly, Nancy, a participant in the present study, noted the lack of mentors when she entered the Navy and spoke to how mentorship may have prevented her experiences of continual military sexual trauma.

A major difference between the 'secret societies' noted by participants of this study and the "support networks" noted by Cheney et al., (2015) was the hidden and closed nature of the former. The secret societies as described by participants in this study may reflect a consequence of needing to hide one's authentic self while driven to be in authentic relationships; a way of dealing with a paradox of connection within a milieu in which one's true self was illegal (Jordan, 2001).

Similarly, although lesbian Veteran participants in other studies also endorsed the importance of what was termed 'support systems' (Vaughn, p. 84, 2014), the support was not noted to be protective. In Vaughn's work, (2014), participants included significant others, family, and non-military friends in their support systems. This is different from the secret societies noted by others, where 'membership' was seemingly limited to service members.

Gay men in Trivette's (2010) study spoke of similar, but different, groups. Called the gay underground network, (GUN), Trivette (2010) characterized the networks in this way:

"GUN...is a very loosely structured network of gay and lesbian service members who find each other either by chance or through connections that other people know. Many of my subjects describe being able to tap into this network wherever

they were and claimed that it was incredibly easy to find other gay and lesbian personnel...Some didn't even think of it as a network, per se, but simply noted how easily they met up with other gay personnel and the social contacts that grew from such connections (p. 223, 2010)

While some participants endorsed the ease in which they located GUNs, others in Trivette's (2010) study noted they were not able to find networks at different locations. Additionally, participants in Trivette's study did not speak of protective aspects of GUNs. Use of code words, or aliases, as endorsed by participants in the current study to protect the identity of members, was not noted.

### **Hunted: Witch-Hunts**

Anna's experience as a target for a witch-hunt was not unique nor a new phenomenon in the military. While widespread in the military during the latter half of the 20<sup>th</sup> century, lesbian baiting or witch-hunts occurred as far back as the 1930s (Benecke and Dodge, 1990). Researchers have suggested that witch-hunts were a means by which men attempted to gain or regain control over women. They sought to deal with the insecurity they experienced due to changing job roles, through unfounded accusations of homosexuality, an identity that was illegal in the military (Benecke & Dodge, 1990). Women were accused of being lesbians when they rebuffed male advances or if they brought charges of physical or sexual assault against fellow service members (Benecke & Dodge, 1990; Damiano, 1999). Heterosexual service members, often women, could be and were accused of homosexuality (Benecke & Dodge, 1990; Damiano, 1999).

The increase in witch-hunts coincided with the increase in women within the military, as well as the changes in the occupations women were allowed to perform

(Benecke & Dodge, 1990). While prohibited from direct combat roles until recently, women were no longer relegated to historically female positions in the military, (i.e. nursing, administrative position).

Research conducted by Benecke and Dodge (1990) suggested individual women and entire companies could be targeted by witch hunts. During the witch hunts, military service members would go to great lengths to get ‘confessions’ of lesbian activity from women, up to and including threatening a woman’s family. During intensive questioning, female service members would be threatened with loss of child custody unless she gave the names of other lesbian service members (Benecke & Dodge, 1990).

### **Hunted: Preyed Upon**

Extant research suggests male service members preying upon women for the purpose of sexual assault and harassment is pervasive and long-standing in the military. Wolff and Mills (2016) also utilized the word ‘prey’ to describe the MST experienced by a participant in their study “One veteran who was gang raped described how some men at her duty station would prey on women” (p. 843). The assault occurred in the service prior to 1973 (Wolff and Mill, p. 843, 2016). This is reminiscent of Debra’s interview when she also reported perpetual pursuit while she was stationed in Vietnam during that war.

Naval airmen preyed upon service members and civilians, male and female alike, during the Tailhook conventions that occurred prior to 1992 (Burgess, Slattery & Herlihy, 2013). In an example of the attacks perpetrated during Tailhook ‘91, airmen stood on both sides of a corridor. The men sexually assaulted women as they walked down the middle of the hall (Ogden, n.d.). The point was made that some women sought out and enjoyed the sexual interactions (Browne, 2007). However, many women, including



young civilian women, were not aware of the danger posed by walking down the hall and suffered sexual harassments and assaults. Three different investigations of Tailhook '91 took place. Ultimately no one was found criminally responsible for the assaults (Browne, 2007; Ogden, n.d.).

