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# Treatment of Women Veterans with PTSD

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Julie Boucher is a senior majoring in Psychology and minoring in Social Welfare. Her

research on women veterans with posttraumatic stress disorder was completed under the mentorship of Dr. Arnaa Alcon of the Social Work department. This research is a continuation of work presented at the 2012 National Conference on Undergraduate Research in Ogden, UT ; and was recently presented at the 2014 National Conference on Undergraduate Research in Lexington, KY. Julie is thankful to her mentor and the staff of the Office of Undergraduate Research for providing her with the opportunity for personal and academic growth.

**T***his study addresses the question, what is the most effective treatment method for female veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) diagnosed with Post Traumatic Stress Disorder (PTSD)? Female veterans experience unique difficulties when dealing with symptoms of PTSD that their male counterparts do not. Some of the causes of their PTSD are different as well. Evidence suggests that treatment programs should be developed in a manner that tailors to gender-specific needs. This research consisted of a thorough review of the literature, including peer-reviewed articles.-*

The purpose of this research is to evaluate the top three conventional treatment methods for veterans with PTSD and analyze them according to the particular needs of female veterans. The top three treatments are addressed in detail. Prolonged Exposure Therapy (PE) and Cognitive Behavioral Therapy (CBT) are the most widely used therapies by the Veteran's Health Administration (VHA) for female veterans of OIF and OEF with PTSD. Eye Movement Desensitization and Reprocessing Therapy (EMDR) is close behind. PE consists of four major parts: psycho-education, breathing skills, real-world practice, and talking through the trauma repeatedly. CBT is a psychotherapeutic treatment that addresses dysfunctional thoughts and feelings that occur from PTSD. EMDR is a form of psychotherapy with eight phases, each dedicated to tackling the current symptoms and the triggers that the patient experiences.

Analysis of the research indicates that PE may be most effective for treating PTSD in women. In general, women are more receptive to treatments that involve talking about their emotions and interpersonal problems, which is the specific focus of PE. It helps to bring back memory of the trauma that may be missing, and it decreases many symptoms when successful. PE also costs less than other treatments and can be accomplished in a short amount of time, as little as one to three months.

Research on Posttraumatic Stress Disorder (PTSD) has mainly included male subjects. It is only recently that researchers are focusing closely on the unique aspects of females with PTSD, specifically female veterans. Interestingly, at the same time PTSD research was being conducted on male veterans of the conflict in Vietnam, those who studied women who had experienced sexual

assault found an almost identical symptomology (Vogt, D., 2007). That being said, it is widely known today that women who experience any form of sexual assault are at great risk of getting PTSD.

Women also may experience Military Sexual Trauma (MST) which the National Center for PTSD defines as “any kind of unwanted sexual attention, including insulting sexual comments, unwanted sexual advances, or even sexual assault” (NCPTSD, 2010). Studies have shown that military women are much more likely than military men to experience all forms of sexual harassment (Street, Gradus, Stafford, & Kelly 2007). Another aspect of PTSD that is much more prevalent among women than men is eating disorders. While eating disorders have not typically been considered a part of PTSD, researchers have found they are common in women with PTSD (Forman-Hoffman, Mengeling, Booth, Torner, & Sadler, 2012).

This literature review focuses on American female veterans of OIF and/or OEF who have been diagnosed with PTSD as a result of their military service overseas. PTSD is defined by the American Psychiatric Association (APA) in the Diagnostic and Statistical Manual of Mental Disorders, Fourth edition, Text Revised (DSM-IV-TR) as “exposure to a traumatic life event or string of events that brings upon symptoms such as intrusive recollections, avoidance/numbing, and hyper-arousal” (DSM-IV, p. 468).

Women’s roles in the military are rapidly changing. In 2013 Defense Secretary Leon E. Panetta lifted the ban against women serving in combat roles in the U.S military (Bumiller, Shanker, Connely, & Baker, 2013). Although women have only recently been authorized to hold combat positions they have been exposed to combat directly and indirectly in OIF and OEF, more than in any other war in the past. One study published in 2010 concluded that “OIF/OEF women were younger, received more hostile/friendly fire... than PER [Persian Gulf veteran] women” (Fontana, Rosenheck, & Desai, 2010, p.755). There is also evidence that women veterans of the Vietnam conflict were less susceptible to direct combat since they were behind clearly drawn enemy lines, whereas in Iraq and Afghanistan there are no clear lines; the enemy could be anywhere and everywhere (Turner, Turse, & Dohrenwend, 2007).

