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TREATING TRAUMA IN SPECIAL POPULATIONS: LESSONS FROM WOMEN VETERANS

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Despite high rates of victimization in women, life-threatening trauma in women veterans has been largely overlooked. The experiences of this special population, while distinct in some respects, also relate to the clinical care of women trauma survivors in general. Histories of women in the U.S. military and data from clinical settings suggest that women veterans confront various life stressors both within and outside the military context. The extent and effect of these experiences on adjustment and their implications for treatment of women survivors, however, have not been systematically explored. This article describes the planning and evolution of one of the first specialized PTSD programs for women veterans. Larger numbers of traumatized women veterans are likely to seek mental health services over the next decade. Attention to their unique experiences and those of other special populations can significantly influence the care provided to female trauma survivors in general.

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There is growing evidence for the interactive and cumulative effects of various forms of major life stress (Breslau et al., 1991). Women who experience trauma are at increased risk for a spectrum of subsequent revictimization (Breslau & Davis, 1992; Resnick et al., 1992). In addition, exposure to trauma is likely to impact multiple domains of functioning. For example, studies examining civilian trauma in women have noted that two significant effects of victimization are markedly increased rates of health complaints (Wolfe et al., 1993) and the subsequent overutilization of medical health resources (Koss, Woodruff & Koss, 1990).

Despite increasing interest and knowledge surrounding post-traumatic stress disorder (PTSD; Breslau et al., 1991; Davidson & Foa, 1991, in press; Norris, 1992; Wolfe & Keane, 1993), attention to trauma in women veterans has been notably lacking (Wolfe, 1990). This is surprising in light of the National Vietnam Veterans Readjustment Survey's recent finding that 8.5% of female Vietnam theater veterans suffer from war-related PTSD while an additional 7.2% show partial symptoms of the disorder (Kulka et al., 1988, 1990). Preliminary reports from Operation Desert Storm already suggest that some subset of female personnel from that conflict currently suffer from stress symptomatology related to a broad spectrum of experiences during their military or wartime service (Rosenheck et al., 1991; Wolfe,

Brown & Kelley, in press). Furthermore, these figures do not reflect the considerable rates of other major psychological disturbances associated with war-zone exposure in these women (Cooke et al., 1992; Kulka et al., 1988, 1990) or the incidence of noncombat-related PTSD (Van Devanter & Morgan, 1983; Walker, 1985).

The issue of traumatic stress in female veterans is important given the vastly increased numbers of women who now serve in the United States Armed Forces. Women today constitute nearly 4.5% of the total veteran population and over 10% of the active duty force compared to 2% during World War II, and there are indications that these rates will continue to grow (Dienstfrey, 1988; Wolfe, 1990). Although empirical data have begun to demonstrate the prevalence of war-related stress in women veterans (*e.g.*, hazardous occupational exposure; Dienstfry, 1988; Wolfe et al., in press), further data on both wartime and life (*e.g.*, physical assault) traumatic exposure are now needed for clinical diagnostic and treatment purposes.

Several factors may account for the lack of progress to date in studying trauma in women veterans: These include the reluctance of some women to report traumatic events, clinicians' resistance to inquire about them, limitations in existing mental health resources, and a legal-societal context that is often unsympathetic to the needs of victims and survivors in general (Koss, 1990; Wolfe, 1990). For female trauma survivors, reluctance to seek mental health assistance and clinicians' corresponding lack of familiarity with survivors' experiences, especially those of veterans, may also contribute to the narrowed scope of psychological care (McVicker, 1985).

In this article we describe the development of one of the first psychology-based outpatient PTSD program for women veterans and offer data to illustrate various clinical characteristics and needs of this population. Although the discussion emphasizes experiences faced by women veterans (*e.g.*, life threat in the war zone; extensive exposure to death and dying; sexual assault), analysis of clinical material and pilot data reveal a broad range of trauma across the lifespan. Many of the issues raised here have implications for the larger segment of women (and men) who meet with catastrophic stressors in the course of their lifetime (*e.g.*, criminal assault, natural disaster, accident survival; Kilpatrick et al., 1985; Kilpatrick & Resnick, in press; Koss, 1990).