### **Hidden, Hunted, and Betrayed in the Context of Military Sexual Trauma and Institutional Betrayal**

As would be expected, the semi-structured interview questions utilized during the study were informed by the parent study purposes. The purpose of the parent study (Mattocks et al., 2015) was to:

examine lesbian veterans' experiences with perceived stigma and discrimination in VHA healthcare; examine veterans' perspectives on disclosure of sexual orientation to VHA providers; and understand lesbian veterans' perspectives on improvements in VHA healthcare to create a welcoming environment for LGBT veterans. (p. 2)

During the course of the interviews, 10 of the 24 participants volunteered, without prompting or questioning, that they had experienced at least one episode of MST. A particularly striking finding, reports of sexual assaults shared by study participants, contributes to the importance of this research.

#### **Military Sexual Trauma**

As defined by the VA via Federal law (Title 38 U.S. Code 1720D), MST is psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or

sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training.” Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character. (Katz, p. 4, 2016; VA, 2015)

Unfortunately, MST is not a new phenomenon within the United States armed services. Experts note that it is difficult to gather accurate prevalence rates as many survivors have not reported the assaults, and researchers do not utilize the same definition of MST within studies (Katz, 2016; Parnitzke Smith & Freyd, 2014; Wilson, 2016). Prevalence estimates range from approximately 25% (Booth et al., 2012), to 33% (Forman-Hoffman, Mengeling, Booth, Turner, & Sadler, 2012), and 41% (Barth et al., 2016). In a recent meta-analysis, Wilson reported prevalence rates between 20-45% (2016).

Based on nearly 17 years of records, the VA reports one in four women Veterans who utilize the VA for care screened positive for MST, although a recent meta-analysis suggests the actual number of Veterans who experienced MST may be higher (VA, 2016; Wilson, 2016). Given the prevalence reported by the VA, it would be expected that 6 of the 24 participants in this study would have suffered MST. The number of women in this study who reported MST was higher (at 10 participants) than this national prevalence estimate. The number of participants spontaneously reporting MST in this study was especially startling as the VA notes women who have experienced MST “do not disclose their experiences unless asked directly” (VA, p. 2, 2015).

These findings of spontaneous disclosure of MST echo research published by Wolff and Mills (2016). While performing a mixed-methods study regarding

participation in a Veteran organization, 90% of the 52 female participants spontaneously reported at least one type of MST (Wolff & Mills, p. 842, 2016). As with the present study, participants were not asked about experiences with MST; and although both groups were asked about military experiences, Wolff and Mills' participants were asked questions regarding discrimination (p. 842, 2016).

Additional similarities between the present study and that reported by Wolff and Mills, (2016), include “constant incidents”(p. 844), and a “pervasive” (p. 845) atmosphere of MST. In a report comparable to Padma's experience, “One participant (1973-1978) described superiors telling her “it was my fault for being sexually attractive or being too sensitive”, other participants in Wolff & Mills' work who served from 1973-1978 noted that men “assumed that women were there for men's pleasure” (Wolff & Mills, p. 845, 2016).

Rates of MST are higher than rapes reported by civilians (Katz, 2016). While analogous to rape perpetrated outside of the military, research suggests that the military milieu in which the assaults occurred creates a different assault experience (Burgess, Slattery, & Herlihy, 2013). Women who have experienced MST often know and work with the perpetrator and are encouraged to be silent about the assault. Per Burgess et al., (2013), for women, the need to be in close proximity to the offender often leads to “...feelings of helplessness” (p. 23).

This is akin to the helplessness Vicki experienced after her MST and the occupational accident she experienced.

### **Institutional Betrayal**

Women who have experienced MST have reported a greater prevalence of PTSD

than civilian women who have reported rape (Northcut & Kienow, 2014). Overall, physical and psychological sequelae stemming from MST are noted to be more severe (Northcut & Kienow, 2014). The clinical ramifications of MST can be long lasting and negatively impact Veterans' quality of life.

Researchers posit that differences in the severity of post-assault sequelae may be secondary to feelings of betrayal, a breaking of a bond, experienced by the women after the respective assaults (Monteith, Bahraini, Matarazzo, Soberay, & Smith, 2016; Parnitzke Smith & Freyd, 2013; Wolff & Mills, 2016;). Participants in the present study as well as Wolff & Mills' reported difficulty establishing trust with VA healthcare providers (p. 846, 2016). Female Veteran participants in the study reported by Wolff and Mills, (2016), noted the institutional betrayal they experienced stemming from the military's inappropriate response to their experiences of MST led to some seeking healthcare from private healthcare systems.