There are conflicting reports regarding the prevalence of PTSD among veterans, especially the specific population of female veterans who have served in OIF and/or OEF. For example, one nationally representative study reports that, regardless of gender, anywhere from 14.7% to 30.9% of returning military veterans have PTSD (Sundin, Fear, Iversen, Rona, & Wessely, 2010). Despite a lack of agreement on the prevalence rate, even

at the low end, estimates of frequency of the disorder demonstrate that significant numbers of women veterans are experiencing PTSD.

Female veterans have unique problems with PTSD. One result of PTSD among women can be the effect it may have on their parenting skills. As mentioned before, Military Sexual Trauma (MST) is much more common among women than men. As a result of MST, women are more likely to walk around with feelings of numbness and emotional detachment, and acting as if they do not care about the ones they love. These behaviors can have negative consequences for their children, for example, because children are too young to understand the symptoms and may internalize the lack of emotion as their mother not loving them.

When a woman experiences MST from a fellow soldier in her unit she feels betrayed. She has to protect herself not only from the enemy but from her “brothers in arms” next to her. This can also carry over to her parenting style, as she can become detrimentally over-protective of her children, attempting to compensate for when she could not protect herself (Mason, 2010). Society implies that women should refrain from showing aggression, so the angry emotions about what has happened often become repressed, until the woman cannot take it any longer and easily flies off the handle toward the people she loves. Often these women do not realize when they are yelling or what exactly it is they are yelling about, which can also have negative effects when directed toward their children. (Mason, 2010).

There are many reasons why PTSD is a problem in female OIF/OEF women veterans and why it is necessary to find a tailored treatment program for this cohort. For example, women are more likely to have experienced trauma pre-military, which leaves them open for and exacerbates a new military trauma. Women struggle more with interpersonal problems in a combat zone more so than men. “Gender harassment,” which is defined as “behaviors that are not sexually based, but are hostile or degrading and occur on the basis of one’s biological gender” are reported as a problem by many women (Street, Vogt, & Dutra, p. 690). Such behaviors often reinforce traditional gender roles and cause women to work harder than their male counterparts for the same recognition and respect of co-workers and higher-ups.

The lack of a social support system and positive interpersonal relationships within the military is also a problem primarily for this cohort, as sometimes they are the only female soldier in their company and are oftentimes overrun by a male presence. Some researchers have said that socially supportive relation-

ships in Iraq and Afghanistan are major resilience factors for interpersonal stressors (Street, et. al 2009).

Prolonged Exposure Therapy (PE) and Cognitive Behavioral Therapy (CBT) are the two most widely used therapies within the Veteran's Health Administration (VHA) for female veterans of Operation Iraqi Freedom and Operation Enduring Freedom. Eye Movement Desensitization and Reprocessing (EMDR) Therapy is a third empirically-supported treatment of PTSD. Various group and couples treatments also have been found to be effective. Researchers are now exploring various mindfulness techniques that can be incorporated into PTSD treatment, such as Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), Mindfulness-based stress reduction, Mindfulness-based cognitive therapy, and Mindfulness-based relapse prevention (Vuganovic, Niles, Pietrefasa, Potter, & Schmertz, 2011).

Prolonged Exposure Therapy (PE) is most commonly used as an intervention for patients with PTSD. One particular study (Tuerk, Yoder, Grubaugh, Myrick, & Acierno, 2011) goes as far as affirming that PE is especially helpful not only to veterans with PTSD, but specifically to those who have served in Iraq and Afghanistan and seek services in a VA hospital setting.

Prolonged Exposure Therapy (PE) generally consists of 90-minute sessions held once a week. Major components of PE are as follows: psycho-education regarding common reactions to the trauma one has experienced, along with a detailed description of the treatment; self-assessment of anxiety using subjective units of distress (SUD's), a common tool in the measuring of emotions; repeated *in-vivo* exposure to places otherwise avoided because of the trauma; and repeated, prolonged, imaginal exposure to traumatic memories, followed by the discussion of the memories (Tuerk, et. al, 2011).

