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Resiliency and Posttraumatic Growth Following Sexual Trauma in Women Veterans of Iraq and Afghan Wars

SPECIAL COLLECTION: WOMEN OF THE IRAQ WAR

RESEARCH

VICTORIA MCKENZIE
ELIZABETH H. ANDERSON
AMARIS MAYDON
GEETHA SHIVAKUMAR

*Author affiliations can be found in the back matter of this article

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ABSTRACT

Women veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) experience a myriad of traumatic stressors, including high rates of Military Sexual Trauma (MST). Furthermore, there is an upsurge in combat exposure, length and number of deployments, and/or perceived personal danger in these eras compared to women veterans of previous eras. These stressors can increase the risk of developing post-traumatic stress disorder (PTSD). Women veterans with combat exposure and/or MST experience PTSD differently than civilian women or military men, and therefore may require tailored and integrative treatments. Interventions that focus on resiliency and posttraumatic growth (PTG) may help decrease symptom presentation, increase quality of life, and reduce the utilization/cost of care. Moreover, resiliency-based interventions could offer a recovery-oriented framework that reinforces positive psychology constructs that may promote growth following trauma. To investigate these concepts, we interviewed four women from the OEF/OIF/OND eras who have experienced MST and/or received a diagnosis of PTSD. We explored four major areas: experiences of life after military, impact of trauma on factors that influence resiliency, helpful and unhelpful interventions for trauma recovery, and the concepts of resiliency and posttraumatic growth. These women generally felt a sense of lost identity following trauma and in post-military life, and they expressed a desire for therapy groups to support and foster connections to women with similar experiences. We also observed that they had a general understanding of resilience but lacked in-depth knowledge as it could apply to trauma recovery and welcomed opportunities to learn these skills in group settings.

CORRESPONDING AUTHOR:
Victoria McKenzie
University of Texas Southwestern Medical Center, Department of Veterans Affairs, US
victoria.mckenzie@utsouthwestern.edu

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The past decade has seen unprecedented numbers of women joining the military who have later been deployed in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Per the US Department of Veterans Affairs (2017), 299,548 women service members were deployed for contingency operations in Iraq and Afghanistan between September 2001 and February 2013. As of 2019 there were more than 1,300,000 active-duty members in the Army, Navy, Marine Corps, and Air Force (16.9% women) and 807,602 people (20.6% women) serving in the Reserves (US Department of Defense, 2019; Disabled American Veterans, 2018). According to a report written by the Defense Advisory Committee on Women in the Services (2017), women make up 17.5% of all active-duty officers and 15.8% of active duty enlisted personnel. In 2016 all restrictions against women serving in combat roles were lifted and now women hold positions that place them in direct combat, which may increase their experiences of danger. As of 2017, 1.9 million of the 19.6 million living veterans were women (9.5%). OEF/OIF and Operation New Dawn (OND) era women are the fastest growing group within this cohort and according to a report released by the United States Census Bureau in 2020, it is projected that this number will increase to 17% by 2040 (US Department of Veterans Affairs, 2017; Vespa, 2020). Women veterans seeking Veterans Health Administration (VHA) care present with a wide range of diagnoses, symptoms, and concerns. The top four conditions of women veterans treated at the VHA include PTSD, Major Depressive Disorder, migraines, and lower back pain (US Department of Veterans Affairs, 2017). PTSD accounts for nearly twice the general health care utilization among OEF/OIF/OND women veterans (US Department of Veterans Affairs, 2017). Given this, there is a need for research on women's coping abilities and strategies upon military discharge in terms of reintegrating with their families, careers, and communities (Mattocks et al., 2012), all of which could help protect against the effects of traumatic stress (Pietrzak et al., 2009). It is crucial for Veterans Affairs (VA) healthcare providers to understand women's experiences both during their military service and while adjusting to life after military discharge. Knowledge of these experiences could help with timely detection and treatment of mental health concerns before they become chronic and recurring conditions (Barth et al., 2015).

