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Female Veterans' Perspectives on Chronic Pain Impacts and Healthcare Challenges: A Qualitative Study

RESEARCH

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ABSTRACT

Female service members experience higher rates of injury compared to males, due to physiological differences, poorly fitted equipment, and female-specific health issues. They are also at greater risk of posttraumatic stress disorder and military sexual trauma. As more women transition to civilian life, many encounter difficulties accessing appropriate care, compounded by lack of military cultural competence among civilian healthcare providers and limited understanding of available services. This study aims to explore the impact of chronic pain on female Australian Defence Force (ADF) veterans, their experiences in obtaining optimal healthcare, and their perceptions of healthcare needs. Qualitative data were collected from 23 Queensland-based ex-serving female ADF members with chronic pain (M = 52 years of age), through six focus groups (four online, two in-person). Participants had served in the Army (44%), Navy (30%), or Air Force (26%) for an average of 10.2 years, with pain duration ranging from four to 60 years. Data were analysed via an inductive thematic approach. Four main themes were developed, with corresponding sub-themes. Findings reveal how military culture, systemic healthcare barriers, and perceived poor provider understanding contribute to delayed diagnoses and below evidence-based standard care. Participants called for improved clinician training in military cultural awareness, trauma-informed care, and greater awareness of available services, emphasising the urgent need for gender- and veteran-informed approaches to support the health and wellbeing of female veterans. Recommendations will inform the development of an education module for primary care providers, with the goal of improving chronic pain outcomes for female veterans in Australia.

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Since 2011, the number of females serving in the Australian Defence Force (ADF) has increased significantly, with women recruited into frontline combat roles since 2016 (Australian Government Department of the Prime Minister and Cabinet, 2018). By 2021, women comprised 21.2% of the Regular (full-time) ADF (Australian Bureau of Statistics, 2022). This will translate into a growing cohort of female veterans who eventually transition into civilian life–with many unique service-related health conditions.

Chronic pain, which disproportionately affects women, is highly prevalent among ADF personnel and veterans, with rates between 27%–57% (Pain Australia, 2022). Almost 90% of transitioned and Regular ADF members report some degree of pain and disability (Kelsall et al., 2018), and in 2021, a significant number of male veterans had chronic conditions such as arthritis (33%) and back problems (30.8%) (Australian Institute of Health and Welfare, 2024). Female military personnel experience higher injury rates than their male counterparts (Jones et al., 2017; Schram et al., 2022), due to physiological and biomechanical differences (Miller et al., 1993; Orr et al., 2011), poorly fitted equipment designed for the average male physique (Epstein et al., 2015), and heavy load carriage contributing to spinal strain, and reduced core stability (Sherman et al., 1997). Additional risk factors include the female athlete triad (i.e., amenorrhea, osteoporosis, and eating disorders), which can arise from intense physical exertion, operational stress, and menstrual suppression during deployment (Cline et al., 1998; Rauh et al., 2006) and increase susceptibility to stress fractures (Orr et al., 2011). Pelvic floor dysfunction is another under-recognised issue that increases injury risk and impacts quality of life (Sherman et al., 1997).

The management of chronic pain is often complicated by associated mental health conditions that have resulted from military service. Female military personnel report higher rates of posttraumatic stress disorder (PTSD) than males (Van Hooff et al., 2018), which intensifies pain severity and functional interference, and can negatively impact quality of life (Hadlandsmyth et al., 2024). Females are also at an elevated risk of military sexual trauma (MST; Crompvoets, 2021). Those with a history of MST report more physical and pain symptoms, and more severe pain (Cichowski et al., 2017; Frayne et al., 1999). Mixed evidence also exists that gender differences in pain coping strategies and pain perception, including higher perceived stress and pain catastrophizing, and lower levels of pain self-efficacy compared to their male counterparts (Burgess et al., 2024), may also impact intervention needs. Further, the prevalence of opioid prescribing also complicates the management of chronic pain in female veterans. It has been reported that women with musculoskeletal pain are prescribed more medications than men (Wijnhoven et al., 2007), including higher rates of opioid-sedative combinations, which carry increased health risks (Campbell et al., 2010; Oliva et al., 2015).

Not only is specific management of chronic pain in itself challenging, but also, on transition to civilian life, many female veterans face further challenges accessing healthcare tailored to their unique needs related to healthcare, mental health, and social support (Levander & Overland, 2015). Considering an intersectionality framework, female veterans' military experiences and healthcare outcomes should be understood in the context of their multiple identities (e.g., gender, ethnicity, disability, sexuality, age, military factors [rank, service type]) and associated societal discriminations and marginalisation (Meade, 2020). This highlights the need for services tailored to the unique needs of a diverse veteran community and cautioning against a 'one-size-fits-all' approach.

In Australia, the Department of Veterans' Affairs (DVA) is the government department responsible for providing support, services, and information for ADF veterans and their families. Veterans may access DVA-funded support for healthcare for approved conditions. Those who hold White Cards are required to have DVA accept their specific condition and treatment (i.e. an injury or disease arising from military service), with mental health conditions covered by Non-Liability Health Care; this requires no need to establish a causative relation to military service. Those with a Gold Card are provided with all medically necessary treatment, regardless of causation. However, not all veterans choose to access DVA services.

Cultural competency, the degree to which providers are sensitive to the unique needs of each veteran and relevant issues of concern within the veteran population, is vital to effective patient-centred care and therapeutic rapport (Coll et al., 2012). Most civilian healthcare providers, unless they specifically work with veterans, may not have received formal training on military culture or the specific health needs of military personnel. This gap in training can result in a lack of cultural competence when treating military-connected patients. International data; mainly US-based, indicate that only about 13% of civilian healthcare providers demonstrate readiness to deliver culturally competent, evidence-based care (Tanielian et al., 2014). In Australia, there is a lack of empirical studies assessing clinicians' cultural competence (Lane & Wallace, 2020), and there is a need for more training and resources to address gaps in military cultural competence of civilian healthcare providers (Prevett & Lamb, 2025).