Program Development

To begin to examine the needs of this minority group, the Women Veterans' PTSD program at the Veterans Affairs Medical Center, Boston[1] was developed. Recognizing the importance of comprehensive evaluation and treatment of trauma, this program emphasized clinical services related to life stressors and accompanying symptomatology across all life periods. Clinical data were systematically gathered using interviews and tests largely developed for use with male veterans since, with the exception of recent developments in the area of rape (Kilpatrick & Resnick, in press), few psychometric instruments exist for delineating components or sequelae of traumatic stress in women and female minority populations in particular (Breslau & Davis, 1992). Instruments used included the Mississippi Scale for Combat-related PTSD (Keane, Caddell & Taylor, 1988) and empirically derived PTSD scales of the MMPI/MMPI-2 (Keane, Malloy & Fairbank, 1984), tests increasingly shown to yield quantifiable estimates of PTSD symptomatology in a variety of populations (Wolfe & Keane, 1993).

Since most of the available PTSD instrumentation has been developed with men, there are serious issues around the valid use of these measures with women. In fact, input from women during earlier clinical contacts indicated that a number of semantic changes in certain psychometric instruments and interviews were necessary to render some items salient for this population. For example, the wording on two Mississippi Scale items was modified when it was found that certain adjectives and descriptive item phrases did not elicit endorsement despite the presence of a particular symptom. In addition, it was necessary to modify the assessment to include examples that were more representative of women's unique stressor experiences (*e.g.*, military trauma). To accommodate this, a comprehensive war-time exposure scale was developed that was based directly on the experiences of women veterans (Wolfe, Furey & Sandecki, 1989; Wolfe et al., in press). This was necessary since war-zone exposure has characteristically been defined on the basis of men's combat (*i.e.*, infantry) activities (*see, for example*, Keane et al., 1989). Preliminary analyses of

[1] In 1991 the Veterans Administration was formally renamed the Department of Veterans Affairs.

the new scale's psychometric properties in fact showed that women's Vietnam war-time exposure contained two broad dimensions not systematically quantified or delineated in prior research, one of which may have been specific to women veterans' vocations (*e.g.*, exposure to life-threatening or horrific medical environments; contact with the dead and dying) and another which relates more directly to women's experiences in contemporary American society (*e.g.*, severe harassment; physical and sexual assault; Wolfe et al., in press). The latter incidents, increasingly found in the general female population (Breslau et al., 1991; Norris, 1992), were also investigated through a number of structured interviews and checklists currently used to assess PTSD and other Axis I diagnoses in veterans (*e.g.*, the Boston Structured Interview for PTSD; the Structured Clinical Interview for DSM-III-R; Spitzer & Williams, 1985; *see* Wolfe & Keane, 1993 for a review). The broad diagnostic scope of these instruments facilitates the detection of the subtle and cumulative correlates often associated with traumatic stress.

Preliminary Clinical Findings

This section presents preliminary descriptive data on an initial subset of nine female veterans seeking outpatient services through our program. The women typify our larger program sample; their data were chosen to focus attention on important clinical features. All of the women described are veterans from the Vietnam War or post-Vietnam era. One Vietnam veteran also served during the Korean conflict. Although the data must be considered preliminary based on the small size of the sample, they appear to address a number of concerns in dealing with the spectrum of female survivors. In addition, the findings highlight the need to delineate characteristics of special trauma populations.

During the evaluation phase, four of the women in our sample identified war-zone stressors (*e.g.*, exposure to rocket or mortar attack; recurrent contact with grotesque dismemberment; life/death decision-making activities) as the primary source of lifetime trauma. Despite military service, the remaining five women delineated primarily non-war–related trauma (*e.g.*, rape; incest) which had occurred at other points in life. Regardless of trauma etiology, psychometric assessment using the Mississippi Scale showed that all of the women scored well into (and, in some cases, above) ranges previously established as clinically significant for treatment-seeking male combatants with the PTSD diagnosis (Keane, Caddell & Taylor, 1988; Kulka et al., 1990). Several of the women had scores commensurate with those of male veteran PTSD inpatients. Women with histories of exclusively military trauma (Group 1) scored significantly higher on the Mississippi Scale ($M = 127$, $SD = 3.92$) than their counterparts with non-war–related trauma (Group 2; $M = 111$, $SD = 8.08$; $t(6) = -3.56$. $p = .012$), suggesting that the women with war trauma were experiencing considerably more PTSD symptomatology at the time of evaluation. This finding contrasted sharply with clinician-based interview data that focused more extensively on behavioral parameters of adjustment. For example, interview data showed that women with military versus non-military trauma had substantially lower rates of unemployment secondary to psychiatric problems (0% vs. 80%) and noticeably lower levels of acute inpatient psychiatric intervention in the past two years (0% vs. 60%). Overall, these findings highlight the fact that symptoms may be manifested in varying ways and that a broad range of assessment tools are needed to identify the presence of traumatic stress symptomatology in different populations.