### **Betrayal Trauma**

Freyd developed betrayal trauma theory to explicate how and why children were able to forget abuse suffered at the hands of their caregivers (1996). The theory suggested that a child is unable to remember the abuse, is 'betrayal blind' (p. Freyd, 1996; Freyd & Birrell, 2013) because the child must continue to rely on the abuser for food, shelter, and other safety needs. Betrayal blindness may provide an explanation for the lesbian Veterans who experienced MST and yet remained in the military for extended periods of time. Some participants noted they had enlisted in the military to escape difficult homes, or because of a lack of employment opportunities. Discharge may have appeared intolerable to women who had little in the way of skills or outside resources.

Individuals who experienced MST may have experienced several levels of betrayal trauma: individual betrayal as well as institutional betrayal. Institutional betrayal occurs when an institution that has been established as one that protects members, such as the US military, betrays members in some way (Freyd & Birrell, 2013). Lesbian Veterans suffered from both individual betrayal trauma when their colleagues in the armed forces assaulted them, and institutional betrayal when, having experienced MST they sought to report the crime only to have the military as an organization betrayed them. The ramifications of that betrayal can include suicidal ideations and attempts (Monteith et al., 2016).

The military allowed an atmosphere in which the assault would be perpetrated, in what Benecke and Dodge (1990) described as an “institutional form of sexual harassment” (p. 216). Women who had experienced MST would be discouraged from reporting the assault, or retaliated against if she did report the assault (Bell, Street, & Stafford, 2014; Burgess, Slattery & Herlihy, 2013; Mengeling, Booth, Torner, & Sadler, 2014; Wolff & Mills, 2016). Experiencing a poor response to the reporting of MST has been labeled secondary victimization and results in even more severe sequelae than just the assault alone (Campbell & Raja, 2005).

Lesbian Veterans in this study who experienced MST while serving in the military reported experiences similar to those in work published by Wolff & Mills, (2016). It is worth noting that most participants in this study were older women, between the ages of 41 years and 50 years, and the majority had served prior to 2001. This is significant because much of the present research regarding the effects of MST examines younger Veterans who served in OIF and OEF. Little research has examined the

biopsychosocial sequelae of MST in older women.

It is also worth noting that these women wanted to talk about what they had experienced during their time in the service. Experiencing MST was an important event, as evidenced by each woman's voluntary disclosure of the information within the narrative of her time in the military. This apparent need to speak about MST experiences is not unique, in that Wolff and Mills, (2016), noted a similar occurrence. Additionally, Olive (2014) reported that college-aged participants he interviewed for a study also spontaneously disclosed experiencing a sexual assault.

### **Strengths and Weaknesses**

As this study was a secondary analysis, there are weaknesses inherent to this study. This study did not reach theoretical saturation, as the study design did not allow for the recruitment of additional participants. It is possible that a larger study may suggest additional insights that are significant for lesbian Veteran utilization of the VA, and relationships with VA HCPs.

The discrete sample of 24 participants did not allow the researcher to explore MST with participants who spontaneously reported it; nor were the researchers able to question the 14 other participants regarding their experiences (if any) with MST. Details of the MST experienced by the participants in this study were not given, nor asked for, as MST was not the phenomenon to be examined in the work published by Mattocks et al., (2015). The data may be negatively impacted by recall bias (Hassan, 2005; Lincoln & Guba, 1985). Participants reported separating from the military between 3 and 46 years prior to participating in the parent study. Their responses to interview questions may have

been colored by the passage of time.

This study also has strengths. The 24 participants were recruited from multiple geographic locations within the US and US territories, and was culturally and ethnically diverse. The findings related to the identities of hidden, hunted, and betrayed in the context of MST and institutional betrayals are strengthened because of the heterogeneous sample. The similar findings reported in the study published by Wolff & Mills, (2016), lends credence to the findings from this research study, and suggests that these findings transcend sexuality.

### **Future Directions**

There are important implications of the lesbian Veteran identity. The significance of their identity for lesbian Veteran treatment and the treatment of other older women cannot be underestimated. Some women participated because of the offered honorarium; others may have participated in order to have their story heard. Practitioners note that having a conversation with an empathetic other regarding an experienced trauma can be therapeutic. Although the study was not meant to be therapeutic, it is possible that the women felt emotionally validated by sharing their experiences with the researchers. This is important to the well-being of this group of women. The significance of these findings to nursing education, practice, and research are similarly important.