It is important to understand the experiences of female veterans living with chronic pain to inform the provision of optimal healthcare for this population. This study explored the chronic pain experiences of Queensland-based female ADF veterans, and their perceptions of healthcare needs. Findings will inform the development of an education module for primary care providers, with the goal of improving culturally competent care, management, and health outcomes for female veterans in Australia.

METHODS

STUDY DESIGN

Qualitative research is a methodology that explores and understands the human experience, by gathering perceptions and experiences or observing and interpreting rather than collating numerical data. This study utilised thematic analysis—a method for identifying, analysing, and reporting patterns within data—with an inductive approach to explore the lived experiences of participants as they are without pre-conceived notions or theoretical interpretations (Braun & Clarke, 2006).

We employed this design to capture the experiences and perceptions of female ADF veterans with chronic pain relating to how military service has impacted their health, specifically in terms of their chronic pain and its sequelae, and the experiences they have had in accessing optimal healthcare since transition from the military. Additionally, we determined how female veterans perceived their health care management could be improved, and obtained their suggestions regarding content of an educational resource for clinicians who treat female veterans with chronic pain. This approach values the concept of co-production with veterans, who are able to bring their expertise and lived experience to provide richer data to the co-creation of knowledge and resources (Boyd et al., 2025).

To achieve this, we undertook small focus groups with Queensland female veterans, with open-ended questions to guide organic discussion towards the study objectives. Ethical approval was granted by the Australian Department of Defence and Veterans' Affairs Human Research Ethics Committee (DDVA HREC 514–23). All participants provided informed consent before participating in this study.

RECRUITMENT AND DATA COLLECTION

Participants were recruited via social media advertisements, ex-serving organisations (ESOs), veteran communities, and word of mouth. Participants were included if they were a female ADF veteran over 18 years of age, resided in Queensland due to grant funding specifications, and reported chronic non-cancerous musculoskeletal pain for over three months. Potential participants underwent phone screening to confirm eligibility, provided signed informed consent electronically, and completed a brief online demographic survey. Focus groups were offered in person or via Microsoft Teams, and audio recorded. Six groups of between three to five participants were conducted between May 2024 and July 2024. Due to the sensitive nature of the workshops and potential trauma-related disclosures, participants were provided with a list of available mental health support services and were followed up with two to three days after the workshops to establish well-being status.

DATA ANALYSIS

Data management was supported by NVivo (v.14) software. Focus group transcriptions were de-identified before being analysed thematically, using an inductive approach (Braun & Clarke, 2006) by two researchers. Prior to analysis, each researcher; a psychologist and a musculoskeletal physiotherapist, both civilian clinicians with over five years' experience working with veterans, completed a reflectivity statement to recognize and account for their personal biases, and enhance objectivity and transparency in analysis. The researchers familiarised themselves with the data by reading and re-reading the transcripts, then independently generated initial codes from one focus group before meeting to compare and discuss similarities and differences.

A new coding list was adopted for a second transcript to be independently coded by each researcher before a second inter-coder reliability check. A preliminary coding framework was generated (Creswell, 2003) and adopted for coding of the remaining transcripts. The researchers then worked together to collaboratively group related codes into themes, capturing key patterns in the data and accounting for collective meaning making within focus groups and overall frequency of topic discussion. Identified themes were reviewed to ensure accurate reflection of the data and revised accordingly. As new themes emerged, coding of earlier transcripts was reviewed as part of constant comparative analysis. No new themes emerged after six focus groups when data saturation was met. Due to logistical constraints, instead of participant member checking, the draft thematic map was reviewed by two civilian registered psychologists who work with ADF veterans to check credibility and trustworthiness, and their feedback was incorporated. All coding and interpretation were then discussed and validated by the researchers before finalisation of themes.

RESULTS

PARTICIPANT DETAILS

Twenty-three participants attended the focus groups. The ages of the participants ranged between 32–72 ($M = 52.3$), and pain had been present from four to 60 years, with comorbid mental health condition(s) reported by 87% ($n = 20$). Thirty percent ($n = 7$) of the participants had served in the Navy, 44% ($n = 10$) in the Army, and 26% ($n = 6$) in the Air Force, serving between 1–29 years ($M = 10.2$). Pain was perceived to be related to ADF service for 96% ($n = 22$) of the participants, with 70% ($n = 16$) reported receiving DVA support for chronic pain as an approved condition, and 48% ($n = 11$) reporting feeling their pain was currently well managed (Table 1).