*In-vivo* therapy provides exposure to any objects, activities, or situations that a patient may be anxious about due to the trauma. This exposure allows the patient to confront their anxieties head on. It is experienced through "homework assignments" given to the patient to complete between sessions. These assignments gradually expose patients to their fears in a safe process. For example, if one was shot, he or she might gradually be introduced to visiting a shooting range, as this is a common aversion for someone who experienced PTSD after being shot in the line of duty. In addition to the *in-vivo* session(s), imaginal exposure is done during weekly sessions. In these sessions, the patient re-visits the traumatic episode in their mind repeatedly, while talking through the experience with a counselor. This type of imaginal work becomes incredibly detailed and intense. Counselors guiding this therapy must approach the

details of the trauma cautiously with their patient, as the patient may pull away and become withdrawn. These treatment sessions are sometimes recorded by the counselor so the patient can review the recording in between sessions if they think it will help (Tuerk, et. al, 2011).

Research shows that PE has more evidence for effectiveness than any other therapy (Jackson, J., Thoman, L., Suris, A.M., & North, C.S. 2011). This consensus includes the fact that PE intimately targets the avoidance symptom cluster of PTSD that is so evident and debilitating. This is one of the main criteria for PTSD that causes the patient to avoid anything associated with the trauma and brings about emotional numbness that was not evident before the trauma (DSM IV, 2000). Anger and hostility are also symptoms significant to PTSD. In one meta-analysis of treatments for PTSD that specifically target anger-related problems it was discovered that PE was more effective in alleviating anger with female sexual assault survivors when compared to Cognitive Behavioral Therapy (CBT) (Galovski, T.E., Elwood, L.S., Blain, L.M., & Resick, P.A., 2013).

In 2011, Tuerk, et. al published a particularly strong evaluation study which examined the effectiveness of PE for this specific cohort. This was a large-scale study conducted by the Veteran's Health Administration (VHA). They found that many existing studies support the efficacy of PE for veterans, and the Institute of Medicine discloses that exposure therapies are "the only treatment approach with sufficient efficacy data for combat-related PTSD" (Tuerk et al, p. 397). Treatment retention was sufficient, suggesting that although this can be an intense therapy to go through, it is well handled by veterans with PTSD.

A second treatment for women veterans with PTSD is cognitive behavioral therapy (CBT), which focuses on "realistic thinking." A Greek philosopher, Epictetus, was quoted as saying "People suffering a major trauma are, it seems, disturbed in the long term, not so much by the trauma as by the consequent view which they take of themselves and their world" (Joseph, 2011, p. 31). This age-old interpretation stands as the basic principle behind CBT (Joseph, 2011).

PTSD is both an anxiety *and* a stress disorder; therefore, those affected face a vicious cycle. It causes more difficulty for the PTSD patient to deal with current stressors in their lives than the person who does not have PTSD. If the patient with PTSD is in a negative or anxious mood, memories of the trauma may arise, causing dysfunctional thoughts about oneself and the world surrounding them. CBT attempts to break this cycle by targeting the negative and dysfunctional thinking, and teaching the patient how to translate these thoughts into realistic thinking (Joseph, 2011).

In CBT, the patient self-reports their thoughts and behavior to the therapist. This is a structured counseling session with an agenda and various homework assignments. Homework assignments are created by the patient and therapist. These assignments target specific distressing and dysfunctional thoughts that the client reports, and are created with the purpose of modifying these thoughts into a more healthy, realistic way of thinking. Homework is always reviewed in detail during the next session. In CBT the therapist is always active “in helping the client by posing questions to evaluate critically the thinking that is leading to distress” (Scott & Stradling, p.32). This approach is the contrast of a psychotherapeutic approach as it is direct and emphasizes the present time. (Scott & Stradling, 1995).

