
THE STATE OF THE AMERICAN VETERAN: VETERAN WOMEN

The Southern California Veterans Study

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EXECUTIVE SUMMARY



This report presents findings from a recently completed study of Southern California veterans focused on the health and well-being of veteran women. The parent study, [The State of the American Veteran: The Southern California Veterans Study](#), was the largest study of veterans ever conducted in Southern California. The study aimed to examine the experiences of veteran women as they transitioned out of the military, as well as to identify challenges veteran women encounter.

KEY FINDING 1

Veteran women experience significant challenges in transitioning from the military to civilian communities, as indicated by the fact that they endorse that they have experienced transitioning difficulties at equal to or higher rates than veteran men.

Recommendation 1. In addition to making continued improvements to the military's transition programs, add and expand on transition topics unique to women's experience. In-depth guidance must be included on steps of transition related to employment, the long-term viability of housing situations, transition expectations, managing military identity and civilians' perceptions of women veterans, and the emotional impact of transition.

KEY FINDING 2

Food insecurity is a major concern for veteran women.

Recommendation 2. Increase screening for food insecurity within Veteran Affairs

(VA) and veteran support organizations (VSOs) and improve accessibility of connected resources. Assess whether transitioning veterans qualify for state and federal food benefit programs. Consider the unique barriers veteran women may face when accessing food support and implement strategies for overcoming such obstacles.

KEY FINDING 3

Veteran women reported significantly higher rates of loneliness and lower levels of social support than veteran men.

Recommendation 3. Increase screening measures for loneliness in veteran women within the VA and VSOs. Provide more targeted opportunities for veteran women to build and/or expand their social networks. Encourage veteran women and non-veteran groups to foster an inclusive environment that is sensitive to the needs and experiences of veteran women.

KEY FINDING 4

Veteran women were more likely to have a probable mental health problem related to PTSD and depression than veteran men and were more likely to be at risk for suicide.

Recommendation 4. Tailor mental health treatments and suicide prevention efforts to consider the unique military experiences that exist between men and women. Abandon the one-size-fits-all approach to sexual assault and suicide prevention.

KEY FINDING 5

Experiences of sexual harassment and sexual assault during military service remain enduring challenges for veteran women.

Recommendation 5. Continue to include military sexual trauma screenings and opportunities for disclosure among women within veteran organizations. Increase veteran women's access to safe environments, especially housing and work environments, as well as ensure veteran women receive effective treatments and care.

KEY FINDING 6

Veteran women reported significant levels of chronic pain.

Recommendation 6. Continue and increase screening for pain status as a common practice, while broadening approaches to include pain assessment and treatment for women. Ensure service environments convey a diverse and inclusive atmosphere. Increase accessibility of healthy and effective pain management tools and continue research on the experience of pain in veteran women.

KEY FINDING 7

Veteran women were significantly more likely to endorse that they encountered logistical barriers to receiving VA health care.

Recommendation 7. The VA must continue to work to improve access to care for veteran women.

STUDY OVERVIEW



BACKGROUND

Just over fifty years ago, women service members were limited by law to comprising no more than 2% of the US military forces. Today, women make up 19.1% of the current military and an estimated 11% of the veteran population (Department of Defense, 2022; Schaeffer, 2024). The number of women within the military and veteran populations continues to grow. There are currently nearly 400,000 women serving in all branches of the military and an estimated two million veteran women. These shifting demographics highlight the need to understand and address the unique challenges to health and well-being that women encounter.

Despite the growing number of women in the military, women continue to experience unique stressors during service. Such stressors include, but are not limited to, challenges involving acceptance, inclusion, and integration; stereotypes about their service and ability to perform duties; increased risk of physical and mental health challenges; gender bias and discrimination; and sexual misconduct that includes harassment, stalking, and assault (Department of Defense, 2022; Office of People Analytics & ForsMarsh, 2024). These military experiences can create an added layer of difficulty as women service members transition from the military to civilian communities and begin the next phase of their lives.

In this report, we present findings from a recently completed study of Southern California veterans focused on the health and well-being of veteran women. The parent study, [The State of the American Veteran: The Southern California Veterans Study](#), was the largest study of veterans ever conducted in Southern California. The study aimed to examine the experiences of veteran women as they transitioned out of the military, as well as to identify challenges veteran women encounter. Recommendations for improving the overall health and well-being of veteran women are provided.

DATA COLLECTION PROCEDURES

The sample comprised veterans living in Southern California, specifically veterans living in Los Angeles County, Orange County, and San Diego County. An online survey approach was used for data collection. Through various recruitment methods, veterans received an invitation to participate in the study and were provided with a link to complete the survey online. The survey took approximately 30 to 60 minutes to complete. All participants received a \$25 gift card. When appropriate, standardized survey items and instruments were used (see Appendix A for a description of measure instruments). All data collection procedures were approved by the University of Southern California Institutional Review Board.

Data was collected between July 2022 and June 2023. A targeted recruitment strategy was used to achieve maximum representativeness of the veteran population in Southern California. The first strategy involved partnering with collaboratives, agencies, and organizations that serve Southern California veterans. Using their contact databases, partnering agencies emailed potential participants the survey invitation and/or shared the opportunity on social media. The second approach used national veteran organizations that identified Southern California veterans from their email lists. Members living within the sample area were emailed by the organization and invited to complete the survey using an online survey link. The final sampling strategy used print advertisements and social media to build a presence within the Southern California community. Avenues such as Facebook, Instagram, X (formerly Twitter), LinkedIn, mass emails, and the survey website promoted the survey opportunity to potential participants.

FINDINGS



VETERAN SAMPLE POPULATION

In total, 3,188 Southern California veterans completed the Southern California Veterans survey. For the purposes of this analysis, participants who identified their gender as nonbinary, other, or preferred not to say, were excluded. This left a final sample of 3,133 veterans, of which 18% were women and 82% men (see [Table 1](#)).

Table 1 **Percentage of sample by gender**

VETERANS BY GENDER	N	%
Women	564	18%
Men	2569	82%
TOTAL SAMPLE*	3133	

*55 participants reported a nonbinary or other gender, or preferred not to say, and were excluded from this analysis.

For data presentation and analyses, all participants were divided into three groups based on when they left the military. The first group was Recently Transitioned Veterans (RTV), who left the military between 2017 and 2022. The second group was Contemporary War Veterans (CWV), who completed their military service between 2001 and 2016. The final group was Legacy Veterans (LGV), who served prior to 2001 (see [Table 2](#)). For further details about the development of the era variable, please see the [Southern California Veterans Study](#). Please note that only variables that demonstrated significant differences between women of different eras are included in the report.

Table 2 Percentage of sample by era

VETERANS BY ERA	YEAR SERVICE ENDED	WOMEN	MEN
Recently Transitioned Veterans (RTV)	2017 - 2022	136 (27%)	430 (19%)
Contemporary War Veterans (CWV)	2001 - 2016	253 (49%)	891 (41%)
Legacy Veterans (LGV)	Before 2001	123 (24%)	893 (40%)
Not Provided		52 (9%)	355 (14%)
TOTAL SAMPLE		512	2569

Most veteran women in the sample were married (41%), aged between 30 and 49 (56%), and had a bachelor's degree or higher (46%). Three out of five veteran women in the sample were White (61%) and 29% identified as from a Hispanic, Latino, or Spanish origin. Half (49%) of the women in the sample were identified as CWV, with RTV and LGV women making up 27% and 24% of veteran women in the sample, respectively. Veteran women were more likely than veteran men to be younger; to be Black or African American; to identify as gay, lesbian or bisexual; to be divorced; and to have recently transitioned.

For veterans who were men, most were married (53%), between 30 and 49 (42%), and had some college or associate degree (58%). Most men in the sample were white (62%) and 28% identified as from a Hispanic, Latino, or Spanish origin. Two out of five men were identified as CWV (41%), with RTV and LGV making up 19% and 40% of veteran men in the sample, respectively. Veterans in the sample who were men were more likely than women to be older, married, and LGV. All sample demographics can be found on **Tables 2 and 3**.

Table 3 Characteristics of veteran sample

		WOMEN	MEN
Age	18 - 29	14%	10%
	30 - 39	32%	23%
	40 - 49	24%	19%
	50 - 59	16%	16%
	60 - 69	11%	16%
	70 and older	3%	17%
Hispanic, Latino, or Spanish Origin	Yes	29%	28%
	No	71%	72%
Race	Asian	7%	11%
	Black or African American	18%	13%
	Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native or Other	14%	14%
	White	61%	62%
Sexual Orientation	Heterosexual or Straight	7%	11%
	Gay, Lesbian or Bisexual	18%	13%
	Prefer not to say or self describe	14%	14%
Marital Status	Single	26%	23%
	Married	41%	53%
	Divorced	24%	12%
	Separated	3%	2%
	Widowed	2%	2%
	Domestic Partnership	4%	4%
Education	Some High School	26%	23%
	GED or High School Diploma	41%	53%
	Some College or Associate Degree	24%	12%
	Bachelors Degree	3%	2%
	Masters or Higher	2%	2%
	Other	4%	4%

The Army was the most represented branch in the sample (35%) for both women (34%) and men (36%), followed by the Navy (33% women; 28% men), Marine Corps (17% women; 22% men), and Air Force (15% women; 11% men). Over half of women (58%) had at least one deployment, whereas 81% of men had deployed at least once. Forty-five percent of women and 57% of men reported serving in combat. Most women (77%) and men (74%) were active duty at the time of discharge and reported separating with an honorable discharge status (89% women; 88% men). Women were less likely to retire from the military than men (11% vs. 18%) and more likely than men to have a medical separation (11% vs. 6%). **Table 4** provides details on the military background characteristics of the sample.

Table 4 Military Background

		WOMEN	MEN
Service Branch	Air Force	15%	11%
	Army	34%	36%
	Coast Guard	1%	3%
	Marine Corps	17%	22%
	Navy	33%	28%
	Space Force	0.0%	0.0003%
Deployments	None	42%	19%
	1	28%	24%
	2	12%	20%
	3	9%	13%
	4	3%	6%
	5 or More	7%	18%
Serve in Combat	Yes	45%	57%
	No	55%	43%
Status at Separation/ Discharge	Active Duty	77%	74%
	Reserve	19%	21%
	National Guard	5%	5%

Table 4

Military Background (continued)

		WOMEN	MEN
Rank/Pay Grade at Separation/ Discharge	Junior Enlisted (E1-E4)	40%	34%
	Non-Commissioned Officer (NCO; E4-E6)	43%	43%
	Senior Non-Commissioned Officer (E7-E9/E9S)	4%	11%
	Junior Officer (O1-O3)	6%	6%
	Mid-Level Officer (O4-O5)	5%	4%
	Senior-Level Officer (O6)	1%	2%
	General/Flag Officer (O7-O10)	0.1%	0.2%
	Warrant Officer (W1-W5)	1%	1%
Military Discharge	Honorable	89%	88%
	General, Under Honorable Conditions	10%	9%
	Other Than Honorable	1%	2%
	Bad Conduct Discharge	0.0%	0.2%
	Dishonorable Discharge	0.0%	0.1%
	Dismissal	0.0%	0.2%
	Uncharacterized	0.4%	0.2%
	Other	0.4%	0.3%
Separation/ Discharge Reason	End of Military Commitment	49%	58%
	Retirement	11%	18%
	Medical Retirement	7%	4%
	Medical Separation	11%	6%
	Administrative/Chapter Separation	7%	5%
	Other	15%	10%

MILITARY TRANSITION

Veteran women reported similar transition challenges to their male counterparts, and in some instances had higher rates of transition difficulties. Women and men reported similar rates of adjustment difficulties and needing time to figure out what to do with their life. However, women were much less likely to report that they were prepared for the challenges they encountered after military transition (28% women; 41% men). They were also more likely to report that they didn't know who they were after leaving the military (48% women; 38% men) and that they felt like they had to start over after leaving the military (75% women; 68% men) (see **Figure 1a**). RTV and CWV women were more likely to report transition challenges than LGV women (see **Figure 1b**).

Figure 1a

MILITARY TRANSITION EXPERIENCES

Percentage of veterans who agree with each statement, by gender

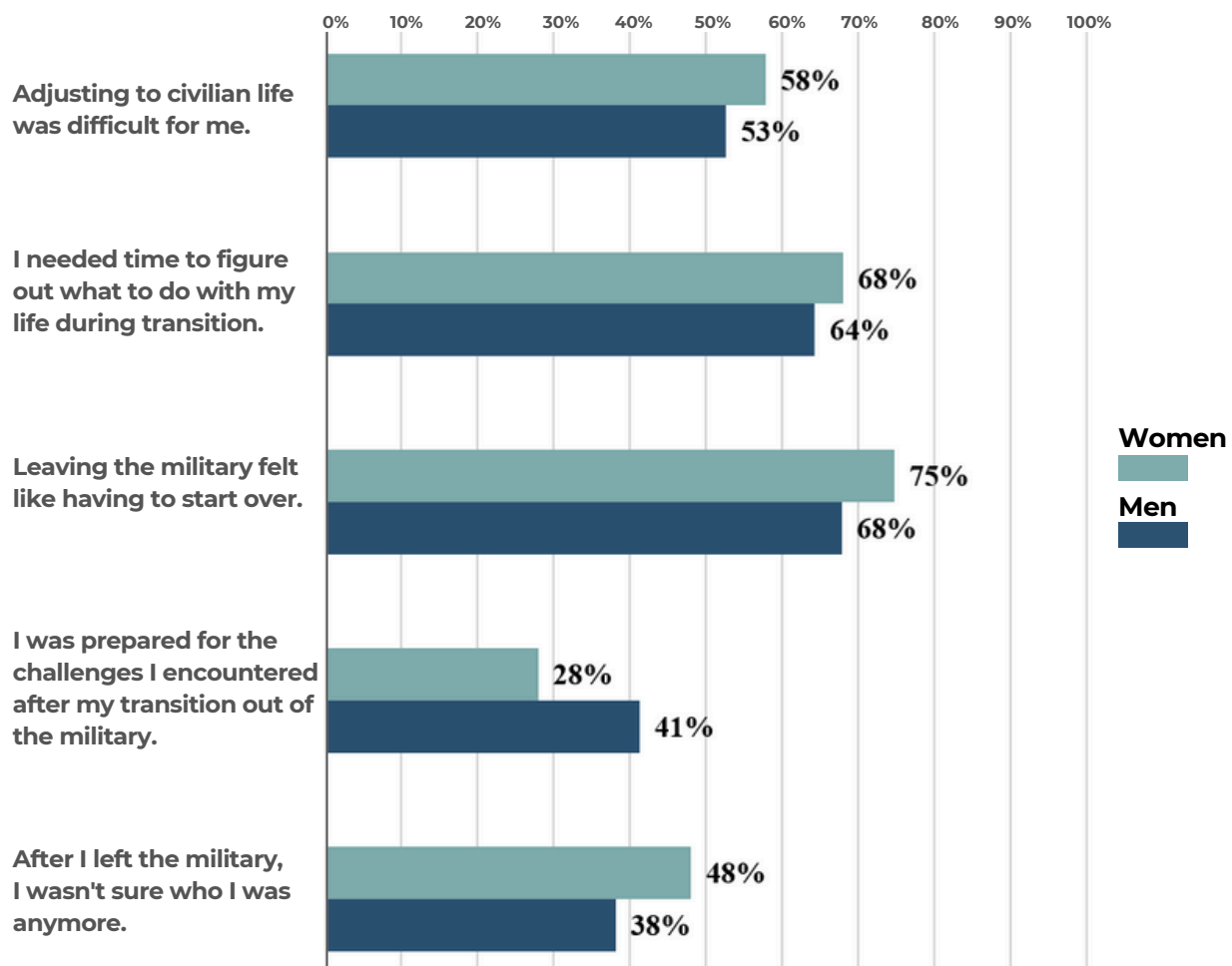
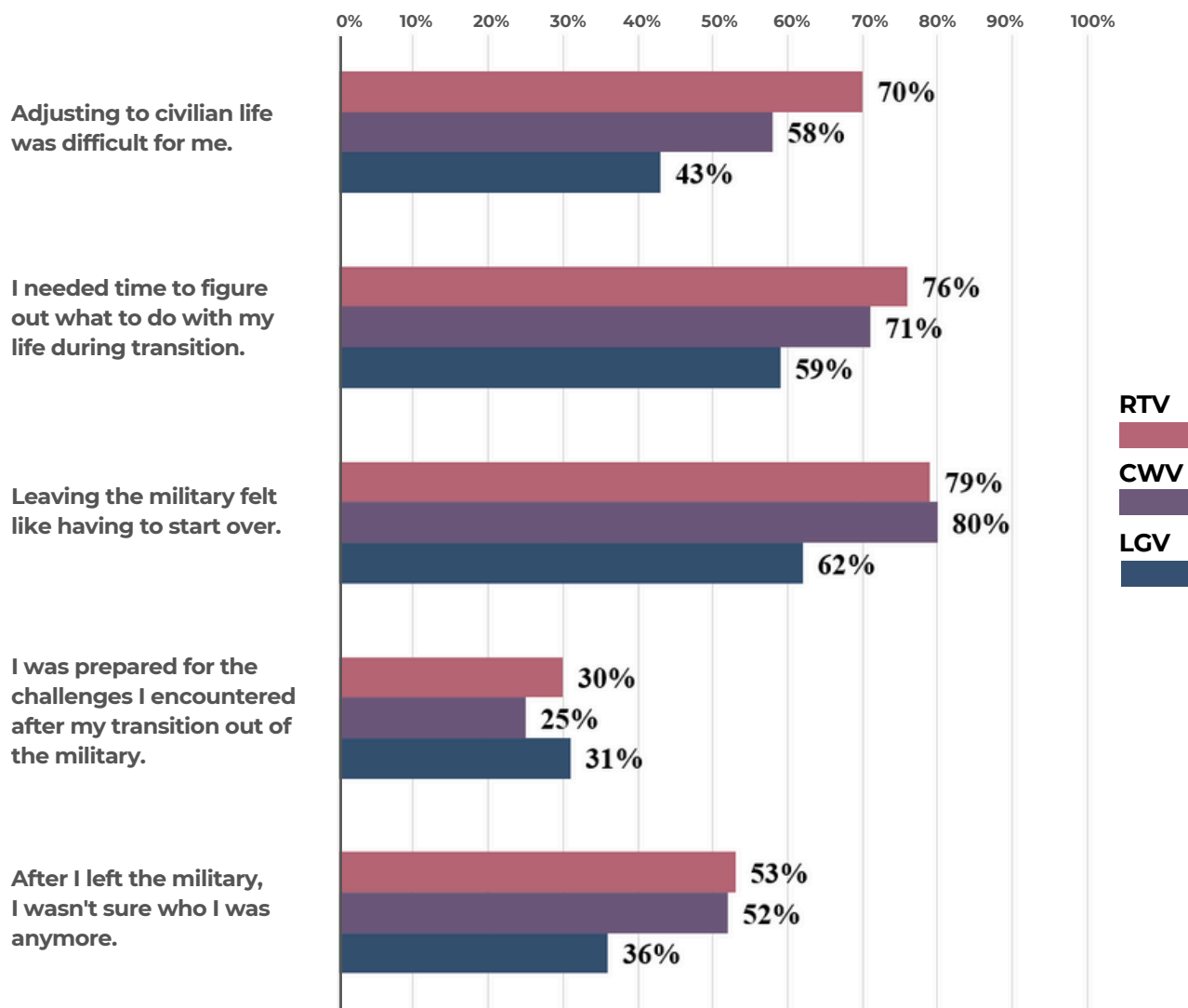