CHARACTERISTIC	PARTICIPANTS
Age, mean (*SD*), range	52.3 (9.5), 32–72
Ethnicity, n (%)	
Caucasian	20 (87)
European	2 (8.7)
Aboriginal	1 (4.3)
Service	
Navy	7 (30.4)
Army	10 (43.5)
Air Force	6 (26.1)
Years in the ADF, mean (SD), range	10.2 (14.3), 1–29
Deployed overseas, n (%)	
Yes	7 (30.4)
No	16 (69.6)
Deployment condition(s), n (%)	
Warlike	5 (71.4)
Non-warlike	3 (42.9)
Peace keeping	3 (42.9)
Other (surveying)	1 (14.3)
Years since discharge, mean (SD), range	22.8 (27.1), 0–54
Reason for discharge, n (%)	
Medical	10 (43.5)
Voluntary	7 (30.4)
Administrative	1 (4.3)
Other	5 (21.7)
Place of residence, n (%)	
Metropolitan/urban	11 (47.8)
Regional	7 (30.4)
Rural/remote	5 (21.7)
Highest level of education completed, n (%)	
Year 10	3 (13.0)
Year 11 or 12	2 (8.7)
University degree	5 (21.7)
Post-graduate study	2 (8.7)
Vocational	11 (47.8)
Current work status, n (%)	
Unemployed	1 (4.3)
Part-time	1 (4.3)
Full-time	5 (21.7)
Volunteer	1 (4.3)
Medical pension	10 (43.5)
Retired	5 (21.7)
Relationship status, n (%)	
Single	1 (4.3)
Married	13 (56.5)
Partner/de facto	2 (8.7)
Divorced/separated	6 (26.1)
Other (widow)	1 (4.3)
Pain length in years, n (%)	
0–5 years	2 (8.7)
6–10 years	4 (17.4)
11–20 years	4 (17.4)
21 + years	13 (56.5)
Pain onset, n (%)	
Gradual	10 (43.5)
Acute	13 (56.5)
Pain related to ADF service, n (%)	
Yes	22 (95.7)
No	1 (4.3)
Which statement best describes your pain?, n (%)	
Always present (always the same intensity)	1 (4.3)
Always present (level of pain varies)	18 (78.3)
Often present (pain free periods lasting less than 6 hours)	3 (13.0)
Occasionally present (pain occurs once to several times per day, lasting up to an hour)	1 (4.3)
Diagnosed with mental health condition, n (%)	
Yes	20 (87.0)
No	3 (13.0)
If yes, condition(s), n (%)	
Posttraumatic stress disorder	13 (65.0)
Anxiety disorder	16 (80.0)
Depressive disorder	15 (75.0)
Panic disorder	3 (15.0)
Alcohol use disorder	6 (30.0)
Substance use disorder	1 (5.0)
Other	2 (10.0)
Currently receive DVA support for chronic pain Approved condition, n (%)	
Yes	16 (69.6)
No	7 (30.4)
Do you feel your chronic pain is currently well managed, n (%)	
Yes	11 (47.8)
No	12 (52.2)

Table 1 Demographic Characteristics of Participants (N = 23).

Group Process

Despite variation between participants' disclosed healthcare systematic awareness and experiences—reflective of differing length of time since discharge, carer roles, or career/advocacy backgrounds—groups were demographically comparable and sufficiently homogeneous to allow for aggregate analysis of transcripts. In all groups, participants

organically engaged supportively, offering validation of challenging experiences discussed, advice on service access, and, at times, extending friendship and aid to each other. Themes and subthemes reflect majority views unless noted as minority perspectives, with illustrative individual quotes included.

THEMES

Four overarching themes emerged (Table 2) from the focus groups, with several subthemes identified.

Theme 1: The Female Veteran Pain Journey

This theme described the female veterans' pain journey, giving context to the factors that contributed to injury and pain, the biopsychosocial impacts, and treatment experiences.

Understanding Military Service Experiences

Group members described their military backgrounds and the cultural and occupational factors that contributed to development of pain and psychological issues. The majority of participants ascribed their pain onset to strenuous basic training regimes, excessive load bearing, and ill-fitting equipment. Many back and lower limb conditions were attributed to carrying disproportionately heavy packs and wearing men's boots during long marches. Role- and service-specific duties also led to chronic overuse injuries. It was collectively perceived that few adaptations to training regimes, equipment, or facilities were made to accommodate female physical differences, leading to greater injury rates.

> [I] joined straight from school, pretty much… Just get in amongst it…Doing, you know, 10–15K pack marches, driving trucks…I did transport. Lots of heavy lifting. No educational knowledge on anything, just…just do it. And if you don't do it, you got bullied…and I guess that all those little injuries then turned into bigger injuries, because you just…you got bullied if you went to the RAP [(*sic)*

THEMES	SUBTHEMES
1. The female veterans' pain journey	*Understanding military service experiences*—recognising adverse cultural norms, malingering stigma, gender-specific challenges, and obligation to follow orders—all shaping pathways to injury and chronic pain.
	The complex development and progression of chronic pain—a multifactorial journey from injury to management shaped by delayed diagnoses, comorbidities, hormonal and medication influences, and a vicious cycle of factors that perpetuate pain.
	Biopsychosocial impacts of pain—encompassing disruptions to career, challenges balancing responsibilities, altered physical activity and functioning, psychological and identity shifts, and experiences of social withdrawal, stoicism, and stigma.
2. Perceived barriers to obtaining optimal healthcare	*Barriers to obtaining optimal care*—multifaceted challenges including financial costs, time constraints, limited social support, difficulties finding suitable providers, access challenges with referrals, relocation and geography, and inadequate DVA coverage and individualised care.
	Systemic factors—Broader challenges with navigating and transitioning between Defence, civilian, National Disability Insurance Scheme (NDIS), and DVA systems.
	Dissatisfaction with treatment—experiences of inadequate or dismissive care, confidentiality breaches, poor record handling, and degrading or misogynistic encounters in military and civilian systems.
	Awareness of entitlements and services—veteran and provider degree and source of knowledge of available supports for pain recovery/management/compensation.
	The weight of self-advocacy—the importance, cognitive load and emotional strain of self-advocating for needs in complex healthcare systems.
3. Perceptions of and experiences with DVA	*Perceptions of and experiences with DVA*—mixed interactions shaped by card type, service-related evidence requirements, system mistrust, slow and stressful processes, overtreatment concerns, and rehabilitation consultant experiences.
4. Recommended facilitators for optimal healthcare	*Recommended facilitators for optimal care*—inclusive access to effective, holistic pain management, trauma-informed and gender-specific care, peer support, and increased female veteran-focused services.
	Provider preferences—desire for clinicians who are ADF culturally competent, attentive and validating communicators, female or women's health specialists, and who offer consistent, long-term care to support trust and therapeutic continuity.
	Recommendations for practitioner education—inclusive tools and training on military culture, DVA processes, women's health and service-specific stressors for chronic pain, tailored for both general practitioners (GPs) and allied health professionals.