There are many studies on the effectiveness of CBT that specifically target military veterans from Iraq and Afghanistan, yet as with many studies targeting these veterans, few are dedicated exclusively to women. The majority of studies tend to be only about men or about men and women together. An open trial of PTSD treatment presented in couple’s format was published in 2004. This was a Cognitive Behavioral Conjoint therapy, which was shown to improve the dynamics of the patient’s family and significant relationships. This is just one example of the evidence existing that CBT can improve family relationships (Schnurr, P.P., Lunney, C.A., Bovin, M.J., & Marx, B.P., 2009).

This form of CBT is specifically designed for trauma survivors, and has been proven effective in additional studies as well. These studies showed evidence of a reduction in negative trauma-related assessments and symptom reduction during trauma-focused CBT for PTSD (Kleim et. al, 2012).

Eye Movement Desensitization and Reprocessing therapy (EMDR) is another evidence-based treatment used to take care of veterans with PTSD, including this particular cohort of females, which consists of eight phases of psychotherapy. EMDR does not address the retrieval or remembrance of the trauma as Prolonged Exposure does. Instead EMDR targets current symptoms and triggers, as well as possible complications the veteran may run into in the near future.

The first phase of EMDR can be identified as “client history gathering.” This is when the therapist and client identify the presenting problem, as well as triggers and cognitive blocks that affect daily functioning. The second phase is client preparation. Here the client receives information about EMDR and how it may help them. This phase can sometimes become the gateway to something called adaptive information processing (AIP). AIP is defined as a process a client goes through that

helps them understand the normalcy of their reaction to trauma (Silver, Rogers, & Russell, 2008).

The third phase, assessment, provides a “baseline of the client’s disturbance that is used throughout treatment as a comparison tool” (Silver et.al, 2008). The fourth phase is desensitization, when bilateral stimulation is used, coupled with elements of the assessment phase. Typically bilateral stimulations such as eye movements, sounds, and physical taps are used to keep the client grounded in the present situation, where they can focus on the therapeutic moment (Silver et.al, 2008).

The fifth phase is installation, which aims to install positive cognitions in the client regarding their trauma. For example the client may switch from “it was all my fault” to “I did the best I could, it was not my fault” (Silver et.al, 2008). For a female this example may come into play if she was raped in the battle zone, or if she was unauthorized to go out on a combat mission while her brothers in arms went without her, and her comrades were hurt or killed in action. These are both frequent occurrences.

The sixth phase is known as the body scan. As described by Silver (2008), “While maintaining a focus on the original trauma experience and the newly integrated positive cognition, the client identifies any disturbing physical sensations”. Bilateral stimulation is then used again to dissipate negative associations. The seventh phase is focused on closure – the client is preparing to end his/her EMDR therapy. The eighth and final phase, termed reevaluation, assesses progression and prepares for the end of treatment. (Silver et.al, 2008). These eight phases are only briefly described, as this is an overview of the aspects of EMDR.

Numerous studies have been conducting on the effectiveness of EMDR use on veterans who battle PTSD, including different case studies and controlled research. One multiple case study consisted of four veterans that requested immediate attention pertaining to their PTSD. Although this study has many strengths it was performed in an abbreviated form due to the restricted time frame the study was granted, and was made up of all men. Regardless of these limitations, it was found that this single, immediate session of EMDR resulted in significant improvement of symptoms, and was said to possibly be more effective than earlier interventions such as Prolonged Exposure therapy (Russell, 2006). According to research done by Leiner, A.S., Kearns, M.C., Jackson, J.L., Astin, M.C., & Rothbaum, B.O. (2012), “EMDR appeared to be beneficial for women who frequently engage in avoidant coping responses following rape.”

The results of said case studies are promising but require further research. It is this author's opinion that treatment providers should have these abbreviated sessions when nothing else is available—especially since the measurements they used, such as the Structured Clinical Interview (SCI), Impact of Events Scale (IES), and the Subjective Units of Disturbance Scales (SUDS), are more than sufficient to analyze results. This short form of treatment allows a soldier to retract from the battlefield and recharge, so they are able to perform their job efficiently. It is certainly not the most desired approach, as thorough treatment would be the best option.