Figure 1b

MILITARY TRANSITION EXPERIENCES

Percentage of veteran women who agree with each statement, by era



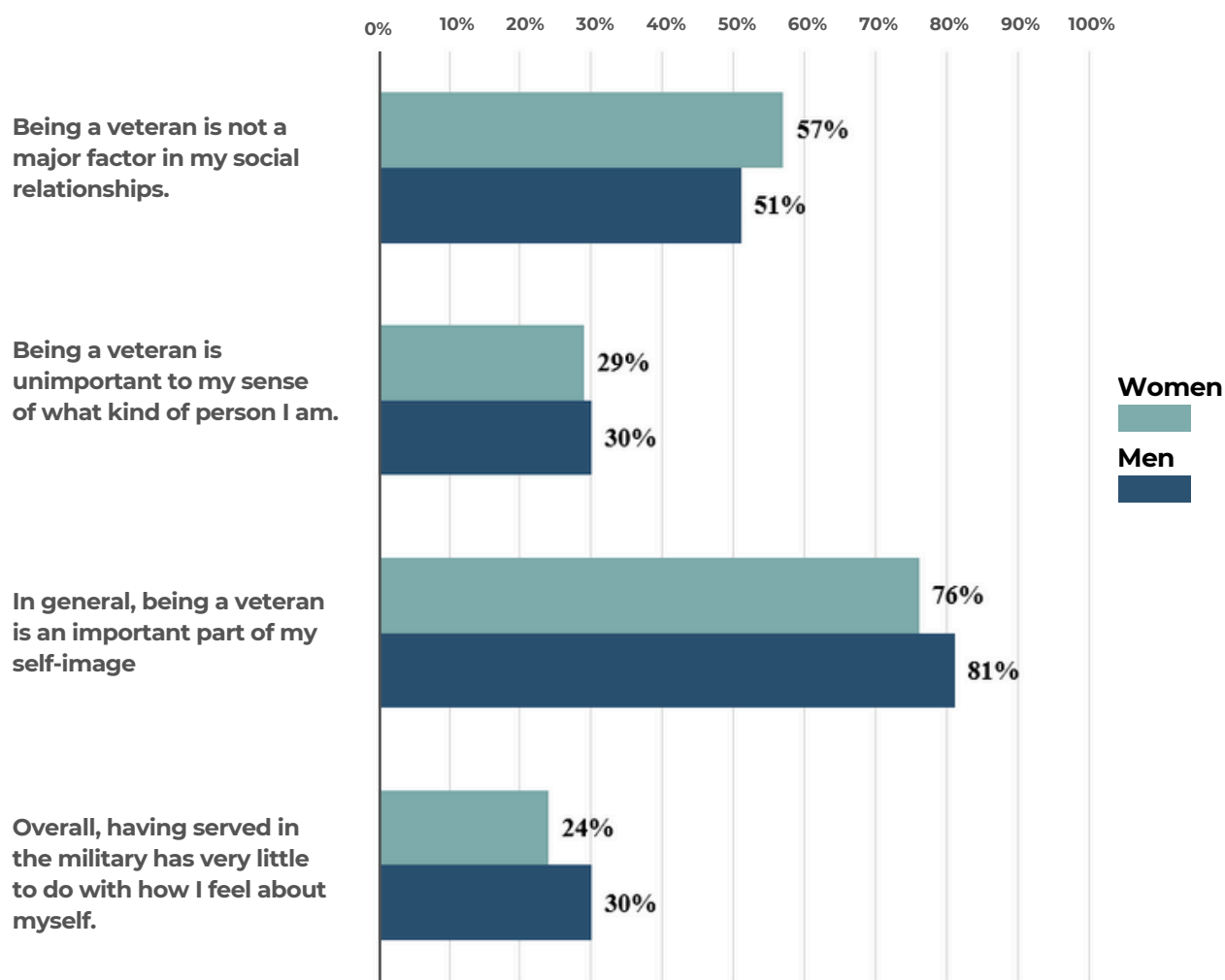
MILITARY IDENTITY

Military service was an important element of identity in both women and men in the study. Most women (76%) and men (76%) in the study reported that being a veteran is an important part of who they are (see **Figure 2**). Strong military identity was reported in both women and men veterans.

Figure 2

MILITARY IDENTITY

Percentage of veterans who agree with each statement, by gender



EMPLOYMENT

Women veterans were slightly less likely to report having a job when they left the military, with 27% of women and 35% of men reporting having a job lined up prior to separation or retirement (see **Figure 3**). Women were more likely to have a job that was similar to their military occupation (31% women; 24% men), but overall rates of similar occupation were low in both groups (see **Figure 4**).

Figure 3

EMPLOYMENT
Percentage of veterans who had a job when they left the military, by gender

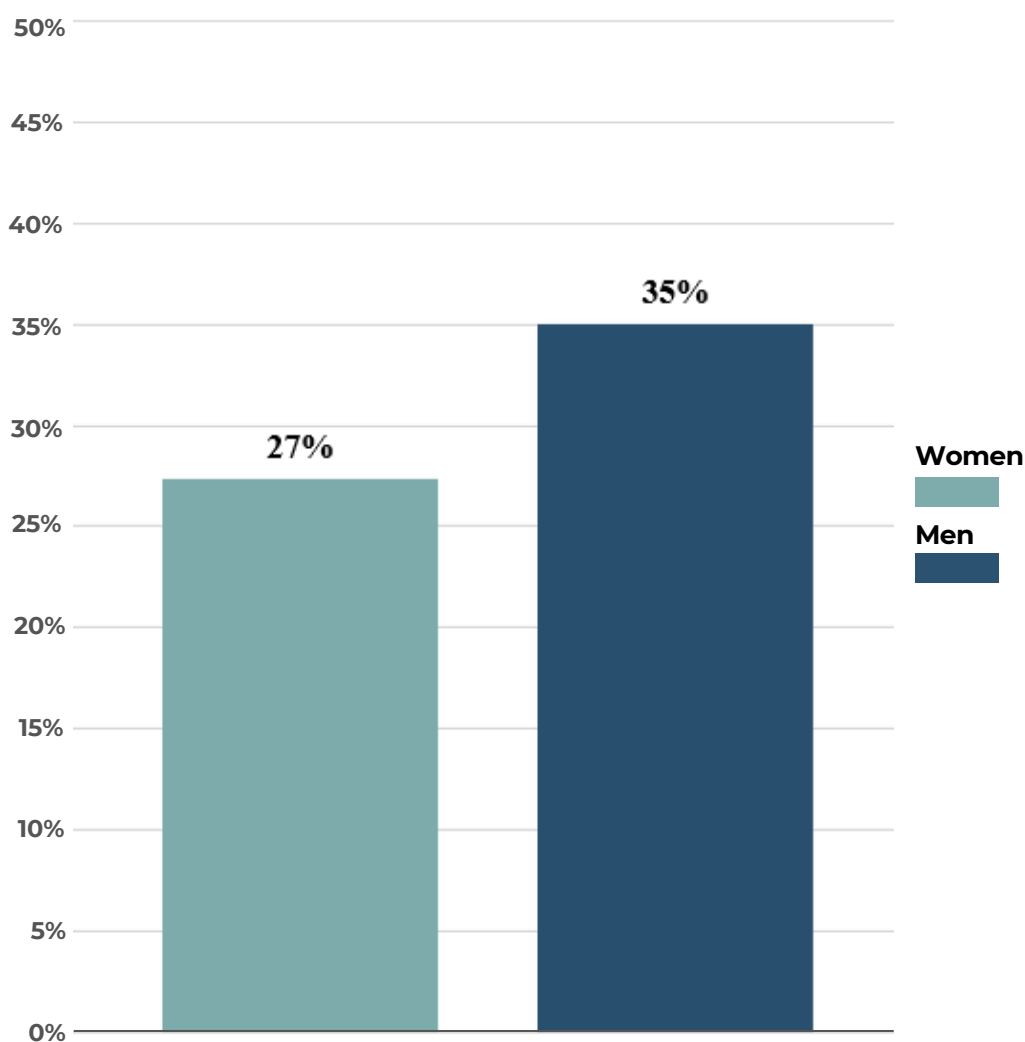
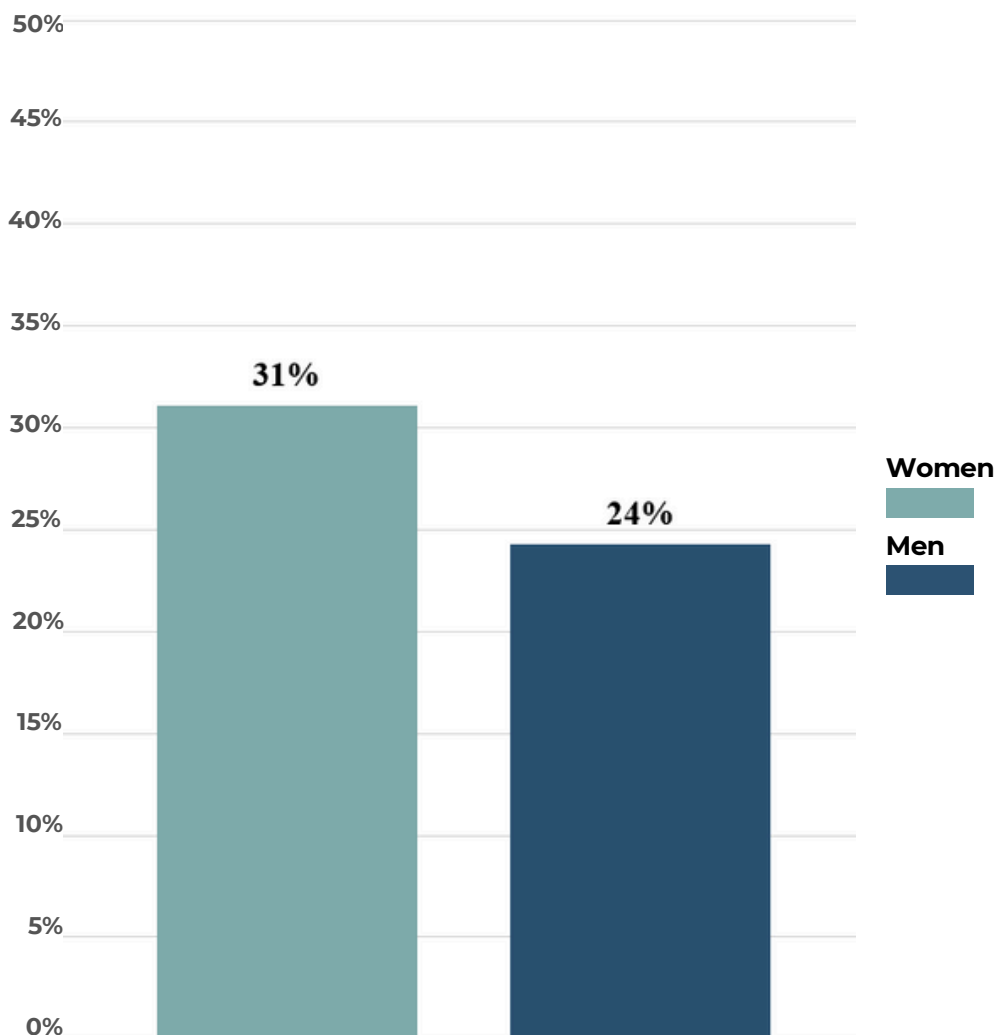
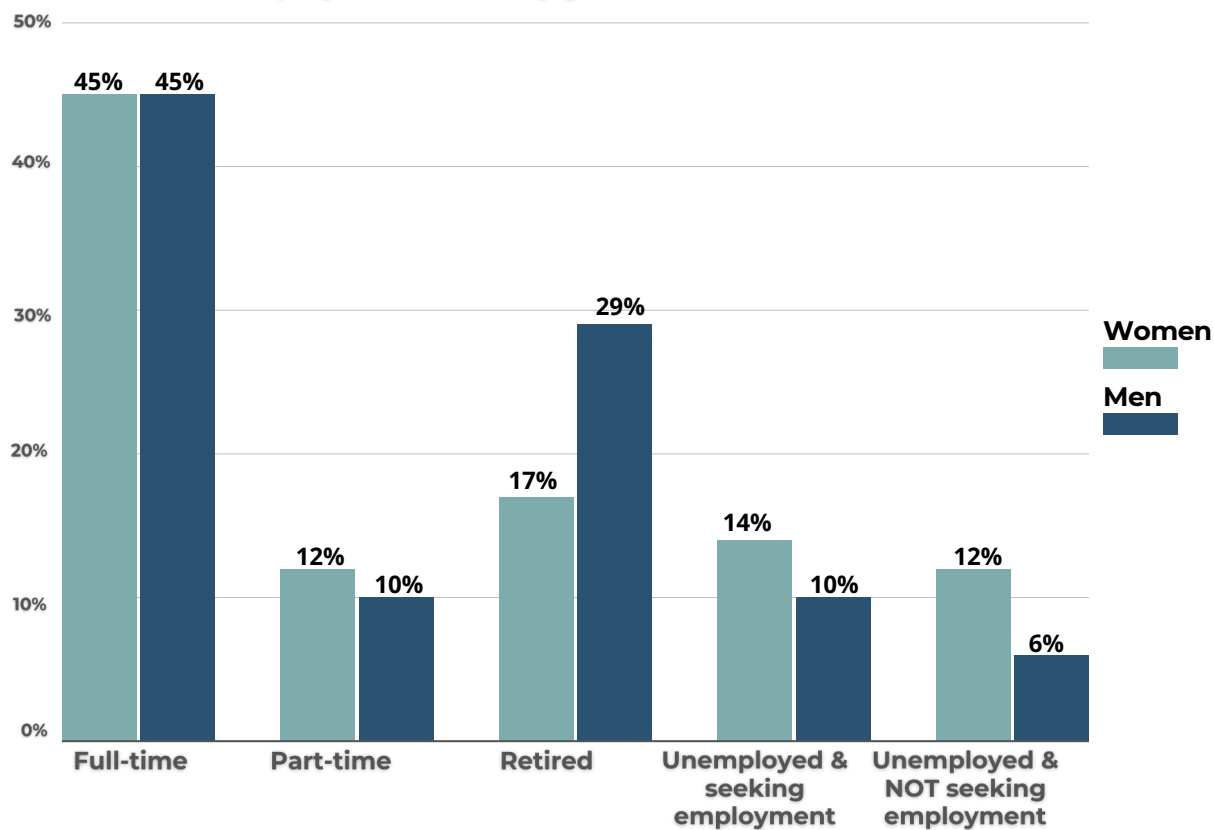
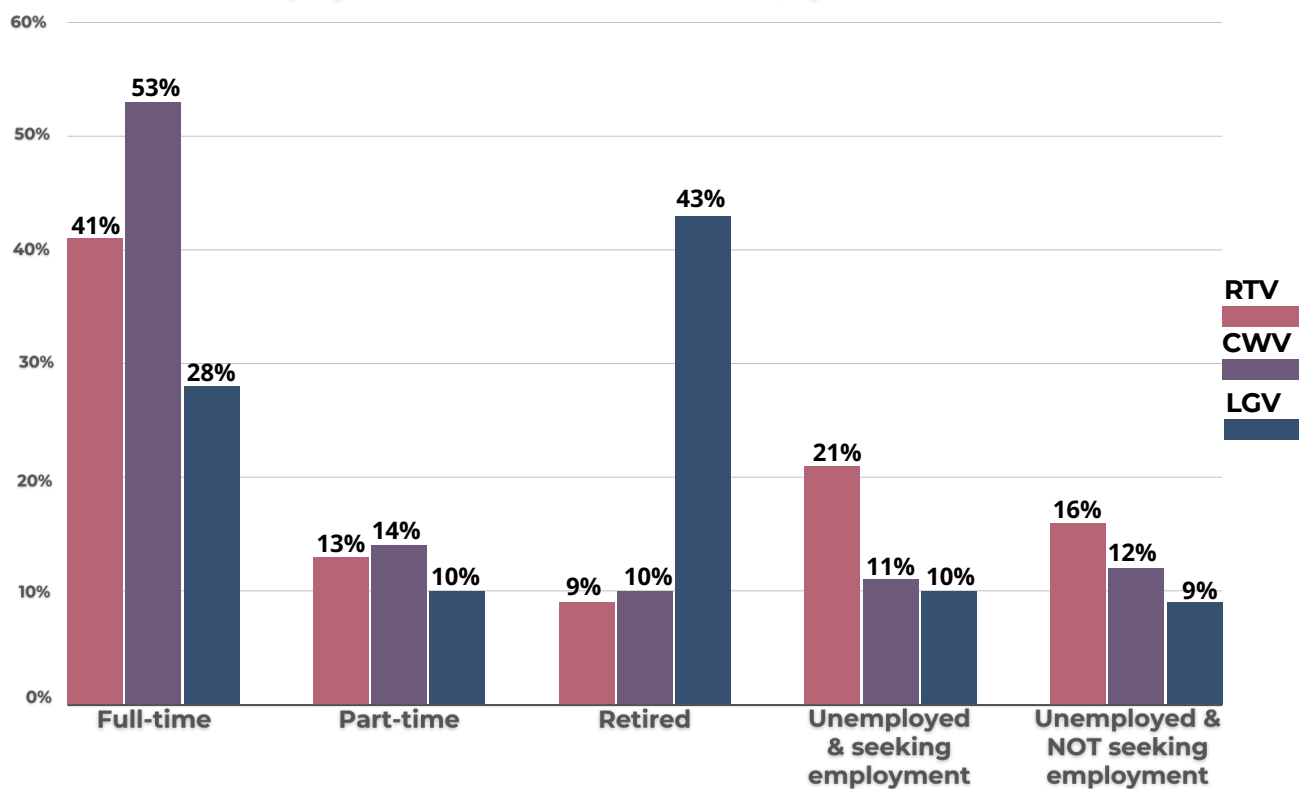