Table 2 Themes and Subthemes Developed from Focus Group Analysis.

> Regimental Aid Post] because you had a busted whatever or a bit of niggly back pain (Participant 10, Army).

The military environment was described by numerous participants as a "boys club," where females were commonly degraded and ostracised. Adverse experiences included bullying, abuse, and misogynistic attitudes. Some participants related being "broken" both physically and psychologically during training, while many alluded to experiences of military sexual abuse and "pranks," which were not addressed by senior authorities.

Group members discussed feeling discouraged from seeking help due to the stigma of being labelled a "malingerer." There was a common perception that health needs were minimised or dismissed. Participants regularly described how they felt required to *"suck it up"* and continue on, due to the military obligation to comply with orders; they had to accept pain as part of the job. Ongoing impacts of this belief and stoicism on reduced help-seeking behaviour were shared by some and validated within groups.

The Complex Development and Progression of Chronic Pain

Group members commonly recounted how pain was initiated early in their military career, stemming from recruit training or early deployments. Many injuries recurred frequently, affected adjacent joints, and multiple surgeries or interventions were reported, suggesting suboptimal outcomes. Frequently, participants had experienced delays in obtaining a definitive diagnosis for prolonged periods of time before accessing appropriate treatment. These delays were often attributed to misdiagnosis, inadequate efforts to investigate aetiology, and a perception that minimal treatment standards were employed to reduce the burden of care for the providers.

> There's a big emphasis on just "Get them through. Treat them minimally. Don't make a big deal about it." Don't go for scans…because if you get scanned and there's anything, you're booted or it causes problems, so they kind of just push it under the rug and tell you to do generic stretches… (Participant 12, Air Force).

The complex interactions of comorbid physical and mental health conditions were discussed. Constancy of pain and inability to perform daily activities commonly led to feelings of depression, stress and anxiety, and a perception of not being believed intensified frustrations. Participants felt that many issues were "brushed off" by healthcare providers as symptoms of menopause, or age-related changes, making some participants feel disregarded.

Group members related how their pain experience seemed to be a "vicious cycle," discussing the flow-on effects of pre-existing health conditions, or resultant treatment side effects. Many participants experienced pain affecting adjacent joints over time. Often, prescribed medications had undesirable side effects, such as dependence, gastrointestinal symptoms, liver damage, and cognitive and mental health impacts. Although some were averse to taking medications due to adverse reactions, ineffectiveness, and personal choice, others took to self-prescribing additional over-the-counter medications. Weight gain was not only an undesirable side effect of certain medications but also related to reduced activity levels and inability to exercise.

> …it's…[w]hen you've got a lot of injuries, compounded injuries and then they can have an effect on one another as well. And then, you know, we…then we have potentially some weight gain, either from medication or the fact we can't move the way that we used to be able to. I found that… umm, that really affected my mental health… (Participant 19, Army).

Biopsychosocial Impacts of Chronic Pain

Chronic pain affected all aspects of participants' lives, ranging from psychological and physiological impacts to social and family interactions, as well as detrimental impacts on careers. Chronic pain impacted mood, leading to impatience, irritability, and feelings of desperation, as one participant claimed, "I just didn't want to live in that much pain" (Participant 2, Army). Participants described behavioural changes and social withdrawal, and pain impacted their ability to attend family functions and other social events. Sense of self was challenged, many participants reported a perceived loss of self-esteem and often felt a sense of personal inadequacy or worthlessness. The impact of pain on ability to exercise was an important issue. Exercise was seen by some as a means of stress reduction, and the loss of this coping mechanism was challenging as many struggled to find alternative activity. The loss of extreme military fitness and change to being unable to exercise was detrimental to sense of identity and mental wellbeing.

> [a]nd it's a grief thing as well, because you lose who you were…like when I had to stop running, it almost killed me because that was part of my identity…. We're trained, we're fit as anything, and then we get chronic pain and we have to stop doing what we did before and we love doing that stuff…I hate that! And…it changes your identity and there's a sense of loss that goes with that (Participant 17, Navy).

Difficulties were faced juggling work/life responsibilities, whilst managing pain symptoms simultaneously. Most participants felt a burden of responsibility, commonly putting their children's or partner's needs first, and neglecting their own health care needs. Trying to coordinate healthcare appointments with caring for dependants was challenging, with some emphasising the impact of child-care and respite arrangements and expenses on healthcare accessibility.

Group members described many experiences of perceived judgement and negative assumptions, not only from healthcare providers, but also from the general community. Some were based on a lack of understanding of military service stressors, and the assumption that only combat experience contributed to significant injury or they were "too young" to have experienced that degree of injury. Some participants also expressed the belief that there was a particular female-specific stigma of having PTSD, describing the greater societal acceptance of males being diagnosed with the condition than females contributing to "segregation of treatment."

Chronic pain was perceived as an invisible condition, and participants felt they were often treated with little empathy as the extent of their disability and pain was not apparent. Some attributed this to their stoicism in the face of pain—as two participants agreed, stating, "You just get on with it" (Participant 1, Navy) and "Yeah, we're women" (Participant 3, Navy). The perception of women being innately strong and resilient prevailed. This attitude persisted from military service, where the culture was to just "harden up."

> There's one thing I constantly hear. It's like "you've got such a high pain threshold", and yet every female veteran I know has a hugely high pain threshold and I don't know whether it's 'cos [sic] we had to suck it up and work through pain when we were in the military. But we're certainly not like the rest of the community (Participant 20, Air Force).