### **Nursing Education**

Both military Veterans and sexual minority individuals, respectively, are vulnerable populations understood to suffer from health disparities. Unfortunately, as noted by Bosse, Nesteby and Randall, (2015), scant content regarding the care of persons

who identify as sexual minority individuals is included in nursing education. A revolution in nursing education is necessary. Nursing education must focus on the health of LGBTQ individuals across the life span, content should be integrated throughout nursing curriculums, and recognize the unique vulnerability of sub-populations, such as lesbian Veterans. Nurse scholars must encourage education surrounding the distinctive needs of the LGBTQ population in order to offer adequate care.

### **Nursing Practice**

Many female Veterans receive care outside of the VA. It is imperative that nurses recognize the need to screen for SM status, Veteran status and for experiences related to MST and sexual assault. Nurses may need additional time to establish therapeutic, trusting relationships with women who have experienced such assaults. Additionally, nurses have a responsibility to provide patient-centered, culturally appropriate care. It is extremely important that nurses familiarize themselves with both populations and their very unique healthcare needs, and the ways in which the intersection of identities may influence those healthcare needs. Nurses should seek out and provide knowledge of available community resources as needed.

### **Nursing Research**

More nursing research is necessary with a focus on the lesbian Veteran, taking a lifespan approach when appropriate. A large cohort of women Veterans is nearing retirement, many of whom will utilize the VA system for their burgeoning healthcare needs. Additional research is necessary to explore the military experience of lesbian Veterans, especially those who served prior to 2001, as less is known about those cohorts.



Researchers note approximately 11-45% of Veterans have not only experienced MST, but may have also experienced traumatic victimization when efforts were made to report assaults. Trauma associated with institutional betrayal may impact their healthcare needs as the female Veterans age. One day female Veterans, both heterosexual and SM, may once again come under the care of large institutions for their long-term healthcare needs. Research is necessary to explore the significance of the military experiences for their quality of life and healthcare.

The care provided to lesbians and Veterans includes screening for sexual trauma that may have occurred throughout the life span. Research suggests that overall, LGBTQ individuals are at an increased risk for sexual assaults (Smith, Cunningham, & Freyd, 2016). Additionally, science suggests that traumas and adverse events that have occurred during discrete periods of time continue to have significance for present and future healthcare needs (Katon et al., 2015; Kalmakis & Chandler, 2015). Research is needed that can explicate the care of older individuals with chronic illness, so that nurses can provide care that recognizes and incorporates the distinct psychosocial needs of older lesbian Veteran populations.

Finally, the similarity of findings between the present study and the one published by Wolff and Mills (2016) suggests the presence of important, concealed experiences that may negatively affect the biopsychosocial quality of life experienced by all female Veterans. Their experiences must be brought into the light and validated in order to be better understood and treated. American female Veterans deserve no less.

## APPENDIX A

### TABLES

#### Table

#### *Participant Demographics*

| <i>Characteristic</i>                          | <i>N = 18</i> |
|--|---------------|
| Median Age Range                               | 41-50         |
| Relationship Status                            |               |
| Married/Partnered                              | 53%           |
| Never married                                  | 32%           |
| Separated                                      | 11%           |
| Divorced                                       | 5%            |
| Currently in a same-sex relationship           |               |
| Yes  | 60%           |
| No   | 40%           |
| Ever in a same-sex relationship during VA care |               |
| Yes  | 86%           |
| No   | 14%           |
| Number of children                             |               |
| 0  | 75%           |
| 1  | 11%           |
| 2  | 11%           |
| 3  | 5%            |
| Sexual Orientation                             |               |
| Lesbian  | 95%           |
| Bisexual                                       | 0%            |
| Straight                                       | 0%            |
| Don't Know                                     | 5%            |
| Race   |               |
| African American                               | 15%           |
| Hispanic/Latino                                | 30%           |
| Asian including Southeast Asia                 | 5%            |
| White/Caucasian                                | 35%           |
| Other  | 15%           |
| Hispanic or Latino                             |               |
| Yes  | 35%           |
| No   | 65%           |
| Religion                                       |               |
| Protestant                                     | 23%           |
| Catholic                                       | 12%           |
| Agnostic                                       | 6%            |
| Buddhist                                       | 6%            |
| Other  | 53%           |