Figure 4**EMPLOYMENT**
Employed veterans who report their current job is similar to their military occupation, by gender

Looking at current employment, women had similar rates of working full-time or part-time than men. However, women were more likely to be unemployed. This included veterans who were unemployed and seeking employment (14% women; 10% men) and those who were unemployed and not seeking employment (12% women; 6% men). Men were much more likely to be retired (17% women; 29% men) (see **Figure 5a**). RTV women (21%) were much more likely to be unemployed and seeking employment than their CWV (11%) and LGV (10%) counterparts (see **Figure 5b**).

Figure 5a**EMPLOYMENT**
Employment status, by gender**Figure 5b****EMPLOYMENT**
Employment status of veteran women, by era

HOUSING

Post-service housing experiences were similar in veteran women and men in the study, and they had similar rates of having a place to live and living arrangements after transition (see **Figure 6**). Veteran women were slightly less likely to report moving in with their parents (31% women; 37% men) and more likely to report moving in with a partner (13% women; 8% men) or not moving (12% women; 8% men) (see **Figure 7**).

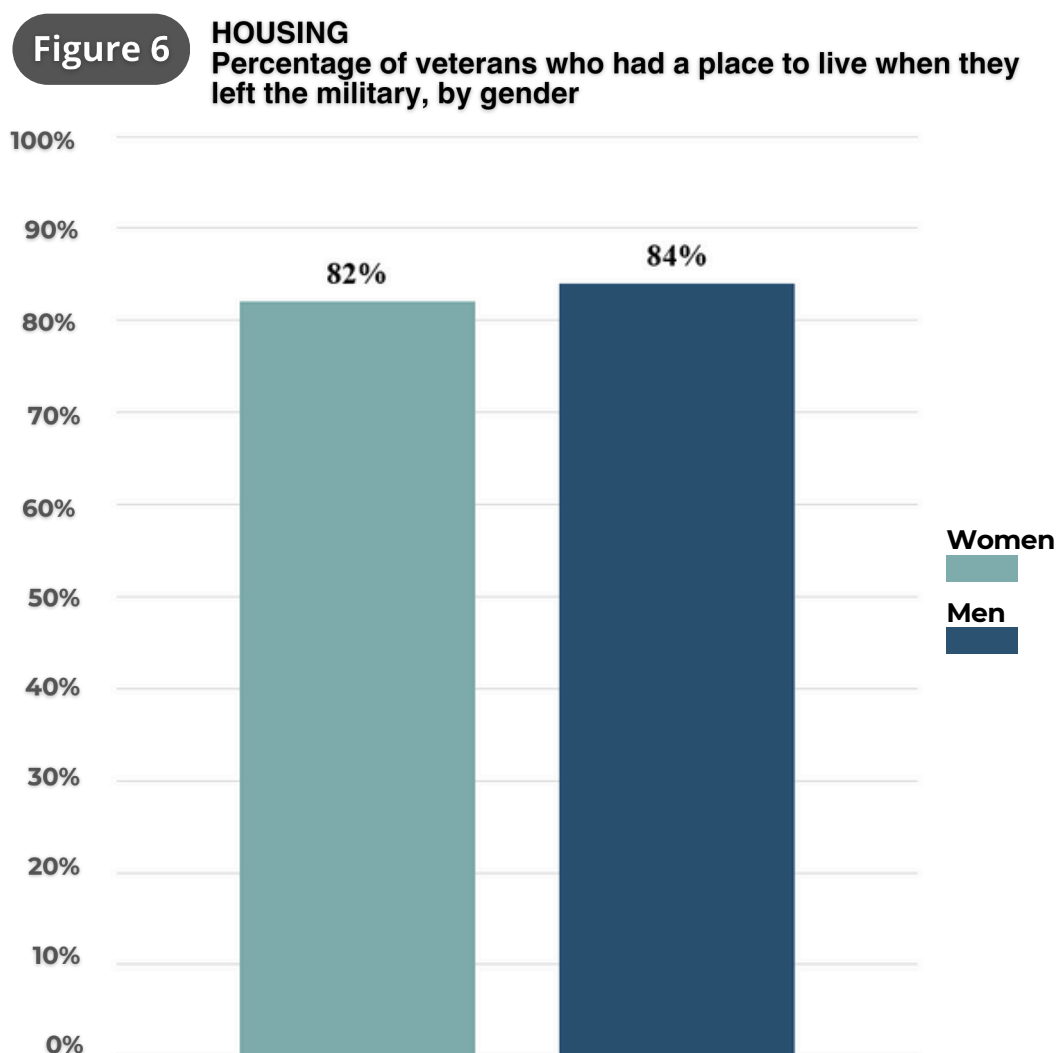
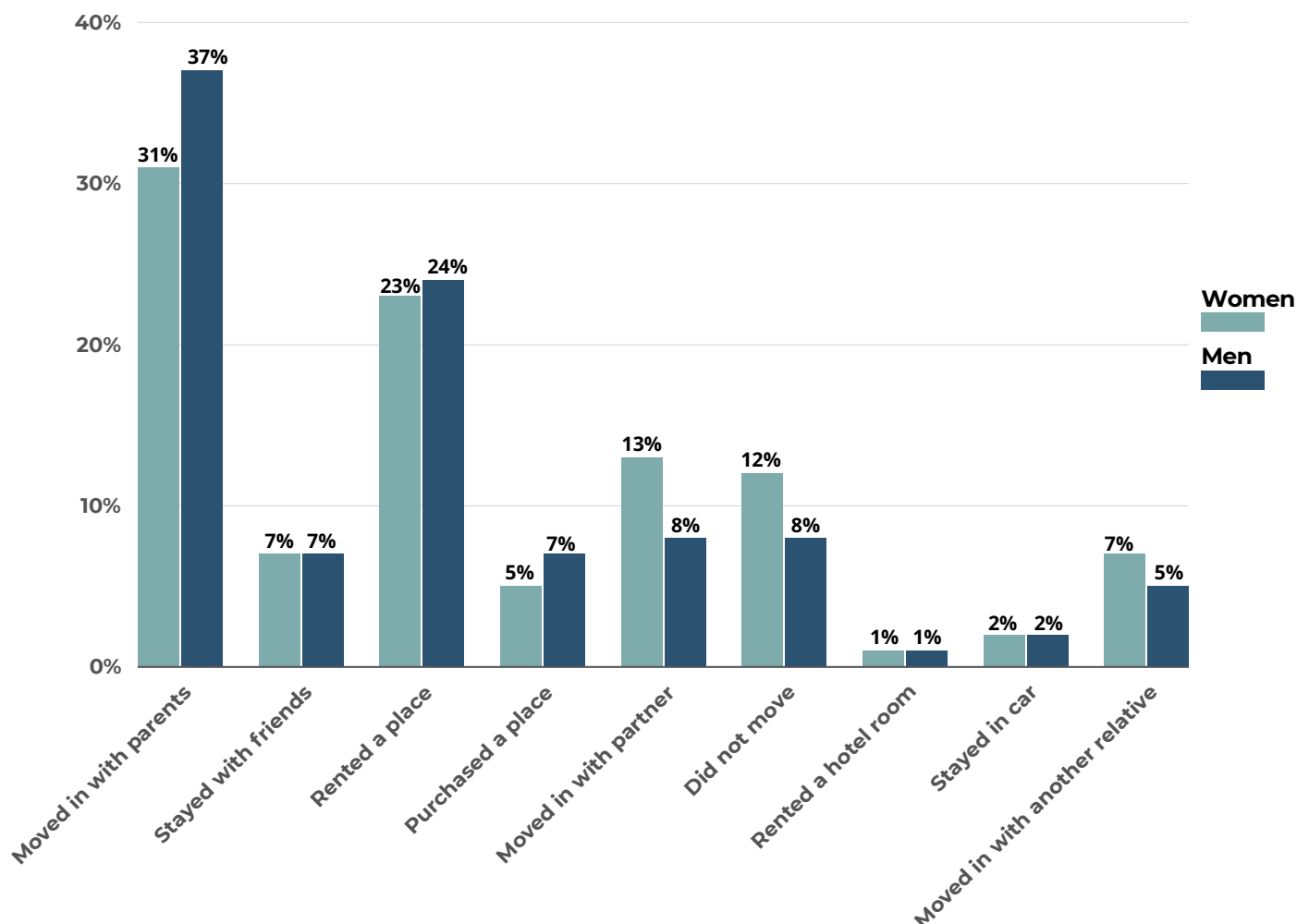


Figure 7

HOUSING

Living arrangement after leaving the military, by gender



Both veteran women and men reported similar rates of housing insecurity. In fact, rates were almost identical in both groups (see [Figure 8a](#)). However, differences were visible in housing insecurity between eras in veteran women. RTV women (13%) were more likely to report not having housing in the past two months than CWV women (8%) and LGV women (6%). RTV women (14%) were also more likely to report being unhoused at least one night in the last 12 months (10% CWV and LGV). Whereas both RTV and CWV women reported the same rate of being worried about having housing in the next two months (13%), LGV women (19%) were more likely than both groups to be worried about their future housing (see [Figure 8b](#)).