The consequences of pain impacted participants' career prospects, in both military and civilian situations. During military service, these women avoided seeking healthcare for fear of being downgraded, restricted from duties, or medically discharged. Some participants described current civilian situations where they were unable to work or had to change jobs to accommodate physical limitations. Many described the challenges of trying to balance a full-time job with attendance at healthcare appointments. This added stress to many participants, who needed to maintain the physical capacity to work, yet could not meet both work and pain management requirements. Some adopted unhelpful coping strategies in an attempt to manage chronic pain. These strategies included "topping up" prescribed medications with over-the-counter medications, exceeding prescribed doses, or excessive alcohol consumption.

Theme 2: Perceived Barriers to Obtaining Optimal Healthcare

Barriers to Obtaining Optimal Care

Various financial costs were identified as a potential barrier to obtaining optimal health care. Some participants described significant personal outlay for healthcare, either when claims were rejected, or having to pay up front followed by a prolonged delay in DVA compensation.

> If the claim is not approved, or…initial liabilities not accepted, like, straight away, then you're forking out. You've already been putting out of your private pocket to pay for all the appointments… and even with the approved claim with DVA, I've been told that unless a specialist request for MRI, then they're not gonna [sic] fund it (Participant 22, Navy).

Difficulty in finding a clinician with whom they could establish rapport and trust was a challenge. Group members collectively emphasised the importance of "getting the right fit" when it came to satisfaction with their healthcare provider.

Poor social support was identified as a barrier to accessing health care. Without adequate support and resources, participants struggled to find time to attend treatments, particularly around caretaking responsibilities, or had disappointing treatment experiences. Examples included attending appointments with children, organising transport home from a day surgery, or as one participant said, "He's still serving…he's good, but you're at home with the kids and you've got no network…you've got no idea where to turn to" (Participant 10, Army).

Various time restraints were seen as barriers, ranging from personal situations to systemic factors. The inability to attend all health care appointments while fulfilling work requirements was challenging. Others felt there was insufficient time during healthcare sessions to address complex needs. Delays in obtaining treatment were attributed to long wait lists to access healthcare providers or services, notably more difficult for rural participants. A frustration expressed by some participants was the multiple General Practitioner (GP) appointments required to renew referrals for ongoing treatment, particularly when accessing multidisciplinary care.

Group members in regional or rural centres expressed access difficulties, often having to travel to the capital city to see specialists or undergo surgery, incurring greater

travel and time costs. Some participants related how long drives to and from appointments would aggravate their pain, often negating the effect of treatment (e.g., physiotherapy). Numerous logistical challenges were faced when participants were required to relocate. Finding a new healthcare team was difficult, with little information available to assist, so participants depended largely on word of mouth or social media groups for advice. Some participants expressed a desire for a central data repository, so a new practitioner had access to their medical history, reducing need to retell their story yet again. These frustrations were associated with a lack of continuity of care and inadequate handover.

Participants shared frustration about DVA not covering some treatments, especially for managing complex health issues. They felt care was not person-centred and did not provide full, tailored support. Inconsistencies in approvals of service-related injuries, such as non-acceptance of a secondary condition related to a primary pain condition were discussed within groups. For example, acceptance of a low back condition for treatment, but not related joints such as the sacroiliac joint or hip. Discussions arose around limited available treatment options, in situations where participants found relief from alternative therapies not subsidised by DVA (e.g., massage), and a limited range of choice available in particular therapeutic options.

Participants felt their health care management was impacted by many providers not accepting DVA patients, as the DVA fee schedule deficit did not cover current provider rates. As one participant stated, "Some of them don't wanna [*sic*] see you under DVA because they don't wanna [*sic*] have to do the reports, the paperwork…they don't get paid as much, either" (Participant 20, Air Force). This limited specific health care options, as well as continuity of care, as expressed by one participant, "…my spinal surgeon had pulled the pin on DVA. So, he doesn't see DVA patients anymore. So that continuity of treatment has gone for me now" (Participant 1, Navy).

Systemic Factors

Group members faced challenges adapting to a new healthcare system after transition from ADF to civilian life. Emerging from the defence system, where healthcare is managed and funded by the ADF, participants often struggled to obtain a Medicare card and understand its function in accessing the public healthcare system. Many were not aware of the services available through DVA, and a number chose not to access DVA support. While improvements in the ADF discharge process were acknowledged by some—particularly those with more recent separations—limitations to the handover from defence to civilian systems were raised. Some participants emphasised that preparing early for the transition process was vital, as many ADF members felt unprepared to manage their own health care post-service.

Navigation of the different systems involved in obtaining healthcare often proved challenging, as one participant expressed, "So the public health system is not set up to really deal with someone with complex and chronic pain and…and, the red tape for getting things through…It just seems to be getting harder and harder" (Participant 20, Air Force). Some participants felt the public healthcare system was unable to provide sufficient access to services they perceived were necessary for dealing with the complexities of their conditions. One participant had been directed to the National Disability Insurance Scheme (NDIS) for individual services not covered by DVA. Although advocates are available through DVA to assist in the claims process, a reluctance to pay for this service was expressed by some, and dissatisfaction with advocates by others, due to perceived inconsistencies in information provided. Some participants enlisted family support to assist in dealing with DVA, as they felt unable to manage it themselves.

> But using an advocate, that's probably helpful for some people but they can't help with the day-to-day, you know, like, day to day things that if you do need—otherwise you've got to join their list and you're on their pile and that type of thing (Participant 15, Army).

Dissatisfaction with Treatment Throughout Defence and Civilian Systems

Some participants expressed dissatisfaction with the treatment they had received within both civilian and military settings. In the civilian system, they often felt that treatment was inadequate for their complex needs, as healthcare professionals did not understand the impact of military service. They perceived there was a lack of holistic treatment approaches, and lack of thoroughness in examination and diagnosis. They described situations where physical treatment approaches were basic, or cases where medications were prescribed with little education about side effects and safe usage. There was a perception that civilian GPs were too eager to prescribe medications as their primary treatment approach.