**Table**  
***Pseudonym and Military Service***

| Pseudonym | Branch of Service              | Years of Service | Years Served | Combat Deployment |
|-----------|--------------------------------|------------------|--------------|-------------------|
| Anna      | Army <sup>A</sup>              | 1983-1988        | 5 years      | No                |
|           | Coast Guard <sup>A, R</sup>    | 1990-2006        | 16 years     |                   |
| Beverly   | Navy <sup>R</sup>              | 1986-1992        | 6 years      | Yes               |
| Colinda   | Army <sup>R</sup>              | 2009*            | 6 years      | Yes               |
| Debra     | Army <sup>A</sup>              | 1967-1968        | 2 years      | Yes               |
| Elaine    | *                              | 1980*            | *            | *                 |
| Frannie   | Army <sup>A</sup>              | 1980-1984        | 3 years      | No                |
| Gabby     | Air Force <sup>R</sup>         | 1994-1996        | 2 years      | Yes               |
|           | Navy <sup>R</sup>              | 2003-2008        | 5 years      |                   |
| Hannah    | Air Force <sup>A</sup>         | 1988-2009        | 21 years     | *                 |
| Izzy      | National Guard <sup>R</sup>    | 1992-1997        | 5 years      | *                 |
|           | Army <sup>A</sup>              |                  |              |                   |
| Jalisa    | Air Force <sup>A</sup>         | 1993-1995        | 2 years      | *                 |
| Kagami    | Air Force <sup>A</sup>         | 1978-1982        | 4 years      | No                |
| Lacey     | Navy <sup>A</sup>              | 2001-2006        | 5 years      | Yes               |
| Madelaine | National Guard <sup>R</sup>    | 1985-2006        | 20 years     | No                |
| Nancy     | Navy <sup>A</sup>              | 1981-1985        | 4 years      | No                |
| Odetta    | Army <sup>R, A</sup>           | 1985-1993        | 8 years      | Yes               |
| Padma     | Army <sup>A, R</sup>           | 1978-2002*       | *            | *                 |
| Queenie   | National Guard <sup>A</sup>    | 2003*            | 29 years     | Yes               |
| Raeanne   | National Guard <sup>A, R</sup> | 2003-2011        | 8 years      | Yes               |
| Sandra    | Air Force <sup>A, R</sup>      | 1983-1987        | 4 years      | *                 |
| Tabitha   | Army <sup>A</sup>              | 1981-1982        | 1 year       | No                |
| Ursula    | Air Force <sup>A, R</sup>      | 1984-2003        | 19 years     | Yes               |
| Vicki     | Army <sup>A</sup>              | 1975-1981        | 6 years      | No                |
| Wanda     | Army <sup>A</sup>              | 1987-2008        | 21 years     | Yes               |
| Yolanda   | National Guard <sup>R</sup>    | 1999-2007        | 8 years      | Yes               |
|           | Army <sup>A</sup>              |                  |              |                   |

A = Active Duty; R = Reserves; \* = Missing Information

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## APPENDIX B

### WORKSHEETS

Worksheet 3. Analyst's Notes while reading a case report

Case ID \_\_\_\_\_

|  |  |
|--|--|
| Synopsis of case:  | Case Findings:<br>I.<br><br>II.<br><br>III.                      |
| Uniqueness of case situation<br>for program/phenomenon:  | IV.  |
| Relevance of case for cross-case Themes:<br>Theme 1 _____ Theme 2 _____ Theme 3 _____<br>Theme 4 _____ Theme 5 _____ Theme 6 _____ | Possible excerpts for cross-case report:<br>Page<br>Page<br>Page |
| Factors (optional):  |  |
| Commentary:  |  |

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Worksheet 4. Estimates of Ordinariness of the Situation of Each Case and  
Estimates of Manifestation of Multi-case Themes in Each Case

**W** = highly unusual situation, **u** = somewhat unusual situation, blank = ordinary situation

**M** = high manifestation, **m** = some manifestation, blank = almost no manifestation

|  | Case A | Case B | Case C | Case D | Case E |
|--|--------|--------|--------|--------|--------|
| Ordinariness of this Case's situation: |        |        |        |        |        |
| Original Multicase Themes              |        |        |        |        |        |
| Theme 1                                |        |        |        |        |        |
| Theme 2                                |        |        |        |        |        |
| Theme 3                                |        |        |        |        |        |
| Theme 4                                |        |        |        |        |        |
| Theme 5                                |        |        |        |        |        |
| Theme 6                                |        |        |        |        |        |
| Added Multicase Themes                 |        |        |        |        |        |
| Theme 7                                |        |        |        |        |        |
| Theme 8                                |        |        |        |        |        |
|  |        |        |        |        |        |
|  |        |        |        |        |        |

High manifestation means that the Theme is prominent in this particular case study. A highly unusual situation (far from ordinary) is one that is expected to challenge the generality of themes. As indicated, the original themes can be augmented by additional themes even as late as the beginning of the cross-case analysis. The paragraphs on each Theme should be attached to the matrix so that the basis for estimates can be readily examined.

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