Although examination of MMPI-2 profiles revealed no noteworthy differences between the two groups, both sets of women veterans showed very marked clinical elevations and significantly elevated *F* scales (*see* Table 1). For the women in Group 1 (war trauma), the modal profile was 8–6–4–2; for the non-war trauma subjects, the modal profile was 8–2–7–6. Both of these profiles, including the degree of elevations are similar to those found in many male combatants diagnosed with PTSD (Keane, Malloy & Fairbank, 1984) as well as other highly symptomatic diagnostic groups, *e.g.*, borderline personality and paranoid disorders (Widiger, Sanderson, & Warner, 1985). Evidence of PTSD symptomatology was further confirmed by scores on two empirically derived MMPI-2 PTSD subscales, PK and PS (Group 1: 33 and 46, respectively; Group 2: 29 and 41, respectively). All of these scores fall well above PTSD cutoff points suggested for use with both veteran and civilian trauma populations (Wolfe & Keane, 1993) and, in some cases, exceed typical outpatient ranges based on male samples. There were no significant differences between the two groups of women veterans on these

TABLE 1. Mean MMPI-2 Scores for Trauma Groups

Validity, Clinical & Content Scales	Nonwar Trauma *t* Scores (*N* = 5)		War Trauma *t* Scores (*N* = 4)	
	Mean	*SD*	*Mean*	*SD*
L	57.80	15.53	52.00	13.93
F	97.80	25.29	90.00	21.18
K	39.40	2.97	38.50	6.76
1	73.40	15.14	66.75	10.78
2	78.60	11.08	80.50	13.60
3	73.20	18.82	63.50	12.37
4	71.00	10.56	83.25	9.18
5	46.60	15.14	53.50	17.46
6	75.40	16.37	84.25	11.44
7	78.20	7.46	81.25	14.89
8	81.40	11.89	88.00	18.24
9	55.00	14.77	65.00	6.78
0	68.40	6.03	68.25	12.42
PK	81.40	5.81	87.25	9.50
PS	82.60	4.39	87.75	8.06
TRT	78.60	9.92	81.00	7.26

subscales. Finally, both groups of women scored in the clinically elevated range on the Treatment Response Scale of the MMPI-2 (*t*'s = 81 and 78.6 respectively). These profiles suggest that these individuals are experiencing marked levels of clinical distress, perceive life change as difficult, are pessimistic about their ability to engender positive change, and may be resistant to the usual forms of treatment intervention. However, until these results are confirmed using a larger sample, the small number of participants limits the generalizability of these findings.

Implications for Treatment and Service Delivery

To date, attempts to provide PTSD services to women have met multiple obstacles. For example, women themselves may not readily recognize the impact of stressor exposure on their functioning or the opportunities afforded by appropriate mental health intervention. Furthermore, tendencies to minimize are often reinforced by clinicians' failure to discuss or inquire about these events. This may be additionally problematic when women present initially as functional in their family, professional, and community involvements. However, as pilot data suggest, women who appear high functioning in some contexts may also suffer from considerable stress-related symptomatology, highlighting the need for informed and comprehensive assessment of PTSD.

For many trauma survivors, the avoidance characteristic of PTSD affects utilization of care. Avoidance of feelings and settings that arouse traumatic recollections is a common phenomenon, often interpreted as ambivalence about treatment. Women survivors with concerns about social intimacy may actively avoid many public or group settings. In addition, behavioral avoidance may be seen in women veterans who were previously exposed to trauma through medical or nursing professions. In these cases, seeking services within large medical centers that serve primarily the seriously ill or severely physically handicapped has often proved intolerable. All of these examples highlight the need to consider innovative methods in delivering clinical services, whether through the use of alternative treatment settings (*e.g.*, administrative wings; satellite clinics or offices) or through active supportive outreach to diminish factors that otherwise obstruct the search for care.