> I don't think I've ever had a physio or a doctor actually look holistically and go well, if you've had hip pain, what are your shins doing? What are your knees doing? How is everything linked and they just don't look at anything else. They just treat those symptomatically (Participant 12, Air Force).

Instances were described where patient confidentiality and privacy were not respected or maintained by other service members (e.g., medics), engendering mistrust and a perception that females were degraded as they were not part of the "boys club."

> And if you weren't in that little group of boys that was, like, in with the medic or whatever, nothing ever happened. Nothing was documented ...or your privacy would constantly be breached because he's in this particular group and made it up with this one (Participant 22, Navy).

Some participants described incidences where personal medical records had been lost or mismanaged. These included mention of missing military records, mismanagement of patient records during handovers, and occasions where their health condition had not been recorded. Numerous healthcare experiences were related, which group members felt degraded due to misogyny and sexist attitudes and often characterised by dismissive comments from male practitioners about "chick stuff," and attributing symptoms immediately to menopause or age.

Awareness of Entitlements and Services

Discussions revealed varied awareness of participants' entitlements and available DVA services. Group members collectively endorsed perceptions that providers often lacked knowledge of veteran entitlements, compensable DVA claims and available veteran services. However, on the positive side, participants' felt that a powerful source of information was through word of mouth, from other veterans, female veteran forums, and social media groups.

> If the GPs actually knew or had some sort of resource that showed them what is available for people on White Cards...They don't realise that they're eligible, and medication, that they're eligible for all that. I wasn't even aware that I could get free mental health until like, two years ago when someone told me (Participant 2, Army).

The Weight of Self-Advocacy

Group members reflected on the challenges of being active participants in their health care management, often needing to push for their needs to be acknowledged. Whilst some took on the role of self-advocate with passion, navigating systems and negotiating for care, many found this role exhausting in the context of "fighting" against the barriers while managing pain. As one participant shared, "...but, you know, when you're in pain...you don't feel up to, you know, standing up for yourself. It's just like, oh, here we go again" (Participant 17, Navy). The emotional and cognitive burden sometimes led to a sense of defeat or resignation, with individuals stepping back from pursuing services due to feeling overwhelmed.

Theme 3: Perceptions of and Experiences with DVA

Much discussion, both positive and negative, revolved around the DVA system. The DVA rehabilitation consultants were believed to be helpful by some participants, and seen as a facilitator to accessing appropriate care, while some expressed a desire for more female consultants, and a female-specific division of DVA that recognised their differing needs. Some participants shared feelings of mistrust for DVA as a system, and a perceived sense of bias in terms of gender make-up of the staff. They felt that females were not treated in the same manner as males. Group members perceived that many enquiries were met with the response that DVA had a large backlog of work, and some gave up on their enquiry due to impatience with waiting "on hold." In one group, it was proposed that the DVA Statement of Principles (i.e. legislations determining factors which can connect particular injuries, diseases, or death with service) was outdated and continued to be tailored to a male-dominated cohort, rather than adapting to recognise female-specific issues.

> I really think that the Statement of Principles haven't been updated in regards to a lot of the Women's Health issues. And we...we've sort of tried to fit into the same category, but obviously we've got other issues. Our...our pelvis is different. Our hips angle a different way...I know a lot of female veterans with hip issues that haven't got through DVA because it doesn't fit into the Statement of Principles. What has been written for a man (Participant 18, Army).

Group members compared the entitlements they had depending on their card type. It became evident that some had little understanding of their entitlements, whilst others were grateful for Gold Card status, a status admittedly envied by some. Group members often struggled to obtain sufficient supporting evidence for the DVA claims process to prove the connection between their pain and military service.

> You know, I had a psychiatrist tell me when I was putting in a claim for PTSD and I asked him for the reports that DVA had requested. He said 'I sent them a letter. What more do they want? They can just deal with that'. So, in effect, stopped me from claiming because I couldn't get reports from him, so I had to find another psychiatrist that did

> understand the DVA forms and was happy to do them (Participant 20, Air Force).

Collectively, the DVA claims process was perceived to be a slow and stressful experience. Participants felt they constantly fought for acceptance of many claims, often feeling despair and frustration with the extensive delays, as one participant stated, "We shouldn't have to fight, fighting to get treatment to be accepted is more detrimental to our health and our physical and mental health than anything else" (Participant 2, Army). Observations were made about instances of overtreatment or providing unnecessary healthcare services (e.g., not reasonably required for the patient's condition) because of DVA status, where appointments were repeatedly scheduled merely because practitioners were able to charge DVA. This perceived financial exploitation of the system (i.e., billing for services or equipment not justified by the patient's needs or preferences) was predominantly the case if the individual had a Gold Card.

Theme 4: Recommended Facilitators of Optimal Healthcare

Recommended Facilitators for Optimal Care

Group members shared strategies or services they found beneficial for their personal pain management, including individual coping strategies or activities, as well as community resources and supports. These encompassed veteran specific medical centres, counselling services, connection with ESOs, and online educational modules. While most participants noted engagement with pain specialists, few disclosed awareness of available persistent pain management multidisciplinary services. Group members emphasised the importance of building a regular multidisciplinary team with coordination support to manage complex needs, with several valuing opt-in services that checked in with them between appointments.

Allied health services were found to be beneficial, and gentle treatment approaches, such as stretching and hot packs, were supported. Walking was advocated as both a physical and psychologically beneficial activity. Some participants shared that cognitive behavioural therapy (CBT) was reported to be of benefit for pain management, and group therapy sessions for mental health provided an avenue for support and motivation from peers. Other beneficial activities volunteered across groups included yoga, massage, acupuncture, hydrotherapy, and natural substances such as magnesium and prescribed cannabis medications.