Women join the military for a variety of reasons. One study showed that 50% of the women they surveyed reported joining the military to escape stressful home environments and that women service members have higher rates of childhood sexual trauma in comparison to civilian women (Surís et al., 2008). Additionally, women experience MST at higher rates than their male counterparts (Barth et al., 2015), have distinct experiences of gender-based violence, and have lower perceived social support than their male peers (Mattocks et al., 2012; Street et al., 2009). Following MST, women service members may experience stigma, negative reactions, lack of support, and concerns about reporting confidentiality (Burns et al., 2014; Portnoy, 2018).

The lack of social support that women service members report feeling during deployment, especially following MST, may exacerbate the effects of perceived traumatic events (Street et al., 2009). While in the military and during deployment, women service members face added stressors that are different from those of their male counterparts, these stressors can be mission related and/or interpersonal in nature. Research by Mattocks and colleagues (2012) has shown that women deployed to a combat zone were more likely to experience emotional distress in response to combat trauma than men. A study by Street et al. (2009) showed that multiple traumatic events across the lifespan can have a cumulative impact on post-deployment adjustment. As for interpersonal stressors, women often have domestic responsibilities such as childcare that they must allocate to others while away, thereby contributing to their deployment related stress and concerns (Mattocks et al., 2012). Research suggests that over 40% of active-duty women have children, and more than 30,000 single mothers were deployed to Iraq and Afghanistan (US Department of Defense, 2006, 2010). In their focus group with OEF/OIF women veterans, Mattocks and researchers (2012) noted that several women mentioned returning home to mismanaged financial and household matters. They also described worrying about finding their place in the family again and difficulties reacquainting with their matured children. Moreover, these interviews found that these women's service time disrupted relationships with family and friends (Mattocks et al., 2012).

Recent research has brought to light additional concerns about post-military interpersonal victimization for women veterans. A growing amount of evidence suggests that previous traumatic events and subsequent PTSD symptoms may be risk factors for future trauma exposure; much of this evidence focuses on interpersonal traumas, such as intimate partner violence and sexual victimization (Street et al., 2009). Many negative emotional, cognitive, and behavioral changes occur during PTSD, which may impact women's ability to access resources, such as social support, that could help protect them from additional stressors (Hobfoll et al., 1995; Street et al., 2009). This is in part due to a common coping strategy of avoidance and isolation and a sense of feeling misunderstood (Mattocks et al., 2012). For example, Pietrzak et al. (2009) found that veterans with a diagnosis of PTSD reported lower levels of resilience and post-deployment social support compared

to veterans without PTSD. Providing a women veterans' support group with a focus on increasing resiliency may help buffer against poor adjustment and protect against the deleterious effects of traumatic stress and depression (Hermann et al., 2012).

RESILIENCY: A POTENTIAL THERAPEUTIC STRATEGY

Resiliency-based interventions have shown promise in addressing trauma and PTSD symptoms in service members. The American Psychological Association (APA; 2012) defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress— such as family and relationship problems, serious health problems or workplace and financial stressors" (para 4). Resilience is also a neurobiological entity that shapes and mediates an individual's response to trauma and subsequent development of mental illness (Rakesh et al., 2019). Resilience can be measured through outcome, ability to adapt, and response (Agaibi et al., 2005). In the context of trauma and PTSD, strengthening resilience may provide coping strategies and result in better outcomes when faced with future traumatic events. Resiliency-based approaches may potentially reduce the salience of and/or impact of interpersonal violence. Importantly, as a result of the adverse experience, resilience is an active, effortful, determined, and integrative positive drive forward (Rakesh et al., 2019; Southwick et al., 2014). This definition implies that resilience techniques can co-exist with PTSD symptoms rather than be conceptualized only as the absence of symptoms following adversity.

Resiliency is noted to have several components, including resilient qualities, the process of resilience, behavior associated with resilience, cognitive mechanisms, and innate resilience characteristic traits (Agaibi et al., 2005; Ballenger-Browning et al., 2010). Each of these can be further separated into coping styles, physical exercise, moral compass and spirituality, social support, cognitive flexibility (pattern of thinking), reappraisal, acceptance, and stress inoculation (Agaibi et al., 2005; Ballenger-Browning et al., 2010). Additionally, many researchers conceptualize resilience as an interaction between person and situation, which allows us to understand how to modify a situation or the psychosocial characteristics that increase resilience in the individual (Agaibi et al., 2005). Furthermore, work by Agaibi et al. (2005) emphasized the importance of post-deployment resiliency interventions that include increasing locus of control, self-disclosure of the trauma experience to significant others, creating a positive group identity as a survivor, increasing the perception of resources, enacting altruistic or prosocial behaviors, finding meaning in the traumatic experience and life afterward, and social connection with a significant community of friends and fellow survivors.