Other personal and situational factors create obstacles in caring for some trauma survivors (Koss, 1990). For example, experience with women victims shows that occupational identity may affect utilization of treatment. Considerable numbers of women are professional caregivers (*e.g.*, nurses; health care specialists) with high levels of competence and accomplishment; many of these women also maintain strong professional identities. As a result, some victimized women find it difficult to acknowledge a personal need for assistance, feeling guilt or discomfort around the issue of seeking help. In some group therapy settings, women who identify with a caretaker role may move insistently into a supportive or group facilitator capacity, even assuming the position of co-leader. If not addressed therapeutically, these issues can undermine sincere efforts to seek out and receive needed psychological treatment. Providing that these issues are resolved, group formats can help lessen feelings of uniqueness, guardedness, and social isolation that female victims often feel. Relatedly, group contexts appear to be especially useful with women veterans who experience considerable isolation from their peer group during or following military service. In addition to group therapy, individual therapy is likely to be especially beneficial early

in treatment in cases where women veterans, similar to other female survivors, are struggling with public disclosure of past behaviors or actions (Herman, 1992).

Situational factors which influence the delivery of care may vary in special populations. For example, anticipating a lack of institutional concern, the majority of women we describe had never previously sought services through the VA system although some percentage had received treatment elsewhere (Blodgett, 1991). However, because the development of specialized PTSD units for women is still in its infancy, many women are admitted to existing acute inpatient psychiatric units where PTSD is not a prominent focus and where unit staff are unfamiliar with the background experiences of women survivors. Consequently, most women that we saw reported that their traumatic experiences received little or no systematic attention. In two cases involving veterans, women recalled being told that military-related events and military/war trauma were not appropriate focuses for their treatment because these topics fell outside the clinician's purview or beyond their expertise. As a result, women coming to our program had generally not discussed critical elements of their backgrounds in prior treatment, reflecting considerable fragmentation of care.

Furthermore, in settings like the VA, women may face additional constraints by being admitted to units that are predominantly male and where PTSD treatment is oriented toward traditional definitions of military (*i.e.*, combat) stress. Thus, for a variety of reasons, the trauma histories of women veterans, like civilian women (Dill et al., 1991), may go undetected. This situation can affect both diagnostic and treatment procedures. In terms of assessment, failure to inquire about trauma can lead to the mislabeling of symptoms and skewing of diagnoses, a serious concern when diagnoses of personality disorder are substituted for PTSD (Herman, Perry & van der Kolk, 1989; Rosewater, 1985). These observations clearly suggest that further intensive education and training relating to specific characteristics of various trauma populations should remain a high priority for both public and private sector mental health professionals.

Given barriers that deter women survivors from seeking services, outreach efforts may require extensive and innovative efforts. For example, with female veterans, this has included attending women veterans' social and commemorative functions, providing community workshops, and placing advertisements and posters in highly visible places. Still, peer referrals and repeated outreach efforts are likely to be necessary for women who show even initial interest.

Future Directions

Mental health professionals in the private sector are increasingly likely to see minority populations including women veterans. Statistics compiled by the VA, for example, show that women veterans, like their male counterparts, utilize VA resources at very low rates (Blodgett, 1991; Fontana et al., 1990; Veterans Administration, 1990). This finding increases the chances that some percentage of women veterans will turn to private practitioners for psychological assistance (Government Accounting Office, 1992). As this article suggests, the issues faced by this population include a broad range of individual and psychosocial factors that are frequently congruent with women survivors' experiences in general, *i.e.*, fears of stigmatization, humiliation, isolation, and disbelief. Similar to other special populations, specific consideration will need to be given to their unique background experiences and stressors, especially when the clinician is unfamiliar with such events (*e.g.*, deployment-related stressors). In such instances, the complex needs of these populations are likely to require careful inquiry to elicit problem areas that might otherwise be overlooked.

Recent research continues to validate high rates of victimization across various populations (Norris, 1992). To ensure appropriate delivery of services, outreach will remain a critical vehicle for accessing these individuals, particularly in cases where symptomatology is obscured by seemingly successful vocational and social adjustment. Further development of specialized treatment settings, clinical outreach methodologies, and professional education serves the dual function of increasing psychological services to women and women veterans while enhancing practitioners' awareness and sensitivity to the long-range impact of unresolved trauma in diverse groups.

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