Figure 8a

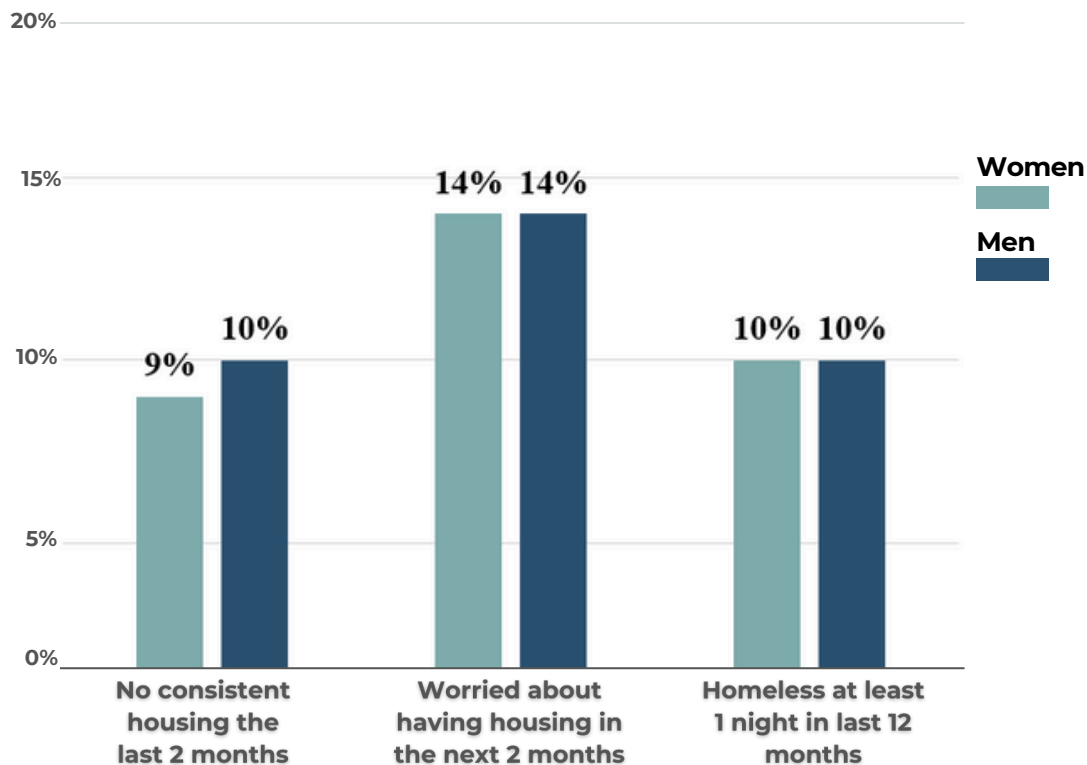
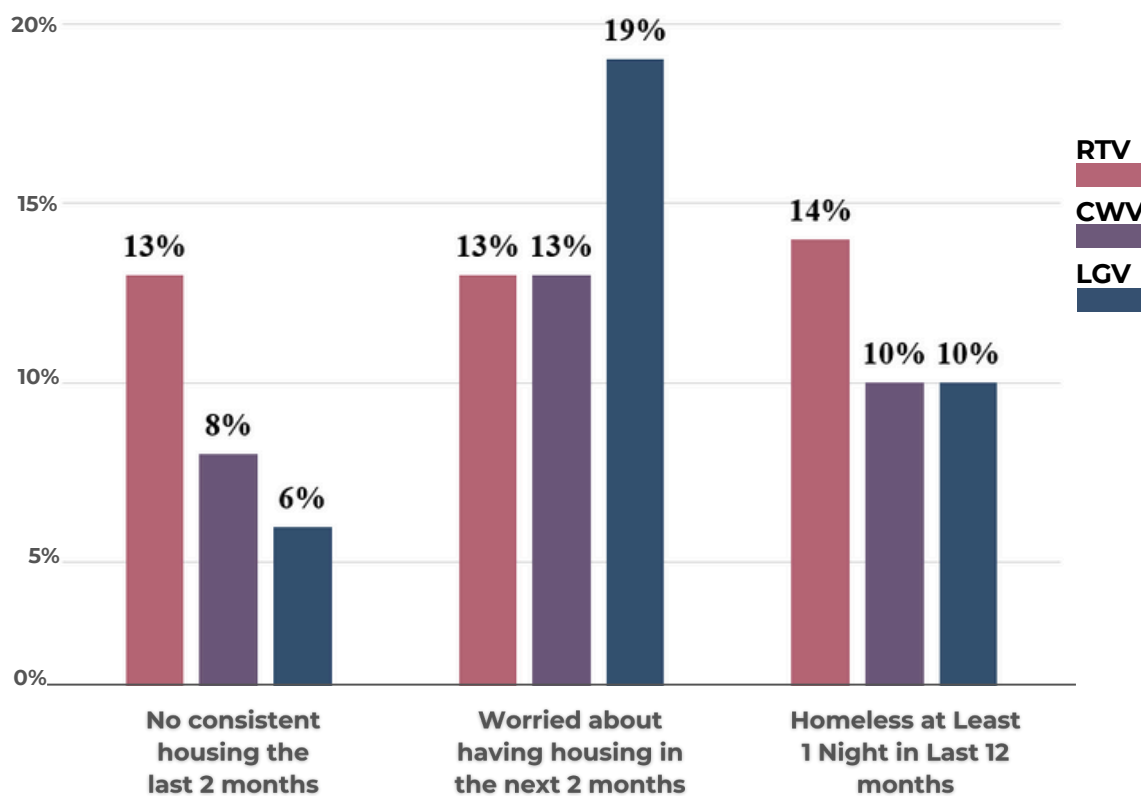
HOUSING
Housing security, by gender

Figure 8b

HOUSING
Housing security in veteran women, by era

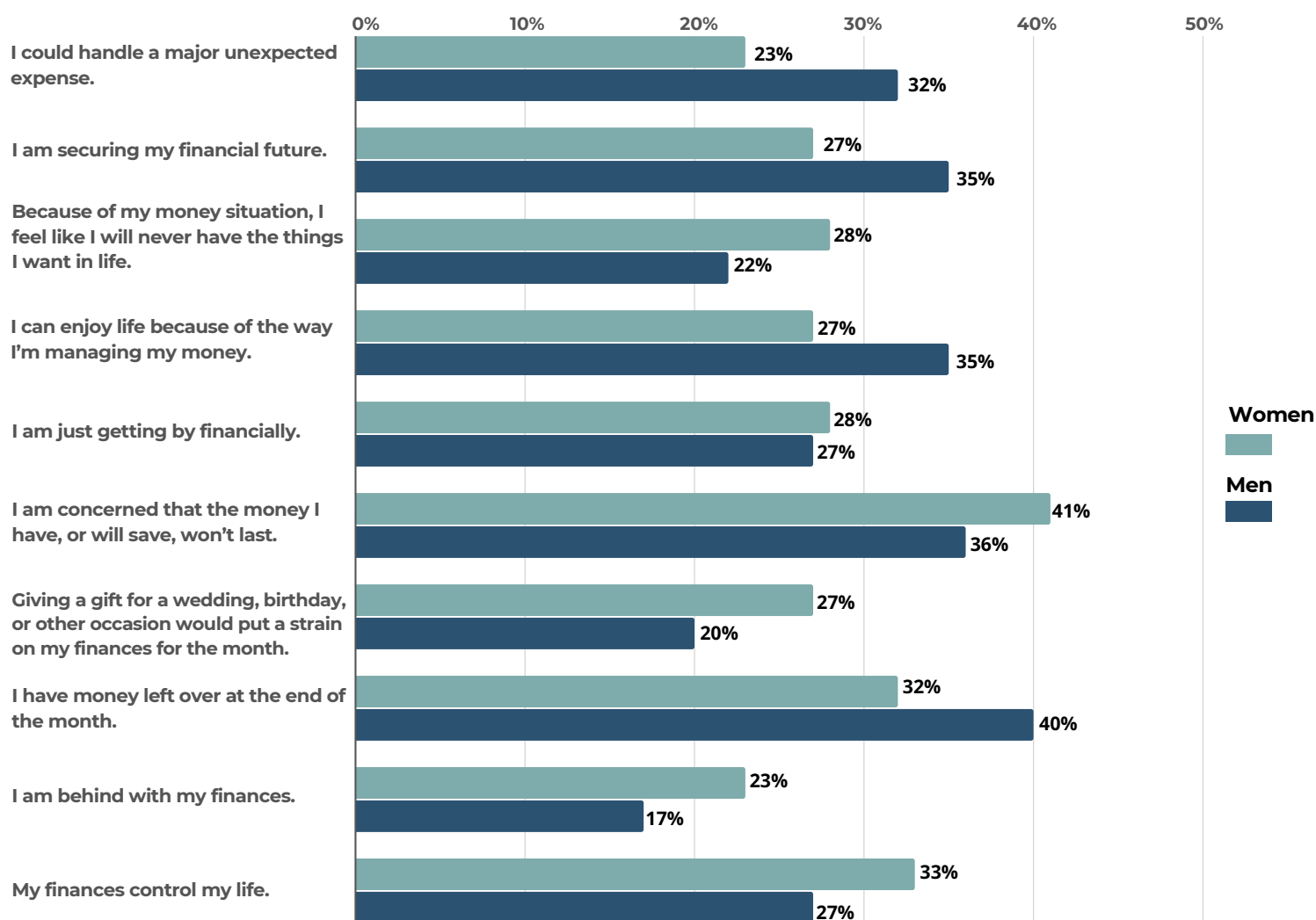
FINANCIAL HEALTH

Veteran women were more likely to report negative views of their financial health than men on almost every financial health item (see **Figure 9**). Veteran women responses to financial health items skewed negatively an average of over six points more than men. For example, women were less likely than men to say they could handle an unexpected expense (23% women; 32% men), less likely to report that they are securing their financial future (27% women; 35% men), and less likely to report having money left over at the end of the month (32% women; 40% men) (see **Figure 9**).

Figure 9

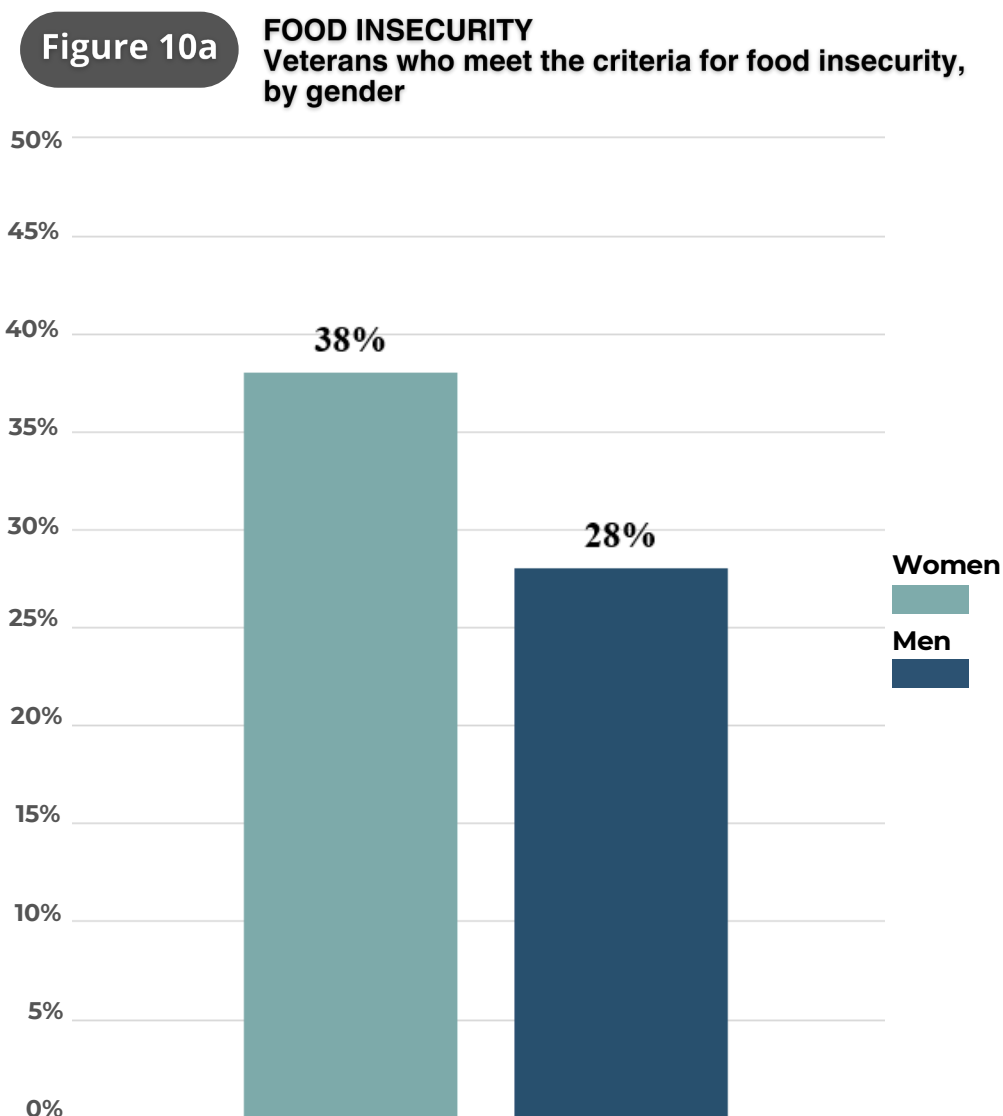
FINANCIAL HEALTH

Veterans who agreed the statement describes them very well or completely, or applies to them often or always, by gender

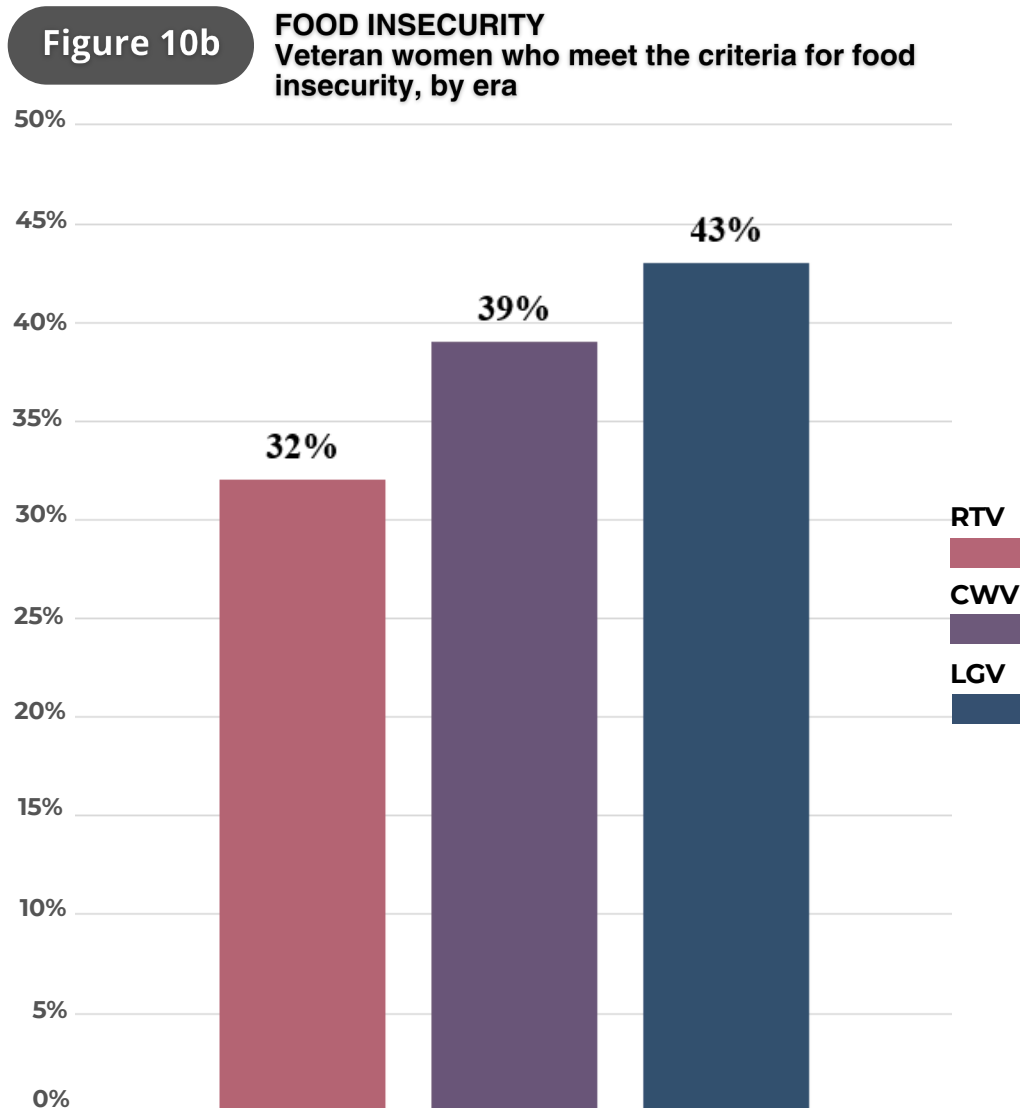


FOOD INSECURITY

A significant number of veteran women met the criteria for food insecurity (38%). Women were significantly more likely than men (28%) to report difficulties with accessing food (See **Figure 10a**).



Differences between eras of veteran women were also observed, with a high number of LGV women (43%) and CWV women (39%) reporting food insecurity. Almost one third of RTV women (32%) also indicated food insecurity (See [Figure 10b](#)).