Most participants expressed a desire for more trauma informed health care that takes into account gender differences in military experiences. For example, having mixed gender groups in PTSD treatment programs may create barriers for some female veterans who have experienced gender-based trauma (e.g., military sexual abuse) or feel uncomfortable around male veterans due to military culture perceptions (e.g., the perceived "boys club" mentality). A desire was also expressed for female-veteran-only spaces and forums, where peer support was important.

> You know, female forums for female vets. I know I went to one…and the entire room, seriously, must have had very similar experiences. Yeah, I think there's comfort from that too, for women. Because then you don't feel so alone. You just feel like, you know, that there's other people that can identify with your experiences and…I think that's really good for mental and physical health. Definitely (Participant 18, Army).

It was expressed that more female focused support is required within the DVA. Having support from good advocates, family, friends, and other female veterans facilitated access to appropriate care.

Provider Characteristic Preferences

Certain characteristics in healthcare providers were perceived as important in improving the healthcare experience. Many group members expressed a preference for seeing a female practitioner, or one that had a greater knowledge of women's health needs, particularly in relation to military stressors on the body. Participants emphasised the importance of clinicians' listening skills; being heard, understood, and believed. All participants expressed a strong preference for providers who had a military background, or a high degree of military cultural competency. That is, they valued a common language and knowledge of military roles, and greater awareness of available veteran-focused services and the DVA system.

> So, I managed to get in and see him, and like I said there was that instant connection because he's like, 'Okay, I understand what you went through, the training' and all that kind of stuff. And that understanding is really, really good, that really, really helps (Participant 2, Army).

Overview of Suggestions for Practitioner Education

Finally, group members were invited to provide thoughts and ideas regarding the content of an education module to be developed as an outcome of this project (Table 3). Participants emphasised the need for education in military cultural competence to understand both predisposing pain

DOMAIN	RECOMMENDATION
Design and format	Checklist of (female) veteran-specific questions that should be asked as a component of a primary intake assessment
	Video format with case scenarios
Content	Resources and services available for veterans on White Cards
	The extent of female involvement in specific military roles, basic training regimes, combat, etc., and considerations required to accommodate for female physiological, biomechanical, and ergonomic differences
	Military-specific stressors on the body, tailored to each service branch and specific job roles
	Understanding of compensable DVA claims processes
	Greater women's health knowledge and impact of pregnancy, hormones, etc. on pre-existing injuries
	Current pain management protocols and treatments
	Overview of military culture and lifestyle
Implementation	On-boarding training module to prepare clinicians for treating veterans
	Extend scope and target to not only GPs, but Allied Health professionals as well

Table 3 Participants' Suggestions for Development of an Educational Resource for Healthcare Professionals.

experiences and systemic factors required to coordinate access to optimal holistic healthcare.

DISCUSSION

This study explored the impact of chronic pain on the lives of female ADF veterans and their experiences obtaining appropriate health care. Our analyses closely aligns with previous work exploring veteran experiences with healthcare provision after transition in a predominantly Australian male veteran population (Ross et al., 2023), which describes similar themes, including systemic issues, difficulties finding appropriate clinicians, additional load on veterans (e.g., stress, time, financial costs), difficulties with transition from military to civilian healthcare, and feeling disregarded. Our study expands on these previous findings by providing a female veteran perspective and identifies female-specific issues, an important knowledge gap in the Australian context.

These reported military service experiences reflect many female veterans' experiences universally (Dubourg, 2024; Godier-McBard et al., 2022; Godier-McBard et al., 2023). As females take up more challenging roles in the military, they face greater occupational challenges in a traditionally masculine military culture. While they may wear the same uniforms, the female veteran identity forms and grows within a different intersectional experience of cultural oppression, as study participants highlighted in their perceptions of the impact of the boys club mentality on their health care management (Meade, 2020). Despite greater injury rates, help-seeking behaviour in female veterans is impacted to a greater degree by military culture, particularly as seeking support within military populations is associated with stigma (Sharp et al., 2015).

International literature widely describes the added stigma with being a woman in the military, and the negative reactions to women voicing in-service, gender-related harassment and discrimination, leading to reluctance to also seek help post-discharge (Burkhart & Hogan, 2015; Eichler, 2022; Godier-McBard et al., 2023; Ul Haq et al., 2024). Veterans organizations should adopt an intersectionality framework to better understand and support women veterans' diverse identities and experiences. This approach would promote inclusion, inform health and mental health services, and guide policies contextualised to the broader barriers women veterans face beyond their service records (Meade, 2020).

Many logistical barriers to obtaining appropriate health care described by these participants, including long wait times to access care, geographical location, difficulty getting time off work, childcare provision, as well as a lack of awareness regarding how and where to access help and eligibility for treatment, are similarly reported in numerous studies (Godier-McBard et al., 2023; Ul Haq et al., 2024). Although not specific to female veterans in our current health care climate, these factors are impacted further by both clinician and veteran lack of knowledge about eligibility for DVA support, available veteran-specific resources, and difficulties navigating civilian healthcare systems. Additionally, an important aspect of optimal care for these female veterans is clinicians with a military background, who have an understanding of the traumas and stressors these women faced during service.

Failure of healthcare providers to acknowledge, understand, and manage sociocultural variations in

the health beliefs and behaviours of their patients may impede effective communication, affect trust, and lead to patient dissatisfaction, non-adherence, and poorer health outcomes (Betancourt & Green, 2010), and the relative proportion of clinicians with a military understanding in civilian society is likely low. This preference is also reflected in U.S. studies, where factors influencing female veterans' use of the Department of Veterans Affairs (VA) healthcare services include concerns about limited privacy, poor quality of care, and limited availability of clinicians with training or experience in serving veteran populations' healthcare needs (Evans et al., 2019; Street et al., 2009; Washington et al., 2006).