The intervention itself will be determined by the specific concept within resiliency that the treatment provider is targeting. Additionally, it may depend on their particular theoretical orientation and/or treatment modality. Helmreich et al. (2017) note that resilience interventions are emphasized by different psychotherapeutic methods, including Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), Attention and Interpretation Therapy, problem-solving therapy, and Stress Inoculation Therapy (SIT). As an example, Helmreich and colleagues (2017) suggest that within the ACT framework, psychopathology is primarily the consequence of psychological inflexibility (including during stress and adversity). ACT aims to foster acceptance and mindfulness skills (e.g., being in contact with the present moment, acceptance, cognitive defusion), as well as commitment and behavior-change (e.g., values, committed action). Within the core principles of ACT, several elements that constitute resilience, such as cognitive flexibility and spirituality, are cultivated and/or strengthened (Helmreich et al., 2017).

Iacoviello and Charney (2014) offered concrete ways to promote resilience in trauma survivors. These authors have suggested mental health providers help clients find and identify with a resilient role model, establish a supportive social network, and face fears instead of avoiding them (using SIT). Additionally, they suggest aiding the survivor in establishing a physical well-being regimen of physical exercise and/or activity and fostering character strengths (Iacoviello & Charney, 2014).

Currently, there are at least seven programs within the military that target resiliency for active-duty soldiers and two programs specifically for veterans. Programs such as the *Military Resilience Training* (2006) and *Comprehensive Soldier Fitness Program* (2008), based in part on sports and positive psychology, aid service members in preparing for the trauma of war and then adjusting to civilian life (Hermann et al., 2012). The *Battlemind Stress Management Training/Military Resilience Training and Battlemind Debriefing* is another US Army strength-based program designed to help reframe ten necessary combat-related skills (each letter of Battlemind represents one of the skills; e.g.",d""is for Discipline and Ordering versus Conflict) that, if left unaddressed, may cause problems in soldiers' post-deployment lives (Adler et al., 2009; Hermann et al., 2012). This program provides education, normalizes transition challenges, and encourages social support (Hermann et al., 2012). Additionally, it has shown to effectively reduce

positive screenings for PTSD, depression, and anxiety for soldiers who completed the program in comparison to those who did not receive the training (12.0% versus 20.5%; Hermann et al., 2012). Other preventative interventions guided by *The Stress Continuum Model* within the Marine Corps and Navy (Navy and Marines Combat and Operational Stress Control doctrine), are intended to promote psychological health and prevent stress disorders. In this program, a toolkit called "Combat and Operational Stress First Aid" provides psychological first aid to help reduce initial distress and increase short and long-term adaptive functioning following exposure to potentially traumatic events (Hermann et al., 2012). This is composed of the following seven steps: assess difficulties, coordinate safety and care, reduce arousal, encourage family and peer support, and restore self-confidence (Hermann et al., 2012). "Moving Forward," a program based in Problem-Solving Therapy (PST, a psychosocial intervention under the CBT umbrella) that focuses on building resilience to the negative effects of trauma, was found to be well received and feasible (Tenhula et al., 2014). PST aims to encourage effective coping in stressful events by helping individuals develop an adaptive worldview (e.g., optimism, positive self-efficacy, acceptance that problems in living are common occurrences and not catastrophes) and effectively implement adaptive problem-solving behaviors (Tenhula et al., 2014). Similarly, Zalta and researchers (2016) piloted a study with 14 trauma-exposed individuals (78.6% female) to investigate the feasibility, acceptability, and effectiveness of Tailored Cognitive Behavioral Resilience Training (TCBRT). Within the five 90-minute sessions, participants identify three areas in which to build resilience and the existing strengths they will use to help build the new skills, work on maladaptive patterns, practice CBT change principles, create and implement action plans (effective goal setting, identifying potential barriers, and strategies to overcome barriers), and review progress (Zalta et al., 2016). This project suggested that this flexible intervention could enhance current functioning, improve quality of life, and build resilience to future traumatic stress in individuals with subthreshold PTSD.