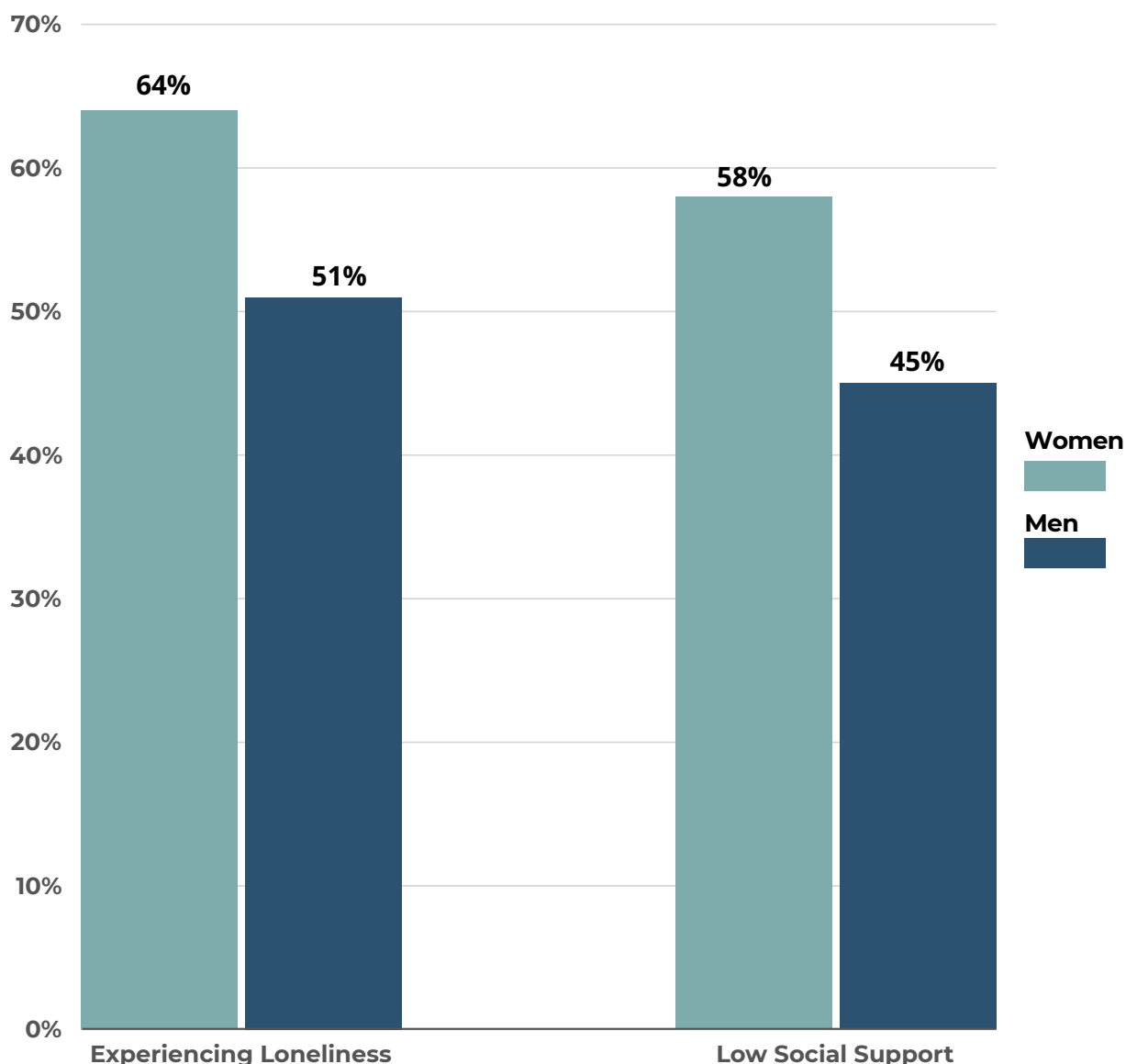


LONELINESS & SOCIAL SUPPORT

A significant number of veterans met the criteria for experiencing loneliness and low social support. This was particularly true of veteran women. Women were more likely than men to report loneliness (64% women; 51% men) as well as to indicate low levels of social support (58% women; 45% men) (see **Figure 11**).

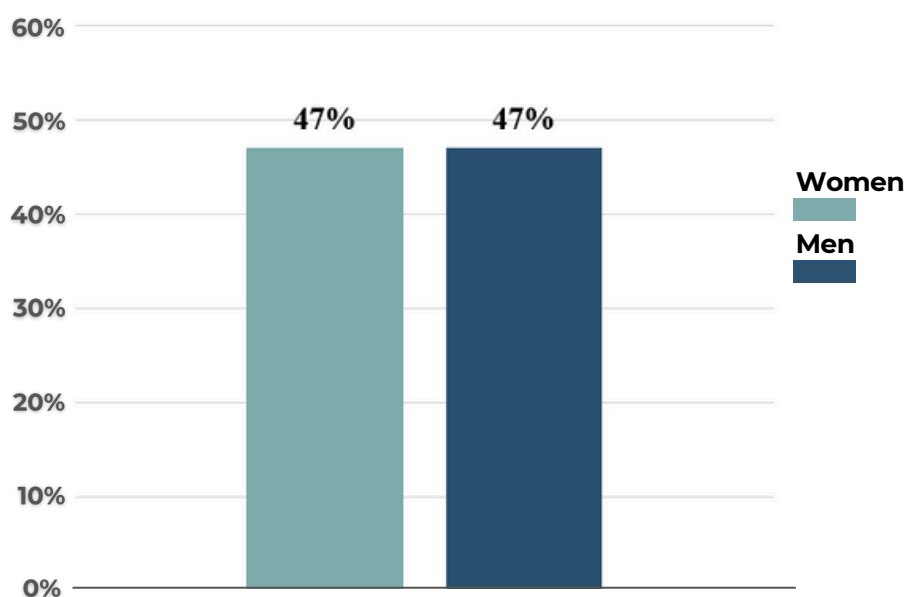
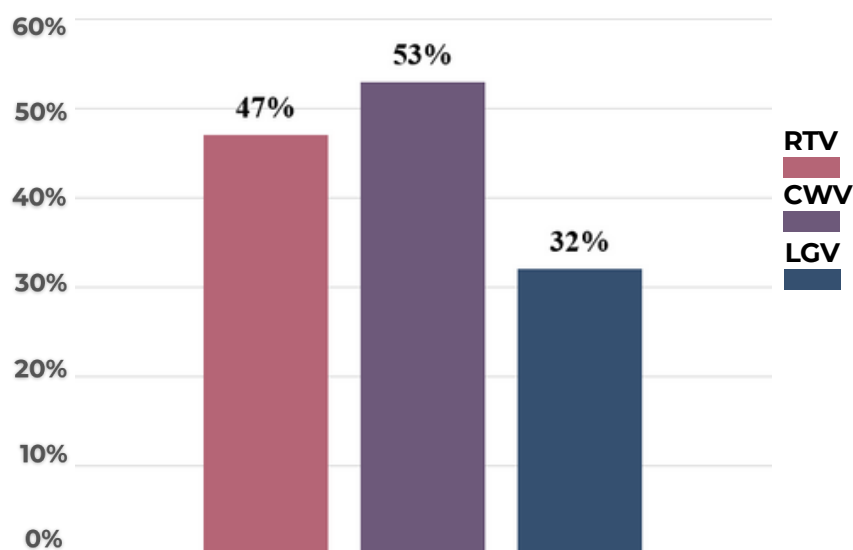
Figure 11

LONELINESS AND SOCIAL SUPPORT
Veterans who meet the criteria for experiencing loneliness and low social support, by gender

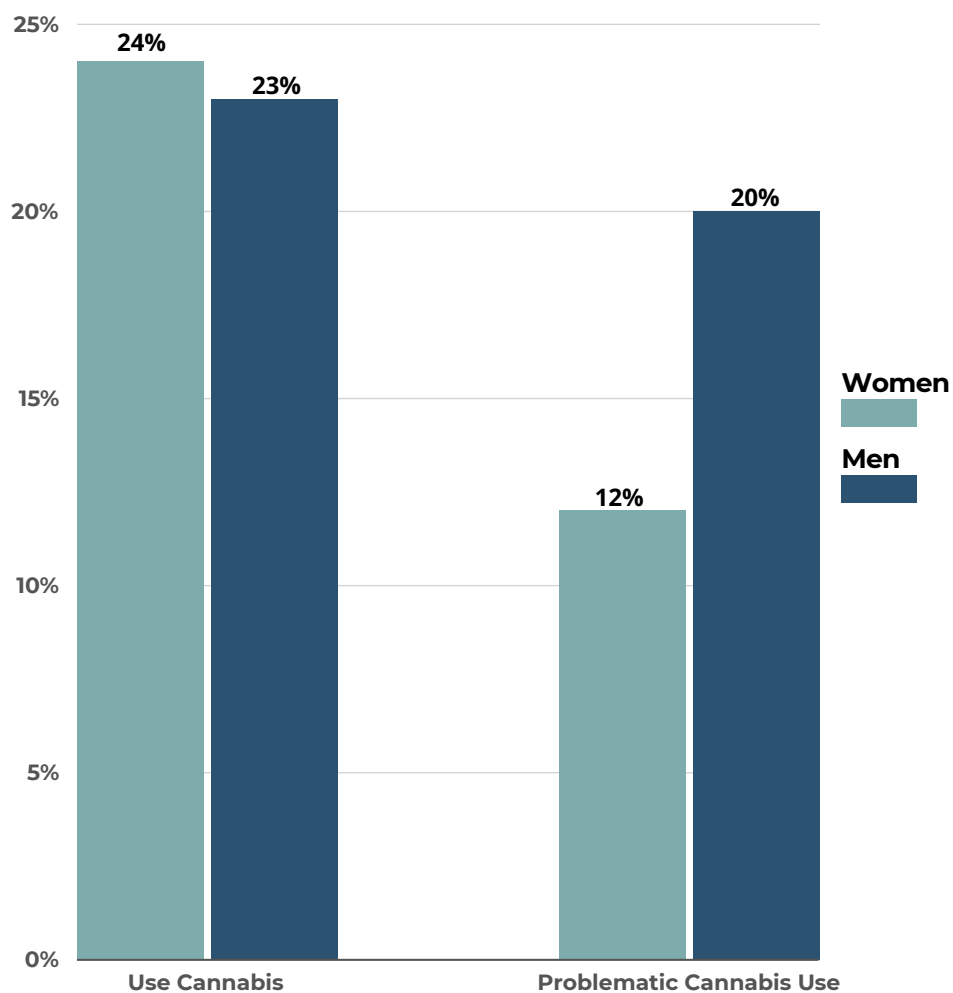


SUBSTANCE USE

No differences were found between veteran women and men when looking at rates of problematic drinking behaviors. Forty-seven percent of both groups meet the criteria for potential hazardous drinking (see **Figure 12a**). However, LGV women (32%) were less likely to report problematic alcohol use than CWV women (53%) and RTV women (47%) (see **Figure 12b**).

Figure 12a**SUBSTANCE USE: ALCOHOL**
Problematic alcohol use, by gender**Figure 12b****SUBSTANCE USE: ALCOHOL**
Problematic alcohol use in veteran women, by era

Women and men used cannabis at the same rate, but women were less likely to meet the criteria for problematic cannabis use (23% women; 32% men) (see **Figure 13**).

Figure 13**SUBSTANCE USE: CANNABIS**
Cannabis use and percentage of users who meet criteria for problematic cannabis use, by gender

PHYSICAL HEALTH

A significant number of women met the diagnostic criteria for moderate to severe physical health symptoms (63%). Women were much more likely than men (44%) to report physical health symptoms (see **Figure 14**). Women were more likely to report feeling tired or having low energy, trouble sleeping, and musculoskeletal pain (see **Table 5**). The most frequently reported symptoms for veteran women regardless of era were feeling tired; back pain; trouble sleeping; pain in arms, legs, or joints; and headaches (see **Table 6**).

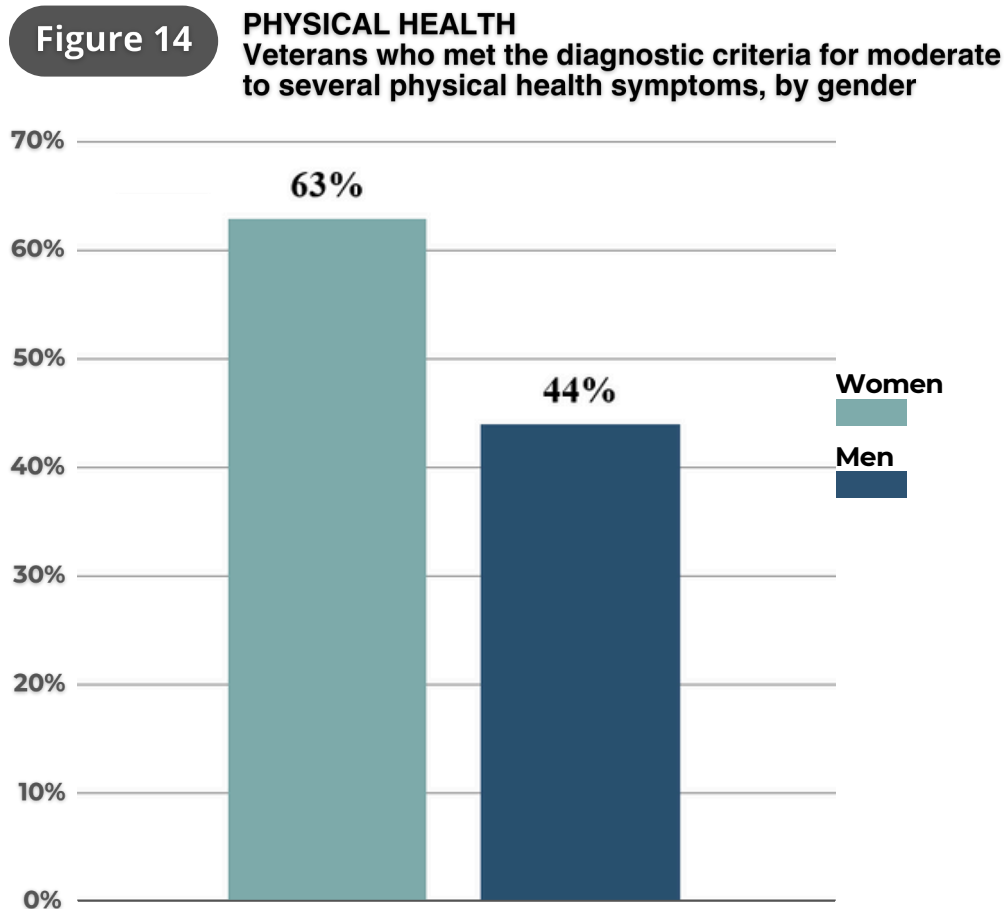


Table 5 Physical Health Symptoms

PHYSICAL HEALTH SYMPTOMS	% WOMEN BOTHERED A LOT	% WOMEN BOTHERED A LITTLE	% MEN BOTHERED A LOT	% MEN BOTHERED A LITTLE
Feeling tired or having low energy	51%	34%	33%	41%
Trouble sleeping	50%	35%	35%	35%
Pain in arms, legs, or joints (knees, hips, etc.)	49%	37%	42%	38%
Back pain	47%	31%	38%	38%
Headaches	33%	40%	16%	37%
Constipation, loose bowels, or diarrhea	25%	35%	15%	30%
Menstrual cramps or other period problems (women only)	24%	24%	---	---
Nausea, gas, or indigestion	22%	40%	14%	35%
Heart racing or pounding	16%	32%	9%	28%
Pain or problems during sexual intercourse	13%	14%	11%	16%
Stomach pain	14%	45%	9%	33%
Shortness of breath	10%	28%	9%	31%
Dizziness	11%	33%	7%	30%
Chest pain	5%	22%	4%	24%
Fainting spells	2%	9%	1%	8%

Table 6 Top physical health symptoms of veteran women, by era

ERA	PHYSICAL HEALTH SYMPTOMS	% BOTHERED A LOT
RTV	Feeling tired or having low energy	58%
	Back pain	53%
	Pain in arms, legs, or joints (knees, hips, etc.)	52%
	Trouble sleeping	51%
	Headaches	40%
CWV	Feeling tired or having low energy	52%
	Trouble sleeping	49%
	Pain in arms, legs, or joints (knees, hips, etc.)	48%
	Back pain	42%
	Headaches	35%
RTV	Trouble sleeping	51%
	Back pain	50%
	Pain in arms, legs, or joints (knees, hips, etc.)	48%
	Feeling tired or having low energy	44%
	Headaches	23%

MENTAL HEALTH

Almost half of veteran women in the study met the diagnostic criteria for post-traumatic stress disorder (PTSD) (46%) and depression (49%), and one third were at risk for suicide (32%). Veteran women reported significantly higher rates of PTSD, depression, and suicide risk than men (PTSD 46% vs. 37%; depression 49% vs. 36%; suicide risk 32% vs. 25%) (see **Figure 16a**). RTV women were most likely to report mental health concerns, closely followed by CWV women and LGV women (see **Figure 16b**).