Delays in definitive diagnosis and treatment was often attributed to clinicians dismissing symptoms as being related to menopause or hormonal issues. Some studies have suggested that this implicit gender bias in healthcare interactions may occur when providers rely on assumptions associated with patient demographics (e.g. age and gender) to quickly fill in the gaps that may be relevant to diagnosis and treatment (Mattocks et al., 2020). Female U.S. veterans have raised the same concerns as our Australian cohort (Rose et al., 2022). Hence, to address the perceived preference with providers with greater expertise in women's health and to reduce gender bias in care, Australian veteran services could adopt elements of the U.S. VA model. The VA improved the quality and availability of women's health providers by introducing policies, including gender-sensitive education of primary care providers regarding female veterans' health issues, and recommended that primary care for female veterans be delivered by a designated provider who is proficient in women's health (Mattocks et al., 2020). In fact, recent Australian recommendations addressing sex and gender bias have emphasized the need for introducing and continuing culturally sensitive training for healthcare professionals, and more education that ensures sex and gender awareness in quality of care for all health professionals (Kirkman et al., 2024).

The biopsychosocial impacts of chronic pain were associated with disruption to coping strategies, social and family interactions, as well as detrimental impacts on careers. The common stereotypical role of the female being the primary caregiver in the family created challenges for these women in balancing family life and work requirements. Similar challenges are reported in international studies, where the disproportionately larger caregiving roles, leading to shifting focus of personal care away from the female veterans, continues after service (Eichler, 2022). Some of these issues may also be associated with the lack of social support networks, which may be partially addressed by improving awareness of community services for current serving members prior to discharge (Feldman et al., 2007). The challenges for women with chronic pain of this gendered organisation of family care are also evidenced in other socioeconomic groups (Rice et al., 2024), emphasizing gendered vulnerabilities in healthcare, social services and society in general.

The loss of identity when returning to civilian society, complicated by the impact of pain on their sense of self described by our cohort, which was associated with grieving and feeling unsupported, invalidated and unappreciated for their service, is not unique to Australian female veterans (Jones, 2018; Street et al., 2009). Women's sense of self and belonging can influence how and when women seek health care, and which services or support networks they access (Crompvoets, 2011). The fact that women have only relatively recently been exposed to combat may influence some sectors of the general public's acceptance of women as veterans, inaccurately perceiving that women are not "real veterans" or are not exposed to "real danger" relative to veteran men (Hardy, 2022); assumptions that participants felt influenced providers not taking their pain experiences seriously. Over time, with growing advocacy and policy changes for contemporary Australian female veterans (e.g., Women Veterans Australia and Women Veterans' Policy Forum) these historical perceptions may be addressed.

The DVA system was not only perceived as challenging to navigate but also tailored to a male-dominated clientele. Relatively recent improvements have been made, with veteran support officers now available at ADF bases to provide support and guidance on the transition process (Department of Veterans' Affairs, 2020). The Provisional Access to Medical Treatment trial was introduced, in which eligible veterans could receive medical and allied health treatment on a provisional basis for commonly accepted conditions while their claims were being considered (Department of Veterans' Affairs, 2021). Additionally, a Women Veterans' Policy Forum endorsed by some study participants was introduced in 2016, which is attended by female veterans and community representatives, providing a platform for female veterans to raise issues with the Australian Government and DVA and to facilitate communication between DVA and the veteran community (Department of Veterans' Affairs, 2024).

Our findings are closely aligned with a previous report (Crompvoets, 2021), which identified similar barriers to accessing support services, gaps in available information, resources, and DVA policies for female veterans. This report also identified a lack of understanding of the veteran identity, lack of trust in confidentiality of DVA funded services and claims processing, stigma associated with mental health issues and treatment seeking, and lack of understanding by civilian healthcare service providers

about trauma exposure and female-specific issues. One recommendation from this report further reinforced by our study included providing training to civilian healthcare providers on issues for female veterans.

Various publications have attempted to provide basic background principles for Australian GPs (Wallace et al., 2021), various training programmes have been developed, and DVA resources and e-Learning for GPs assist health providers to understand the military experience and maintain clinical best practice through their clinical practice software. However, gender-specific pain education resources are limited. This study provides insight into unique female-veteran lived experiences and care needs that will be incorporated into an online educational resource for primary and multidisciplinary providers involved in female veteran chronic pain management to improve service quality and implementation.

LIMITATIONS

Although supporting current female veteran literature, there are limitations to this study. The personal experiences of our cohort cover diverse time eras, and different legislative policies were in place. Since their military service and transition experiences, the ADF and DVA have attempted to address some identified problems in the management of the transition process, and the recent Royal Commission into Defence and Veteran Suicide has provided 122 recommendations for systemic change and improvement (Australian Government, 2024). This must be taken into consideration when interpreting these results, as more contemporary female veterans may relate more optimal experiences as a result of these initiatives. The sample size of this study is small and Queensland restricted. Queensland is home to the highest proportion of ADF veterans (Australian Bureau of Statistics, 2022) and findings are only representative of these participants, thus cannot be generalised to the wider female veteran population. There is also the possibility of recruitment bias, as participants with strong opinions may be more likely to participate in qualitative research.

CONCLUSION

Female veterans require health services that understand their unique needs. Findings from this study provide a female veteran perspective on the challenges faced in obtaining optimal healthcare for chronic pain and their thoughts on how health care could be improved. A strong desire for better education for healthcare providers and tailored support for female veterans emerged. To address this, the recommendations from these female veterans will be implemented to inform the development of an educational resource grounded by female-veteran-specific lived experience case examples and tailored clinical resources, enabling primary and multidisciplinary providers to implement more responsive, equitable, and effective chronic pain management. Future research is forthcoming on the development, implementation, and evaluation of the resultant educational resources translated from this research.

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COMPETING INTERESTS

The authors have no competing interests to declare.

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