Including resiliency-based interventions specific to the needs of women veterans can provide a framework for continued functional recovery and moving beyond baseline to posttraumatic growth, defined as being able to experience positive growth after a negative experience. Similarly, resiliency interventions designed specifically for women veterans with MST or PTSD histories may offer a method for secondary and tertiary prevention by potentially reducing the symptom presentation, impact of interpersonal violence, and utilization and cost of care (Burbiel et al., 2015; Surís et al., 2008).

METHOD

In this pilot study, we explored women's understanding of resilience and posttraumatic growth. We conducted brief interviews with four OIF women veterans with MST and/or PTSD histories that focused on their previous experience and knowledge of resiliency interventions. Our results may have implications in potential treatment options for women veterans, especially the feasibility and willingness of women to participate in resiliency-based interventions that promote growth and recovery. This study is a qualitative examination of women veterans currently receiving mental health services at a VA medical center. All study procedures were conducted in compliance with the Institutional Review Board of VA North Texas Health Care System, Dallas VA Medical Center. The convenience sample, consisting of four women veterans, were recruited via clinician referrals. Veterans who expressed an interest in participating were contacted by a research coordinator and provided verbal informed consent.

Inclusion criteria were (a) being 18 years of age and older, (b) able to give informed consent, (c) identified as female, (d) veteran status, and (e) had either a diagnosis of PTSD and/or a history of military sexual trauma. Individuals with severe cognitive impairment that would prohibit valid consent were excluded from participation.

We used a semi-structured interview guide (see Appendix A) designed to elicit participant's experiences and views regarding resiliency, mental health, and mental health treatment. Questions such as "Can you tell me a little more about that?" were used to prompt further discussion related to prior statements without introducing new topics. Information was also collected on the following: demographics, place and time of military service, clinical diagnoses, military sexual trauma history, and utilization of mental health services. The semi-structured interviews were conducted by a research coordinator via phone and lasted no more than 45 minutes.

The interviews were audio recorded, transcribed, and reviewed for accuracy of content. Three members of the research team read the transcripts in their entirety and analyzed the transcripts independently. Study personnel then labeled text, identifying specific content and recurring themes. The team members compared their findings, addressed differences, and created a theme and subtheme structure. Ultimately, our study identified four main themes with varying numbers of subthemes.

RESULTS

All study participants served during the OIF era (two were OIF only, one OEF/OIF/OND, one OEF/OIF) and had a diagnosis

of PTSD. Three of the women veterans had a history of MST. Participants ranged from 33 to 40 years of age with a median age of 37. Two women identified as Caucasian, one as Hispanic, and one as Asian. The women each served in different branches of the military: Marine Corps, National Guard, Army, and the Airforce. All participants utilized mental health treatment at VA facilities.

The interviews were structured around four major topics: (a) experiences of life after the military, (b) impact of trauma on factors that influence resiliency, (c) what was and was not helpful for trauma recovery, and (d) resiliency and posttraumatic growth concepts. Within the theme of "experiences of life after the military," subthemes were loss of military identity, daily structure, community, and purpose in life. "Impact of trauma on factors that influence resiliency" subthemes were symptoms and behaviors, relationships, and loss of identity after trauma. Sub-themes of "what was and was not helpful for trauma recovery" were what was helpful, what was not helpful, and what could be different. A summary of themes and subthemes, including focus group quotes that illustrate the topics, are presented in ***Table 1***.

DISCUSSION

Our qualitative interviews found that women veterans who served during OIF had a broad range of experiences following traumatic events. The first theme is the loss of identity both following trauma and leaving the military, including a loss of purpose and role. Our finding is consistent with work conducted by Williams and colleagues (2018) that shows the intricate relationship between trauma, military service, identity, and transitions. Their work identified difficulties in renegotiating identity and the place trauma has in the lives of women veterans during re-integration into the civilian world. The participants in the study by Williams et al. (2018) indicated that their ability to form meaningful relationships and maintain stable housing and sobriety were impaired by their PTSD diagnosis. The women veterans also expressed a felt need to isolate and/or suppress emotional reactions to their trauma in order to progress (Williams et al., 2018). As for the military self, research by Demers et. al. (2013) described one of the goals of initial military training as socializing women to the military identity, which is often characteristically male and may conflict with more individualistic values. They note that this could potentially cause women to find themselves living between two incompatible social contexts (Demers et al., 2013). Demers et. al. (2013) proposed that, upon return, this leaves women veterans questioning their identities and wondering how society perceives them. An important observation in our pilot study is that several of the participants worked through some of their identity crisis and regained a sense of purpose/role when they became mothers. These women noted having someone to provide for, protect, and be a role model for was beneficial to their identity development in the post-deployment transition.