It is suggested that researchers concentrate on female veterans in particular, as the ways in which they obtain PTSD overseas in a combat zone are not equal to those that their male cohorts typically run into (Street et.al, 2009). As previously mentioned, because of the different origins of PTSD between male and female veterans, the VA needs to tailor treatments to the needs of females. For example, many female soldiers battle Military Sexual Trauma (MST). Also, due to the differences between the male and female gender, attention should be paid to women who have specifically witnessed or come into contact with direct combat.

For women living with PTSD from service in Operation Iraqi Freedom and Operation Enduring Freedom, Prolonged Exposure Therapy (PE) is one of the top evidence-based treatments. In general, women are receptive to treatments that involve talking about emotions, relationship problems, and other personal problems (Street et.al, 2009). With this in mind, PE is beneficial to this cohort because it focuses specifically on the trauma itself and gives the patient a chance to discuss it in a safe and supportive environment.

These women obtain PTSD and MST most often due to personal attacks by people they trust, causing them to lose trust in others, including their family members. They repress a deep sense of betrayal that they often do not even know exists. They can explode at their loved ones for no apparent reason and, most often, report they have no idea what they are doing. This can have detrimental effects on their children; especially if a woman with PTSD is a single mother and the only caretaker at home (Walsh, 2009). It is for this reason that the most intense therapy is the greatest benefit to female veterans from Iraq and Afghanistan with PTSD.

A study published by Tuerk, et al. 2011 presents particularly valid and thorough methods that PE is, in fact, one of the best treatments for female veterans. This effectiveness study was “the first of its kind”; with a small, diverse sample of OIF and OEF veterans in an urban setting who all participated in PE.

Archival data was used by patients treated in the local VA, by the PTSD Clinical Team (PCT). These researchers used the PTSD Checklist – Military Version (PCL-M) and the Beck Depression Inventory-II (BDI-II-II). Both of these tests were administered frequently to keep track of the subject's symptoms, adding to the strength of the study (Tuerk, et. al, 2011).

PE is arguably the most intense therapy, proven to get to the root of the trauma. The therapist must approach cautiously and be sure a strong rapport is established before treatment begins. The patient must be willing to face their biggest fears. One thing about PTSD is that the client doesn't always remember every aspect of what happened: there are often chunks of time missing, which can be frightening and add to the feeling that the trauma was “no big deal,” as some patients believe they have overreacted (Joseph, 2011). One of the reasons PE is shown to work so well on patients is that it can dig deep into the memory and pull out the missing pieces. For example, it can help the patient realize something as simple as whether or not a certain person was in the vicinity when the trauma occurred. Offering the patient this clarity helps them to feel more at peace about what happened, as there is less “unknown” attached to the trauma.

Intrusive recollections, which can come in the form of intrusive thoughts, flashbacks, nightmares, etc., are an ever present aspect of PTSD. Increased arousal is also a pertinent symptom which shows up as random irritability or anger outbursts, difficulty concentrating, and an exaggerated startle response, just to name a few. Emotional numbness and avoidance of any stimuli associated with the trauma is prevalent (DSM IV, 2000). As PE works to desensitize the client of the traumatic episode these symptoms begin to decline. Cognitive therapy also helps to relieve these symptoms; however this researcher believes PE gets to the core of the problem more rapidly, causing the patient to really face their demons. Cognitive therapy is more focused on the “here and now” thoughts, and not the detailed aspects of what is really bothering the client (Kleim, et. al., 2012).

An additional benefit of PE is that it requires very little financial backing and not a lot of time. Sessions are not limited to a VA clinical setting, as it is designed to proceed at the patient's pace. However, it can take as little as one month, or as long as three months for symptoms to subside and the veteran's quality of life to drastically improve (NCPTSD, 2009). According to the VA's Office of Mental Health Services, the VA has recognized this as one of the most effective treatment methods for PTSD, consequently developing a national training program for VA providers across the country (NCPTSD, 2009). It is for these reasons that PE is arguably the most effective treatment method for female veterans with PTSD. Further research

should be conducted to maximize women veteran's benefits.

The results of this research review may benefit the thousands of women veterans returning from Iraq and Afghanistan that suffer from PTSD. When they return in need of reintegration support, it is this type of information that can help put them on the road to recovery.

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