Figure 16a

MENTAL HEALTH

Percentage of veterans who screened positive for probable PTSD, probable depression, and risk for suicide, by gender

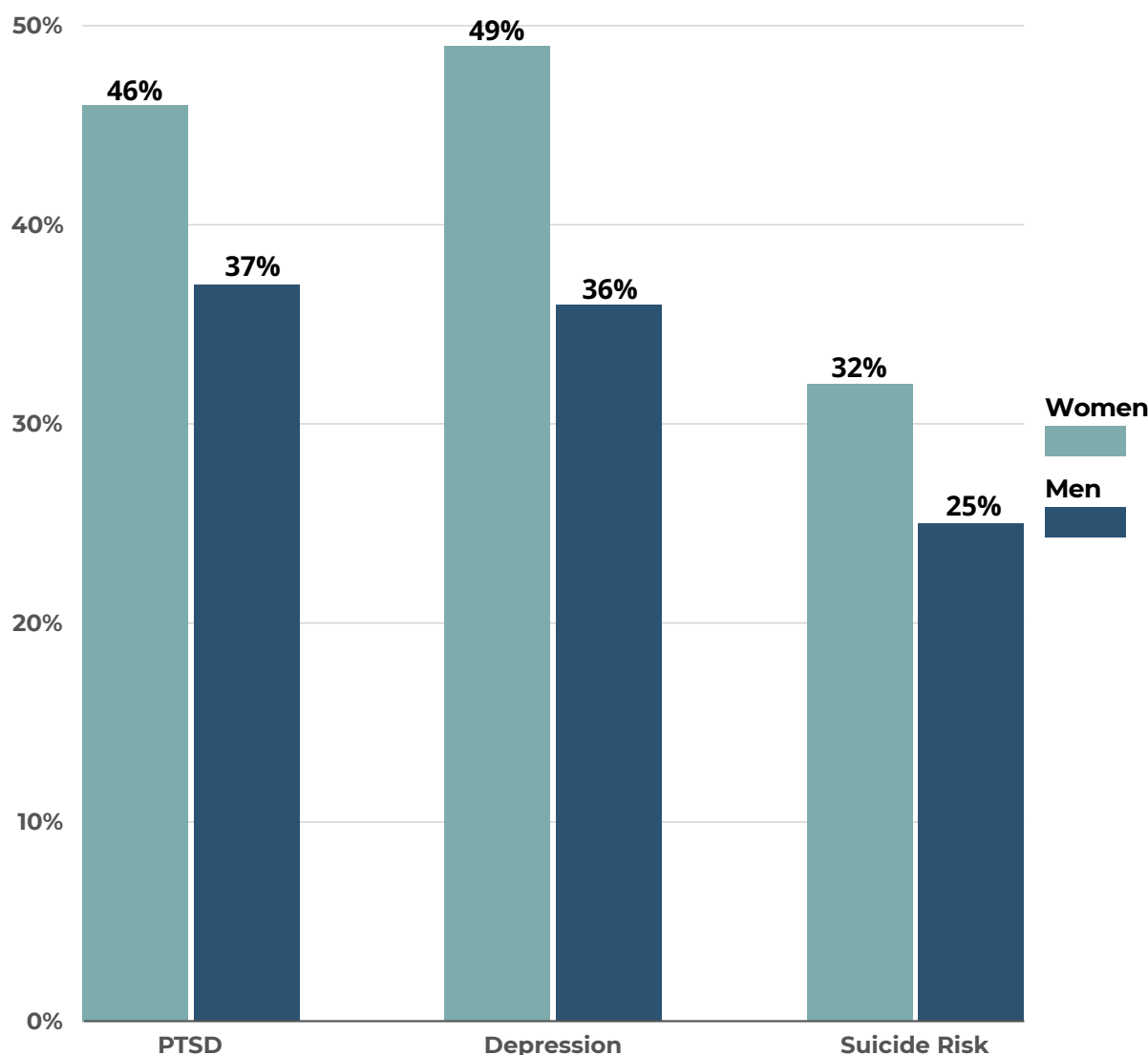
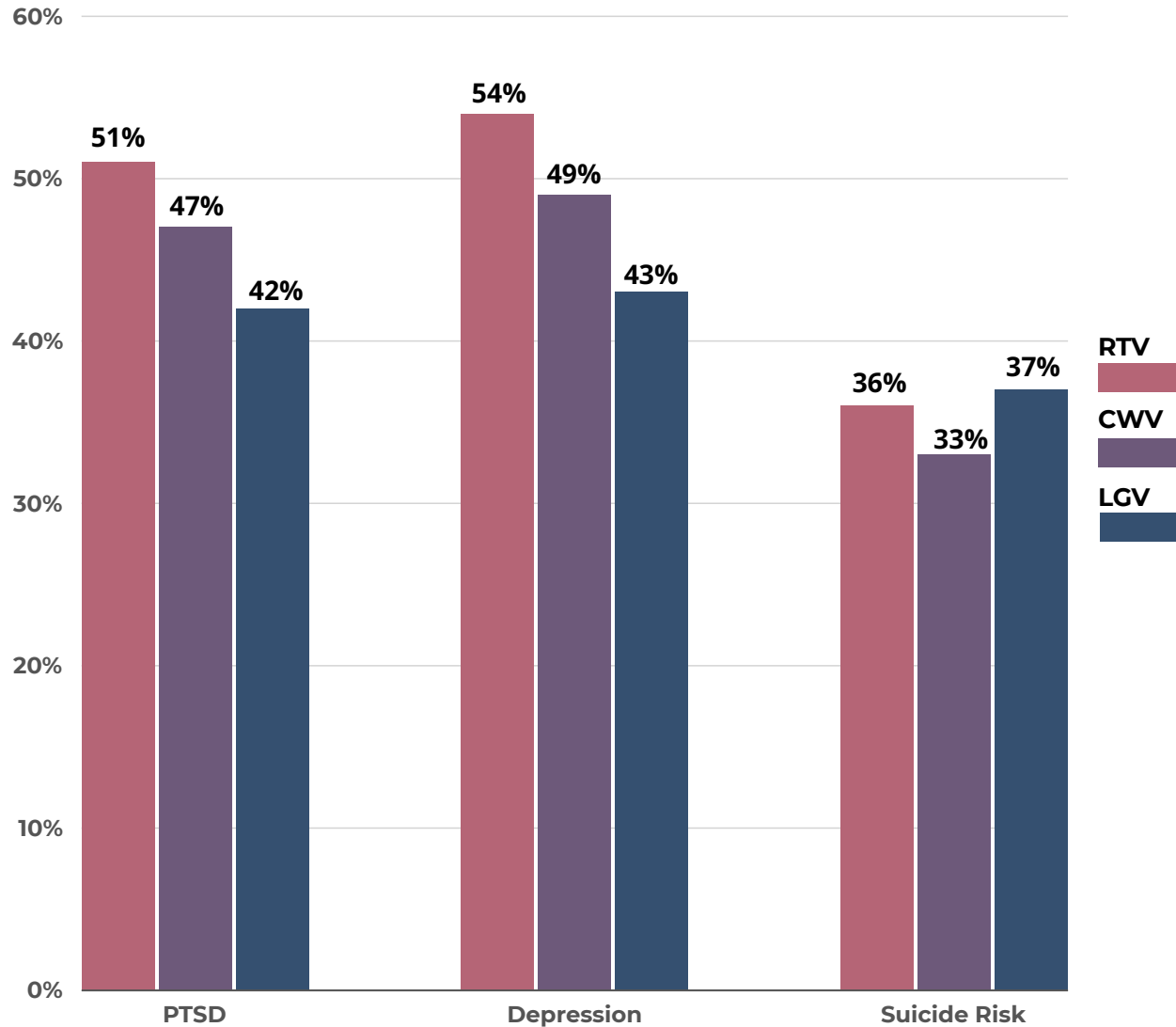


Figure 16b

MENTAL HEALTH

Percentage of veteran women who screened positive for probable PTSD, probable depression, and risk for suicide, by era

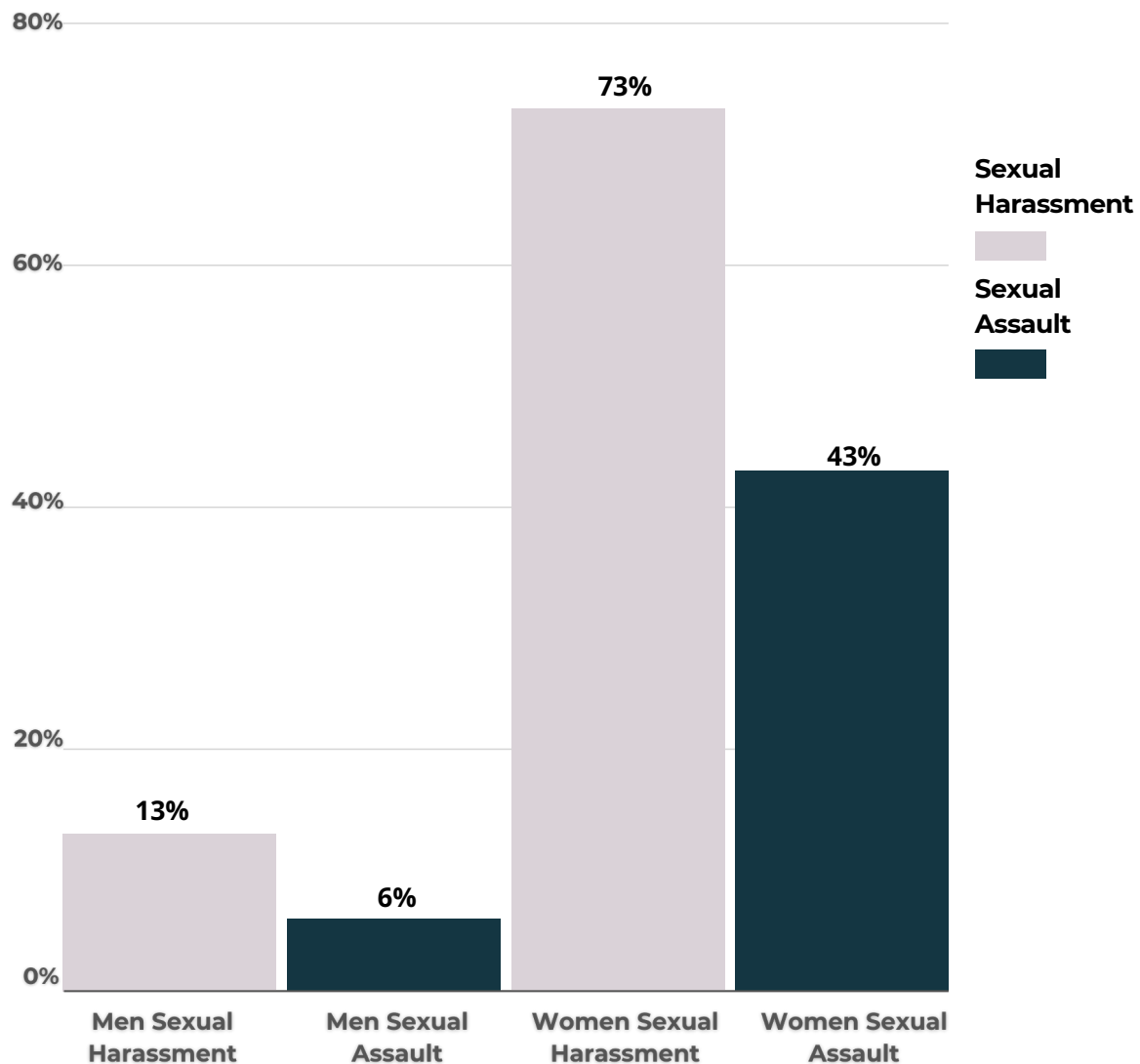


SEXUAL HARASSMENT AND SEXUAL ASSAULT

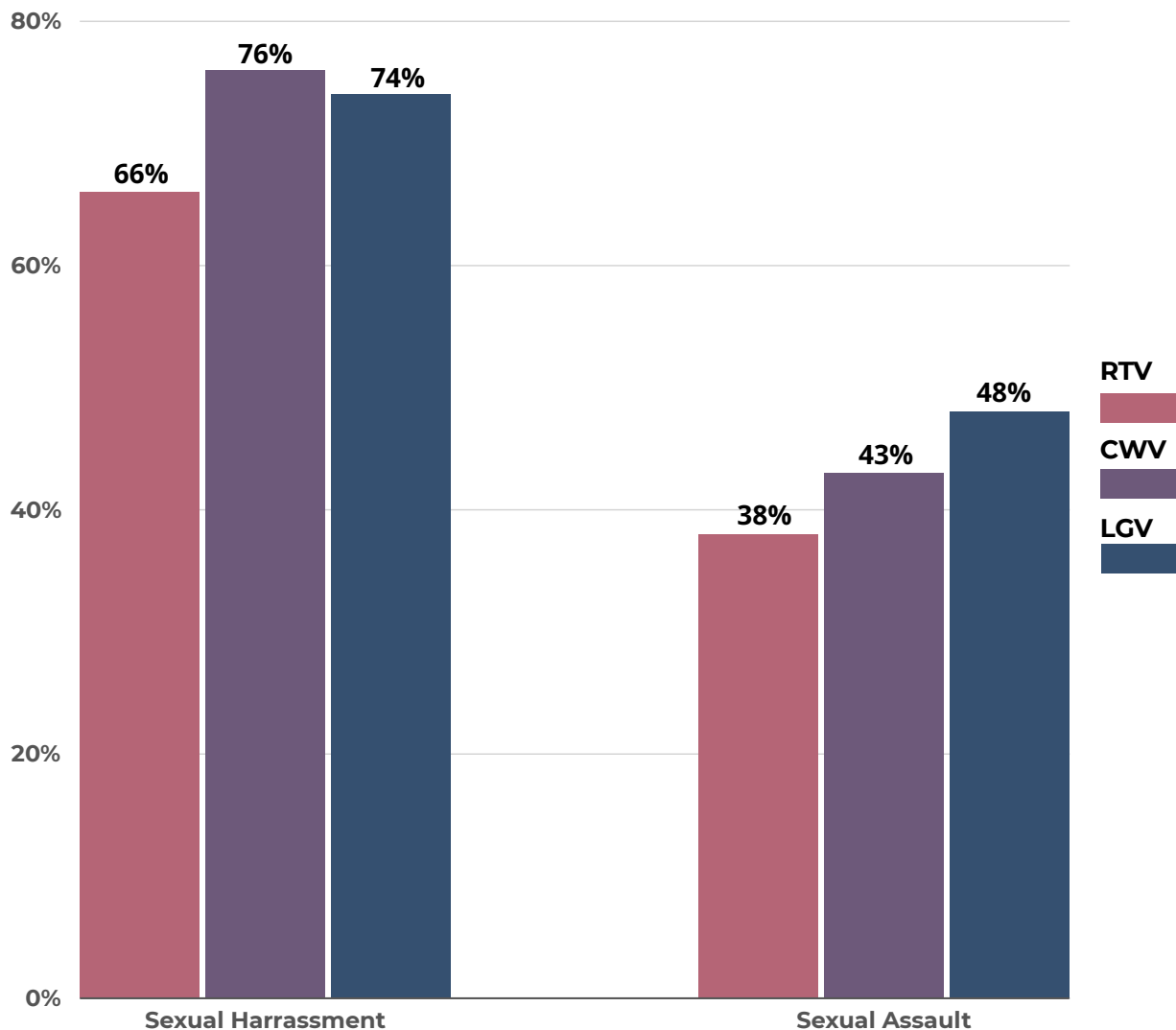
Almost three quarters of women (73%) reported sexual harassment during military service. Forty-three percent of women reported experiencing sexual assault (see **Figure 17a**). As expected, this was significantly higher than reports from men (13% and 6%, respectively).

Figure 17a

SEXUAL HARASSMENT AND ASSAULT
Percentage of veteran men and women who experienced sexual harassment or sexual assault during military service



When examining sexual harassment by era, CWV women (76%) were most likely to report experiencing sexual harassment, followed by LGV women (74%) and RTV women (66%). Sexual assault findings show a small decline by era, with 48% of LGV women reporting, followed by 43% of CWV women and 38% of RTV women (see **Figure 17b**).

Figure 17b**SEXUAL HARASSMENT AND ASSAULT**
Percentage of veteran women who reported sexual harassment or sexual assault during military service, by era

SERVICE USE AND SATISFACTION, AND NEEDS AND BARRIERS TO CARE

Health Care Utilization. Almost two thirds of veteran women (64%) reported the VA as their primary source of health care. This was followed by 14% who reported using a provider through employment insurance, 9% a provider through Tricare, and 6% a provider through state or federal health care. Women were more likely than men to use the VA for their primary health care (64% women; 56% men) and less likely than men to use a provider through state or federal health care (6% women; 12% men) (see **Figure 18**). Veteran women and men were equally satisfied with their primary health care providers (see **Figure 19**).