This sheds light on several places of growth for those in a helping, care-taking role. Clearly, efforts still need to be made in prevention and early intervention within the military regarding trauma/PTSD, MST, and substance use. As our interviews and others have highlighted, these issues continue to be a growing concern that deeply impacts mental health and self-identity. Additionally, there seems to be a need for greater help with the transition from active duty to civilian status. Currently, within the US Department of Defense and US Department of Veterans Affairs there are Military Transition Programs and the VA Transition Assistance Program (TAP) that offer individualized counseling, translation of skills for jobs and employment fundamentals, financial planning, and discussions of benefits and entitlements (US Department of Defense, 2021; US Department of Veterans Affairs, 2021). However, it is possible that greater outreach efforts are needed to bring in more potential users and/or that the programs need to offer more concrete, on the ground support, not just education. Adding a whole-person treatment that includes housing assistance programs, job corps, help with childcare, and connection to a greater network of parents and/or employed veterans could lessen the burden of the transition.

The second major theme of our interviews were women feeling a need for therapy groups for support and to feel connected with other women with similar experiences. Supportive social relationships have been identified as a major resilience factor among military personnel, which makes women veteran's lower perceived social support particularly significant (Bliese, 2006; Griffith et al., 1999; Street et al., 2009). Given this, we believe another key message from our interviews is women veterans' need for community and connection. All participants in our study suggested that a therapeutic group could be an important tool for their recovery. The participants spoke of a desire for a community of women who had gone through similar experiences thereby lessening the feeling of isolation. This is consistent with research by Street et al. (2009) where women veterans spoke of the importance of coming together with other women veterans to share their experiences with deployment and to support each other through difficult reintegration experiences. Moreover, the women veterans viewed connecting with other women veterans as therapeutic and helpful in coping with stressful experiences post-deployment (Street et al.,