Figure 18

HEALTH CARE Primary source of health care, by gender

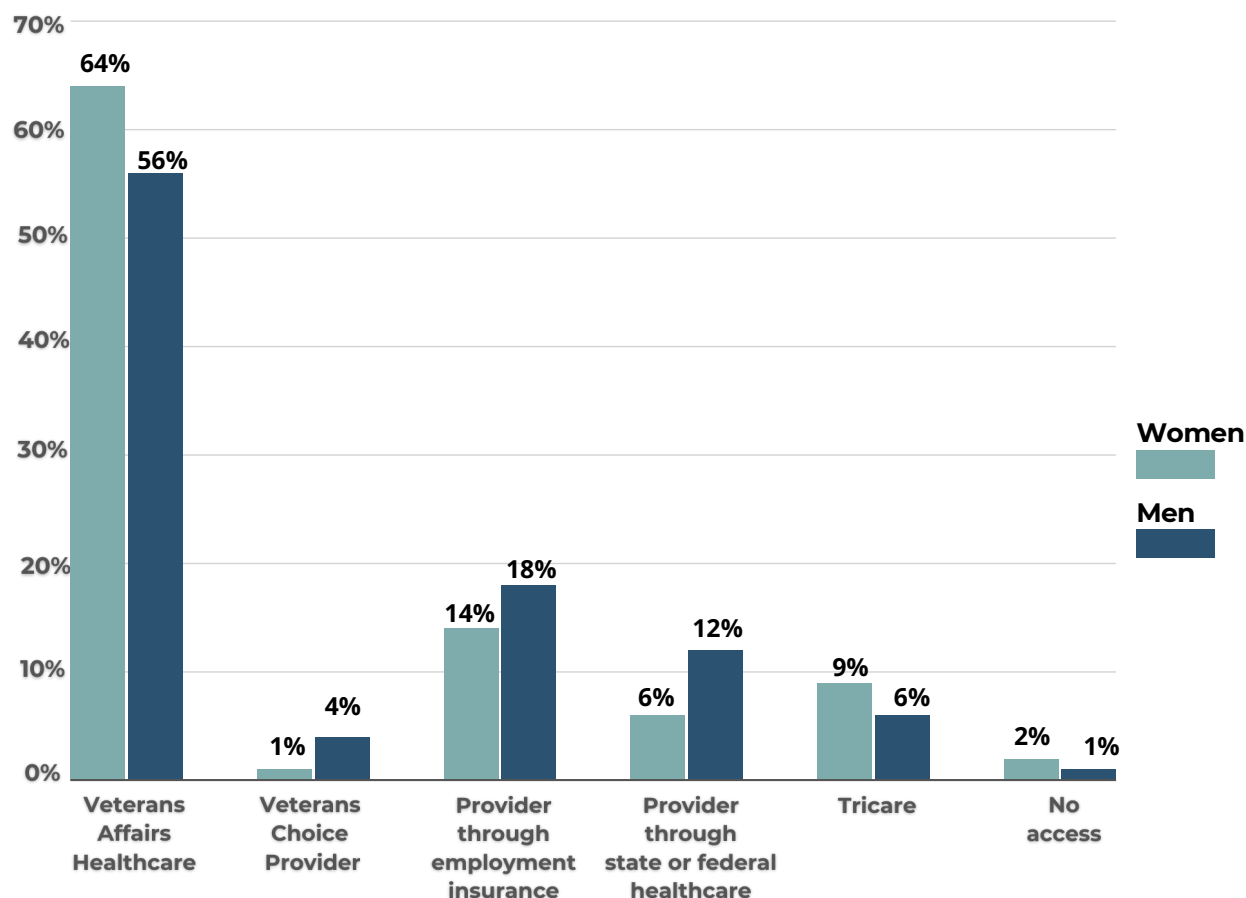
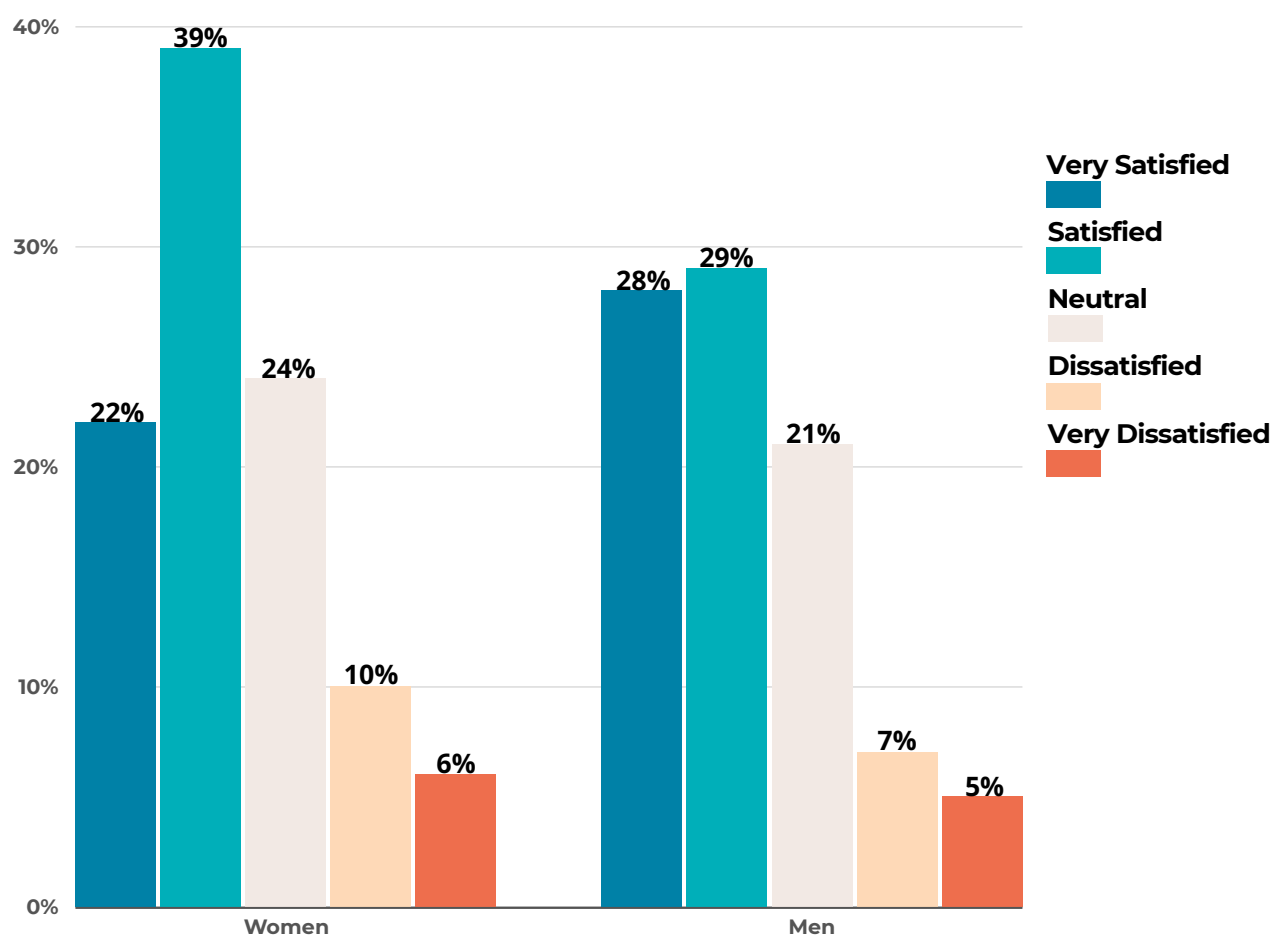


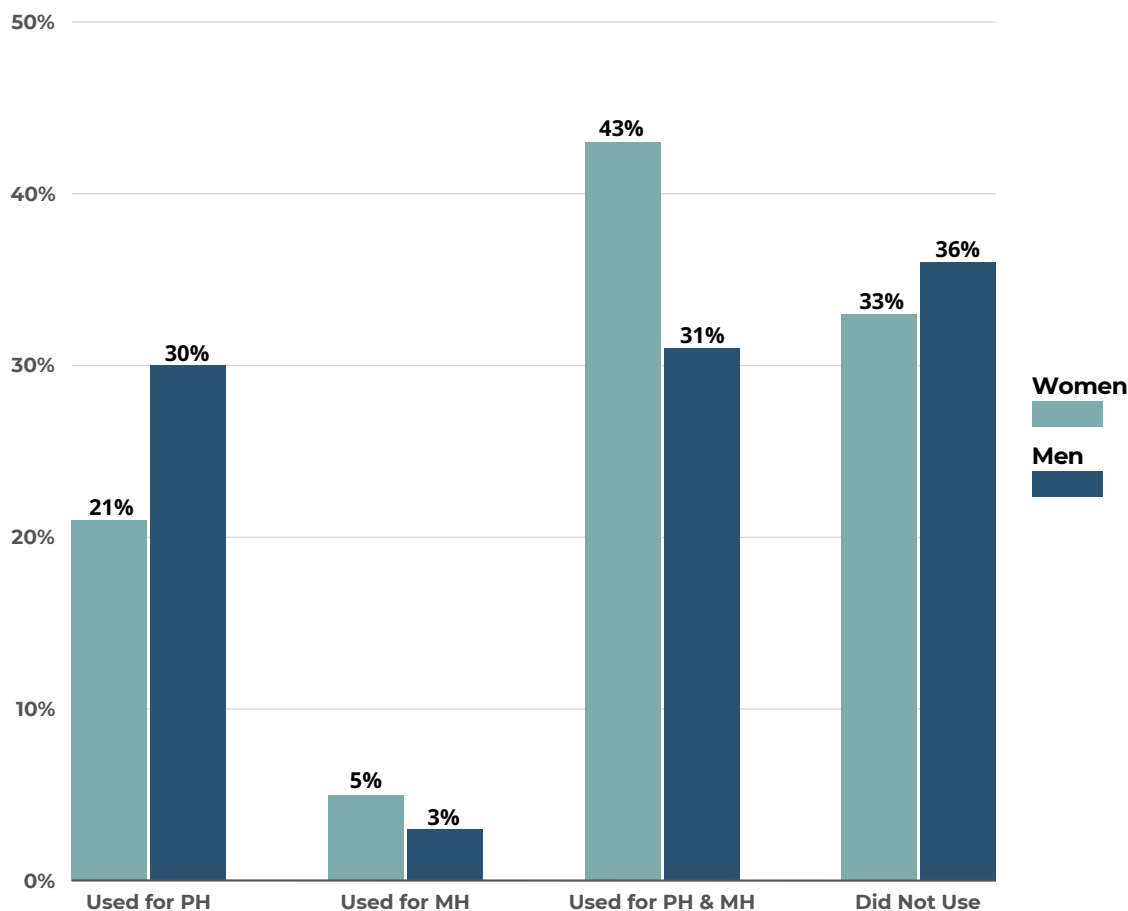
Figure 19

HEALTH CARE
Satisfaction with primary source of health care, by gender

VA Use. Two thirds of veteran women (66%) reported using the VA within the past year, regardless of their primary care provider. Forty-three percent of these women sought care at the VA for both physical and mental health, while 21% used it only for physical health care and 5% only for mental health care (see **Figure 20**). Veteran women were much more likely to use the VA for both physical and mental health care than men (43% women; 31% men).

Figure 20**VA USE**

Percentage of veterans who used Veterans Affairs for physical health (PH) and mental health (MH) care in the past year, by gender

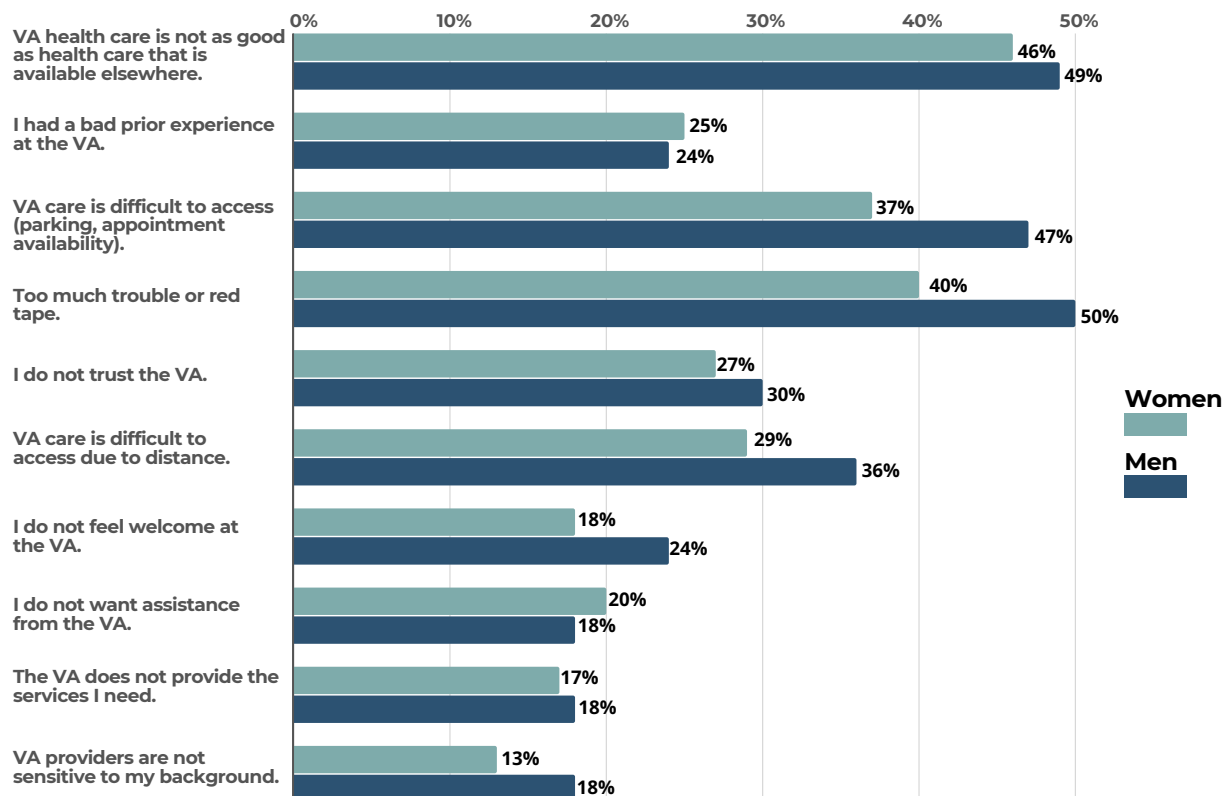


The most common reasons reported by veteran women for not using the VA were “too much trouble or red tape” (50%), “VA health care is not as good as health care that is available elsewhere” (49%), and “VA care is difficult to access” (47%). In general, men and women reported similar rates of reasons for not using VA care. However, women were more likely to endorse logistical barriers such as “too much trouble or red tape” (50% women; 40% men), “VA care is difficult to access” (47% women; 37% men), and “difficult due to distance” (36% women; 29% men). Women were also more likely to report that they do not feel welcome at the VA (24% women; 18% men) and that the VA is not sensitive to their background (18% women; 13% men) (see **Figure 21**).

Figure 21

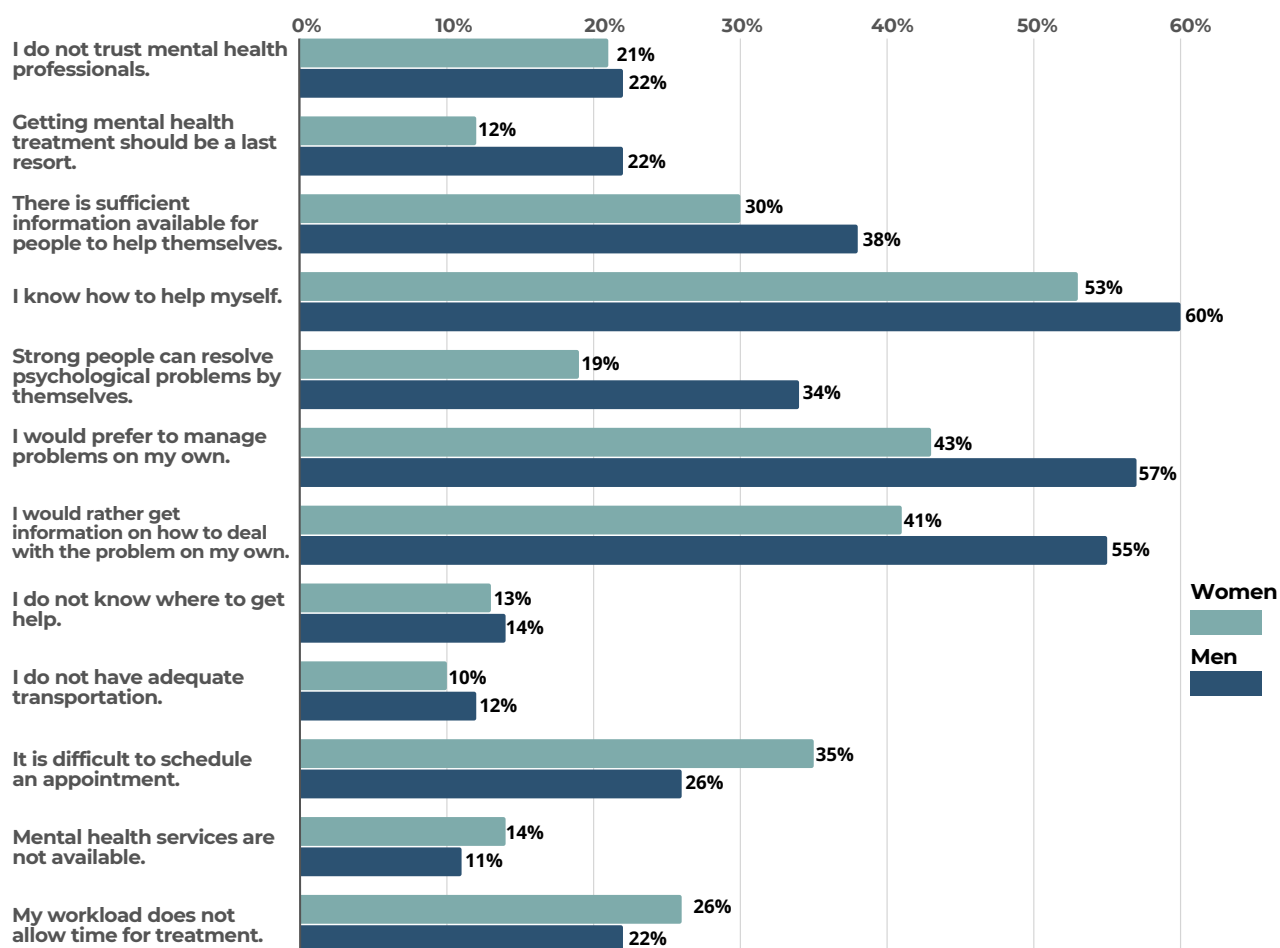
VA USE

Reasons for non-VA use in veterans who have not used the VA in the past year, by gender



Barriers to Mental Health Care. The top reasons for not seeking mental health care were the same for women and men, although women were less likely to endorse each: “I know how to help myself” (53% women; 60% men), “I prefer to manage my problems on my own” (43% women; 57% men), and “I would rather get information on how to deal with the problem on my own” (41% women; 55% men) (see **Figure 22**). Women were much more likely to report difficulty scheduling appointments (35% women; 26% men) and slightly more likely to say their workload doesn’t allow time (26% women; 22% men).

Figure 22 Barriers reported by veterans that prevent them from seeking mental health care, by gender



KEY FINDINGS AND RECOMMENDATIONS



KEY FINDING 1

Veteran women experience significant challenges in transitioning from the military to civilian communities, as indicated by the fact that they endorse that they have experienced transitioning difficulties at equal to or higher rates than veteran men.

RECOMMENDATION 1

In addition to making continued improvements to the military's transition programs, add and expand on transition topics unique to women's experience. In-depth guidance must be included on steps of transition related to employment, the long-term viability of housing situations, transition expectations, managing military identity and civilians' perceptions of women veterans, and the emotional impact of transition.

DISCUSSION 1

Transitioning from the structured military environment to a relatively unstructured civilian environment is a difficult process for many veterans, and women may also experience their own unique challenges. Behaviors learned during military service do not always align with accepted behaviors among civilians. This friction between behaviors that are normal within the military yet at odds with accepted civilian behaviors can make it difficult for veterans to adapt to their new civilian environments. Civilian perceptions and stereotypes of veteran women may also impact their transition experience. Women often leave the military without a trusted peer network, which can make the transition feel especially isolating. An emphasis on the emotional toll that leaving the military often creates would greatly prepare service members for potential feelings of loss of identity, loss of community, anger at having to start over, and rejection from those who did not serve. Addressing and normalizing these feelings and thoughts early on and before the transition occurs would provide service members an opportunity to prepare coping measures and ease the negative impact these feelings may have. While it is up to service members to determine if employment immediately upon separation is right for them, having a job has been found to be one of the best means of ensuring a successful transition and positive well-being after service. More research is needed to better understand the unique stressors women experience during military transition and how prevention and intervention programs can better support veteran women.

KEY FINDING 2

Food insecurity is a major concern for veteran women.

RECOMMENDATION 2

Increase screening for food insecurity within the VA and VSOs and improve accessibility of connected resources. Assess whether transitioning veterans qualify for state and federal food benefit programs. Consider the unique barriers veteran women may face when accessing food support and implement strategies for overcoming such obstacles.

DISCUSSION 2

Living in a high-cost-of-living area such as Southern California likely contributes to higher levels of food insecurity among veterans and non-veterans alike. Although veteran men and women both reported high levels of food insecurity, women were more likely to indicate difficulty with access to food. This is of course connected to financial strain, which women were also more likely to report. Although the current data was collected during a time of high food inflation, the findings align with similar rates of food insecurity found by the VA and RAND, demonstrating the urgency of addressing this issue. Including and increasing screening questions related to food insecurity would assist in identifying and connecting those in need with the necessary resources. Further, as women report more logistical barriers to accessing services, food security programs might consider how they can improve access for veteran women.

KEY FINDING 3

Veteran women reported significantly higher rates of loneliness and lower levels of social support than veteran men.

RECOMMENDATION 3

Increase screening measures for loneliness in veteran women within the VA and VSOs. Provide more targeted opportunities for veteran women to build and/or expand their social networks. Encourage veteran women and non-veteran groups to foster an

inclusive environment that is sensitive to the needs and experiences of veteran women.

DISCUSSION 3

Leaving the military may cause an abrupt change in social environments, social networks, and social behavior that can cause veterans to struggle with creating and maintaining social connections. This abrupt loss of social connections and difficulty creating new connections often contributes to feelings of loneliness, which have been linked to negative physical and mental health outcomes. Although gender differences in loneliness are similar to the general population (most research finds women to be equally lonely or lonelier than men), veteran women reported less social support than veteran men, which is a contrast to their civilian counterparts. Some veteran women report challenges in finding a peer group in which they feel supported and encouraged. They may also be more likely to separate their military and civilian social networks and less likely to share about their military experiences. More research is needed to understand what military-related factors may be contributing to loneliness and lack of social support in veteran women. Although peers, VSOs, and families provide opportunities for connection, increasing opportunities for involvement in diverse social events would be beneficial in attracting veteran women. Conducting events that appeal to women specifically in addition to veteran status may improve veteran women participation.

KEY FINDING 4

Veteran women were more likely to have a probable mental health problem related to PTSD and depression than veteran men and were more likely to be at risk for suicide.

RECOMMENDATION 4

Tailor mental health treatments and suicide prevention efforts to consider the unique military experiences that exist between men and women. Abandon the one-size-fits-all approach to sexual assault and suicide prevention.

DISCUSSION 4

The current study highlights that, taken together, veteran women are more likely than veteran men to experience the combined traumas associated with combat and sexual assault. The likely co-occurrence of traumas associated with combat and sexual assault among veteran women needs to be considered in screening and treatment initiatives. Often these traumas are treated separately. Further, the important finding that veteran women appear to be at greater risk for suicide requires immediate attention. Innovative approaches to preventing suicide among veteran women are needed.

KEY FINDING 5

Experiences of sexual harassment and sexual assault during military service remain enduring challenges for veteran women.

RECOMMENDATION 5

Continue to include military sexual trauma screenings and opportunities for disclosure among women within veteran organizations. Increase veteran women's access to safe environments, especially housing and work environments, as well as ensure veteran women receive effective treatments and care.

DISCUSSION 5

Despite the numerous efforts undertaken by the military to prevent sexual harassment and sexual assault, a significant number of veteran women continue to experience one or both crimes. It is imperative that veteran service organizations continue to provide sensitive and evidence-based support and care for military sexual trauma. Expanding the general screening measures related to military sexual trauma will provide an opportunity for veteran women to disclose their experiences and enhance the ability of service organizations to connect veteran women to the appropriate resources. It is extremely important for veteran and military-connected organizations to appreciate that many veteran women may not be comfortable receiving care or services in environments where veteran men receive their care and services. This highlights the need for the continued establishment of women-only veteran facilities and programs.

KEY FINDING 6

Veteran women reported significant levels of chronic pain.

RECOMMENDATION 6

Continue and increase screening for pain status as a common practice, while broadening approaches to include pain assessment and treatment for women. Ensure service environments convey a diverse and inclusive atmosphere. Increase accessibility of healthy and effective pain management tools and continue research on the experience of pain in veteran women.

DISCUSSION 6

Pain is one of the most common physical health diagnoses among veterans in the VA and has been for decades. That military service is physically demanding is a fact, and it leads many veterans to become injured, resulting in lifelong pain issues. Women with chronic pain are more likely than men to be undertreated or inappropriately diagnosed and treated. Pain in women is also understudied. Appropriate assessment and treatment of pain in women veteran is essential to well-being. That pain can be difficult to effectively manage is readily acknowledged, highlighting the need for improved pain management strategies. It is important to ensure veterans have access to, and knowledge of, effective long-term pain management strategies.

KEY FINDING 7

Veteran women were significantly more likely to endorse that they encountered logistical barriers to receiving VA health care.

RECOMMENDATION 7

The VA must continue to work to improve access to care for veteran women.

DISCUSSION 7

It is well established that women in both civilian and veteran populations are more likely to be impacted by logistical barriers to care. These structural barriers include distance, wait times, difficulty getting time off work, difficulty making appointments, and not having time for appointments. Although this is not unique to veteran women, the administrative bureaucracy of VA care often creates logistical barriers that are difficult to overcome, requiring time and advocacy. Given that women are historically more impacted by such obstacles, the VA's red tape most likely creates added barriers to accessing care for some veteran women. Continuing to work to reduce such barriers and improve access will be essential to improving care for women veterans.

APPENDIX



APPENDIX A: STUDY MEASURES

AUDIT CONSUMPTION SCALE (AUDIT-C)

The Alcohol Use Disorders Identification Test—Consumption (AUDIT-C) (World Health Organization, 2001) is a brief screening tool used to assess alcohol consumption patterns. This is a widely used, quick, and easy method for assessing alcohol consumption patterns and can be useful in identifying individuals who may benefit from further intervention or treatment. In men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. In women, a score of 3 or more is considered positive.

CONSUMER FINANCIAL PROTECTION BUREAU (CFPB) FINANCIAL WELL-BEING SCALE

The CFPB Financial Well-Being Scale (Consumer Financial Protection Bureau, 2015) is a self-report measure designed to assess an individual's level of financial well-being. It was developed by the Consumer Financial Protection Bureau (CFPB) in the United States and consists of 10 items that assess various aspects of financial well-being, including an individual's ability to pay bills, handle unexpected expenses, and plan for their future.

HOUSEHOLD FOOD SECURITY SURVEY SHORT FORM

The Household Food Security Survey Short Form (HFSS) (Swindle et al., 2013) is a self-report questionnaire that assesses the degree to which a household experiences food insecurity. The HFSS can be useful in identifying households that may be at risk for food insecurity and in evaluating the effectiveness of interventions aimed at improving food security. Endorsement of either of these items indicated food insecurity.

MENTAL HEALTH TREATMENT SEEKING

The Mental Health Treatment Seeking Scale (MHTS) (Adler et al., 2015) is a self-report measure designed to assess barriers to seeking mental health treatment. It includes 12 items and asks participants to indicate whether they are a reason for not seeking mental health care.

MILITARY CENTRALITY SUBSCALE OF THE WARRIOR IDENTITY SCALE (WIS)

The Warrior Identity Scale (WIS) (Lancaster & Hart, 2015) is a self-report measure designed to assess the extent to which individuals identify with the role of a warrior or soldier. It consists of 17 items that ask respondents to rate their agreement with statements related to a warrior identity. This measure can be useful for understanding the psychological and social factors that influence the well-being and adjustment of individuals who have served in combat roles. The Military Centrality Subscale consists of four items that measure how veterans view their service in relation to their identity.

NUMERIC PAIN RATING SCALE

The Numeric Pain Rating Scale (NPRS) (Ferraz et al., 1990) is a simple tool for assessing pain intensity. Patients are typically asked to rate their level of pain on the scale, with the numerical rating indicating the intensity of their pain. The NPRS can be used to assess pain intensity at a single point in time or over time, to monitor changes in pain levels, and to guide treatment decisions.

OSLO SOCIAL SUPPORT SCALE (OSSS-3)

The Oslo Social Support Scale (OSSS-3) (Kocalevent et al., 2018) is a self-reported measure of the level of social support. It consists of three items that ask for the number

of close confidants, the sense of concern from other people, and the relationship with neighbors with a focus on the accessibility of practical help. The OSSS-3 sum score can be operationalized into three broad categories of social support: poor social support (3–8), moderate social support (9–11), and strong social support (12–14).

PATIENT HEALTH QUESTIONNAIRE 9 (PHQ-9)

The Patient Health Questionnaire 9 (PHQ-9) (Kroenke, 2002) is a self-report questionnaire that assesses the presence and severity of depression symptoms. This measure can be useful in identifying individuals who may be experiencing depression symptoms, and in monitoring the effectiveness of treatments aimed at reducing depression symptom severity. A score of 10 or higher indicated probable depression.

PATIENT HEALTH QUESTIONNAIRE 15 (PHQ-15)

The Patient Health Questionnaire 15 (PHQ-15) (Kroenke et al., 2002) is a self-report questionnaire that assesses somatic symptom severity. This measure is useful in identifying individuals who may be experiencing somatic symptoms that may be related to a medical or psychiatric condition, and in monitoring the effectiveness of treatments aimed at reducing somatic symptom severity. A score of 10 or above indicates medium to high somatic symptoms.

PTSD CHECKLIST FOR DSM-5 SHORT FORM

The PTSD Checklist for DSM-5 Short Form (PCL-5) (Zuromski et al., 2019) is a self-report questionnaire that assesses the presence and severity of PTSD symptoms according to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) criteria. It is a shortened version of the PCL-5, developed by the National Center for PTSD. The PCL-5 can be useful in identifying individuals who may be

experiencing PTSD symptoms, and in monitoring the effectiveness of treatments aimed at reducing PTSD symptom severity. A score of 7 and above was used to indicate probable PTSD.

SEVERITY OF DEPENDENCE SCALE (SDS) FOR DETECTING CANNABIS DEPENDENCE

The Severity of Dependence Scale (SDS) (van der Pol et al., 2013) for detecting cannabis dependence is a self-report questionnaire that assesses the severity of dependence on cannabis. This measure can be useful in identifying individuals who may be at risk for problematic cannabis use, and in monitoring the effectiveness of interventions aimed at reducing dependence on cannabis. Authors established an optimal differentiating cutoff as a score of 4 or higher.

SEXUAL HARASSMENT AND ASSAULT VA SCREEN

The VA screening for sexual harassment and assault (Mengeling et al., 2019) consists of two questions assessing a single construct that includes both sexual harassment (“While you were in the military, did you experience any unwanted sexual attention, such as verbal remarks, touching, or pressure for sexual favors?”) and sexual assault (“Did anyone ever use force or threat of force to have sex with you against your will?”).

SOCIAL CONNECTEDNESS SCALE

The Social Connectedness Scale (Lee & Robbins, 1995) is a self-report measure designed to assess an individual’s sense of social connectedness or belongingness. This scale consists of eight items that ask respondents to rate the extent to which they feel connected to others and the world.

SUICIDE BEHAVIORS QUESTIONNAIRE-REVISED (SBQ-R)

The Suicide Behaviors Questionnaire-Revised (SBQ-R) (Osman et al., 2001) is a brief self-

report questionnaire that assesses suicidal ideation, behavior, and related factors. The SBQ-R can be useful in identifying individuals who may be at risk for suicide, and in monitoring the effectiveness of treatments aimed at reducing suicidal ideation and behavior. Scores of seven and above indicate risk for suicide.

THREE ITEM LONELINESS MEASURE

The Three Item Loneliness Measure (Hughes et al., 2004) is a brief self-report measure designed to assess an individual's subjective sense of loneliness. This measure consists of three items that ask respondents to rate their level of agreement with statements related to loneliness. The measure can be useful in identifying individuals who may be at risk for poor health outcomes due to loneliness, and in evaluating the effectiveness of interventions aimed at reducing loneliness. A score of six or above indicates loneliness.

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