SUBTHEMES	ASSOCIATED RESPONSES
Experiences with Leaving the Military and Adjusting to Civilian Life	
Loss of Military Identity	"Not being able to put on the uniform … just kind of, uh, hurt … I felt like I was gonna lose a lot of friend and stuff cause a lot of people once they get out you just kind of lose touch with them."
Loss of Community	"When I moved out here, it was to start a new life … and it was hard because I had no friends or no family here and I didn't know the area"
Loss of Daily Structure	"…even if, like you've gone through change, it's like culture shock that's kind of what it felt like; it's like culture shock because you're transitioning from living one way of life to like you're getting out and all that involves."
Purpose in Life	"… my son kind of gave me purpose again, that's what kind of keeps me straight and done, but I know, like, sometimes it helps, it might help somebody to have either a person to look forward to or work towards; it might help in their healing process." "I think I always found in my life, like you know ever since I've had my children, I feel a reason to be here, and I have a purpose."
Impact of Trauma on Factors that Influence Resiliency	
Symptoms and Behaviors	"I don't sleep much, my insomnia, and I would go where, you know, I would hardly eat anything and then there were times I would just eat all the time like diets and stuff; really I would try and wouldn't be able to stick with it, and uh, working out and stuff, like I would, like I would, know I would have to do it but I didn't feel the energy" "… because of that trauma and stuff is why I started drinking more and more, you know, just to try to drown it and it got to where the alcohol wouldn't work anymore, so I was looking for something else so that's how I got hooked on methamphetamine."
Relationships	"I have horrible trust issues, I uh, I lose faith in people very fast, I don't really give people a lot of chances … I don't even like talking to new people … uhm, I don't think of the world as a great, amazing place, I think people are, I don't think people are very good I have uhm, I think a lot of people are just in it for things for themselves" "It makes me feel worthless, it makes me feel like I'm just a sex object, or I'm just something that people enjoy to look at, or like I'm only wanted because of that."
Loss of Identity Following Trauma	"I've never been myself again, since the events." "It was to a point where I felt I was constantly being punished, that I always wondered why I was put onto this earth … because what I'd been through, it felt like there was no end to it and that it just kept going and going and it got to the point where I'm like, why me, why was I put here, what purpose does this serve … that is where I felt, I felt like, like god was punishing me"
What was and was not Helpful for Trauma Recovery	
Helpful	"… it helps because I was able to speak with others who have gone through something similar, so it definitely allows me to know I'm what happened or my situation I'm not alone."
Not Helpful	"I think it would be better to have more females handle some of the cases or you know, just so you could feel a little bit, maybe, a connection or something or maybe they might have some empathy, or they might understand, because when I reported everything it was all male … they didn't quite understand and if they did they didn't seem to care." "The first time I went to group it was for an 8-week outpatient … I was not just going through my traumatic events I was going through their traumatic events as well, so it's like, you are hearing multiple horror stories … and this was males and females it wasn't just females … I don't think it was very beneficial."
What Could be Different	"I felt like … because I was a female I wasn't taken seriously" "… I had to work hard, I had to work hard because 1) I'm a female, 2) I was smaller than a lot of people … I had to prove myself I had to prove … I did earn my rank 2) yes I am somebody that you can listen to and take orders from that's equal to a male solider giving orders … and 3) I'm not weak because I'm a female and so it's just harder to get that respect" "I think, like, being offered the group therapy, because when I first got discharged and stuff, I don't think I was offered the group therapy stuff"
Understanding of Resiliency and Posttraumatic Growth	
Familiarity with Concepts	"Oh boy, post traumatic growth, you know to be honest I've never really heard that very much, what does it mean?" "Being able to bounce back to, to not let something stop you." "Resilience is that like, say something has happened to you, and like you drastically drop and, like, your mood or your weight, or something has happened to you that made you less than what you were at the time, and after that situation happened you are able to bring yourself back to where you were before that situation happened?"
Positive Interest in Resiliency Group	"I think that would be a good idea, especially because you can communicate with other people who have been through that or who have more experience in some type of resiliency and the other people can learn from that."

Table 1 Themes and Subthemes from Individual Interviews.

2009). Our results also reflect research indicating that the maintenance of PTSD is associated with lower social support at homecoming and beyond (Schnurr et al., 2004).

Although it is desired and beneficial, connection to other women veterans and VA services may be a difficult challenge for women who have experienced MST or other traumas. Calhoun et al. (2018) note that more than half (52%) of OEF/OIF women reporting a history of MST were not using any VA health care. The reduced use rate may be due to poor outreach efforts/linkage to VA services, limited knowledge and inaccurate beliefs regarding eligibility for VA services, bureaucratic barriers impeding receipt of VA care, VA environments triggering negative memories, negative interpersonal experiences with VA staff, and perceiving VA settings as unsafe, ill-equipped to address addiction, and insensitive to women-specific needs and preferences (Calhoun et al., 2018). Although some of these concerns need to be addressed on a much larger level, offering women veterans virtual health care services, specifically mental health and group interventions, could be a first step in answering some of the needs many women veterans have shared. Specific to this study, resilience based virtual therapy groups could help minimize avoidance and improve sense of connection and support.

As noted by Iacoviello and Charney's (2014) research, having a resilient role model is an important part of building resilience in the individual. Our participants identified a need for connection and that having a role gives them purpose. Given these two ideas, it could be beneficial for our mental health clinics to set up a resiliency mentor buddy system in which veterans are paired with other veterans that may be further along in their resiliency/mental health journey.

In our last theme, women had general awareness of resilience but lacked a more in depth understanding of the concept as it applies to trauma and recovery. They also welcomed opportunities to learn skills related to resilience in a group setting. In fact, many of the concerns and issues the participants spoke of are targeted aspects of resiliency training (physical, interpersonal, emotional, thinking, behavioral, and spiritual fitness; Meichenbaum, 2012). Importantly, the participants expressed that they were receptive and open to learning more about resiliency. Within the context of these interviews, this included attending a group focused on learning resiliency skills. Our study demonstrates that women veterans are open to incorporating resiliency-based interventions in conjunction with more social and group support. Given that resiliency is an optimistic, positive therapy method, it is likely that other veteran populations would also be open to incorporating resiliency-based approaches into their treatment.

The results of these interviews suggest that this exploration was warranted and there is a need for more scientific investigation of resiliency. There are several directions future research could pursue. One of the first research goals should be to create and test resiliency group interventions specific to different communities and trauma types. Similarly, future research should examine which specific therapeutic interventions and resiliency skills work best for each presenting concern. Collecting data regarding which resiliency interventions work best for whom could help guide decision making for mental health providers. Likewise, due to the newness of several of the current programs, more replication and validation of previous intervention studies and insight regarding effectiveness is needed. It is necessary that research focus on creating tools and protocols for training mental health providers, as well as testing the outcomes of the interventions.

This pilot study has several methodological limitations. We would first like to acknowledge our small sample size ($N = 4$), which limits the generalizability of these results. In addition to this, the participants consisted of a convenience sample that may not be representative of women veterans in general. Furthermore, the participants in the study already utilized mental health treatment at a VA medical center, and their views may not be representative of women veterans who are not currently in mental health treatment and/or are enrolled in VA services. Despite these limitations, this study is unique in its qualitative examination of women veteran's beliefs about resiliency and the acceptability of including this in treatment for PTSD and/or MST.

CONCLUSION

Research by Strong et al. (2017) has distinguished four circumstances that can support or hinder women Veterans' reintegration process. They include: (a) availability of gender-specific Veterans Affairs policies and services, (b) access to education and employment, (c) supports specific to mental health and/or military sexual trauma, and (d) social stigmas associated with being a woman veteran. We believe our results provide support for the idea of expanding treatment options that address several of these circumstances. This would include resiliency intervention models that help promote overall psychosocial recovery specific to women veterans with PTSD and/or following sexual trauma. Notably, this research supports the notion that resiliency groups may be widely welcomed for this population, and that these additional treatment models could help address their gender-specific needs.

APPENDIX A: INTERVIEW QUESTIONS

1. What is your age, race, and gender?
2. What is your rank and where/when did you serve?
3. What is your diagnosis?
   a. Did you experience MST?
   b. Do you have PTSD?
4. What Services/Resources have been offered to you?
   a. Did you utilize them?
   b. For how long?
5. Think back to when you returned home from when you discharged from the military: what sort of resources would have helped you adjust to civilian life?
   a. What was the most difficult part of transitioning from active military to being discharged?
6. What have you learned in group, life, talking with others, therapy etc. that has been helpful for reducing the impact of the traumatic experiences?
7. How has the experience of trauma impacted your:
   a. Health habits: exercise, nutrition, sleep, substance use (Physical fitness)
   b. Current or building of new relationships (Interpersonal fitness)
   c. Experience of and with positive and negative emotions (Emotional fitness)
   d. Adjust/adapt to changing demands, be flexible, problem-solve (Thinking fitness)
   e. Willingness to try new things, relax, learn from mistakes, stay organized and committed (Behavioral fitness)
   f. Find meaning and purpose, Beliefs/practice of spirituality/religion (Spiritual fitness)
   g. feelings thoughts about yourself and your identity?
8. How do you think your experiences differ from other:
   a. (men, ages, demographics, rankings, eras, military unit/branch, etc.)
9. What does the word "resilient" mean to you?
10. What does the phrase "post traumatic growth" mean to you?
11. PROVIDE psychoeducation regarding resiliency
    a. Would you be interested in attending a group that was about resiliency?
12. What tools, resources, or services have been the most helpful in reducing the impact of your traumatic experience?
    a. In what ways, if an, could the services, resources, or tools be improved to better help you post trauma?"

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COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR AFFILIATIONS

Victoria Mckenzie *orcid.org/0000-0002-8116-9582*
University of Texas Southwestern Medical Center, Department of Veterans Affairs, US
Elizabeth H. Anderson *orcid.org/0000-0003-0096-9367*
VA North Texas Health Care System, US
Amaris Maydon *orcid.org/0000-0002-2250-2509*
VA North Texas Health Care System, US
Geetha Shivakumar
VA North Texas Health Care System, US

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