Women Veterans and Their Families: Preparing School and Agency Counselors to Address Their Mental Health Needs.

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Currently women make up approximately 8% of the total veteran population and this percentage is projected to increase to 16% by 2035 (United States Department of Veterans Affairs, 2010). Women are also serving in broader capacities and in jobs traditionally held by men. As a consequence, women are experiencing trauma related to service in combat zones. Combat related trauma as well as other aspects of military service may contribute to developing mental health issues. As a result of recent policy changes by the Veterans Administration, Licensed Professional Counselors (LPCs) will be eligible for jobs as mental health providers for military service personnel (Barstow & Holt, 2011). Counselor education programs will need to be proactive in preparing mental health providers for this population. Programs will need to respond quickly in developing both pre-service and in-service training in order to prepare counselors for providing direct mental health care services for military personnel as well as veterans and families in civilian settings. This paper will include a review of the literature concerning the issues facing active and returning military service personnel with a special emphasis on meeting the needs of women.

Background

Women have served in the military in some capacity throughout all of America's armed conflicts. The Department of Defense's (DoD) policy for assignment of women, dating back to 1994, provides a structure and oversight for making gender diversity a priority, and for purposely supporting women in the military. The DoD reports that accession rates for 2007-2008 were among the highest in the previous ten years; and that women opt for re-enlistment and are promoted to higher enlisted and officer grades at rates consistent to those of their male counterparts (Department of Defense, 2009). The DoD also receives input from the Defense Advisory Committee on Women in the Services (DACOWITS - established in 1951) to assist with strategic planning addressing the roles and well-being

of women troops during and beyond active duty assignments (Department of Defense, 2009). Currently, all branches of the military and over 92% of all military specialties are open to women, and approximately 14.25% of the U.S.'s total active military or 198,000 are women (Department of Defense, 2009). Exclusions for female soldiers are limited primarily to specialties whose emphasis is direct ground combat. The unprecedented engagement of women (12.65% of deployments) in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) reflects the expanding opportunities for women to serve in nontraditional roles and in active duty war zone deployments. DACOWITS, in a 2007 report notes that by addressing the specific concerns of female military troops we better safeguard their mental health and honor their volunteer service and individual sacrifice (Department of Defense, 2009). However, Gamache, Rosenheck, and Tessler (2003) estimated that the expanding number of female troops, the changes in the assignment of women and recent combat initiatives are expected to eventually generate 300,000 mental health care related cases.

Much of the data about OEF/OIF troops remains aggregated, and doesn't distinguish the mental health care needs and concerns that may be unique to female soldiers. A Rand study (Tanielian, Jaycox, Schell, Marshall, & Vaiana, 2008) examined both internal and external contributing factors related to the wellbeing of active and returning troops. This study highlights the impact of DoD policies concerning the OIF/OEF increased ratio of armed forces deployed and the unique pace of deployment for these theatres of operation which has resulted in fewer breaks between deployments, longer deployments and more frequent redeployment to combat. Advances in treatment for physical wounds means that more veterans are surviving prolonged war with new types of causalities (Karney, Ramchand, Osilla, Caldarone, & Burns, 2008). They argue that many of the wounds from the OEF/OIF theatres of war are more difficult to recognize, if not invisible and, consequently, too often go unacknowledged (Karney et al., 2008). Seal, Bertenthal, Miner, Sen, and Marmar (2007) report that for returning OEF/OIF veterans,

43% of the VA hospital in-patients had a primary diagnosis of a mental disorder; 25% of 103,788 returning OEF/OIF veterans receive at least one outpatient mental health care visit; and 44% reported that they returned with a mental health condition. In this group, 7% identified their condition as "serious." Joining Forces America (2008), reports that 40% of returning veterans note that it is somewhat or very difficult to deal with family and marital issues. OEF/OIF troops deployed more than once or longer than 12 months for combat duty were 2.5 times more likely to identify their mental health issues as serious (Joining Forces America, 2008). Those troops with physical and mental health problems find post combat adjustment even more difficult. Other issues identified were outlook on job/career, clarity on future life choices, finances and outlook on life. This study points out intersections of external socio demographic factors and structural inequalities and the accumulated effects on a broader range of domains over the life span, referred to as 'cascading'. They also report that Post Traumatic Stress Disorder (PTSD); Major Depressive Disorder and depressive symptoms; and traumatic brain injury (TBI) are the most extensively assessed postdeployment mental health conditions and cognitive impairments.

A Rand Group study (Harrell & Miller, 1997) presented numerical evidence in support of progress in formally opening specialty classifications to women in the military, as well as developing programs to specifically improve the lives of women in the military such as military leave and career intermission pilot and leave programs This trend has continued with the DoD not only documenting improvements in the way it responds to safety concerns of female troops and the development of proactive plans such as the "Active Bystander Intervention" program. The "Active Bystander Intervention" program educates all military staff to recognize and act on a 'moral duty' to prevent harm to other soldiers, men or women, on or off the combat field (Department of Defense, 2009). They point out that the majority (both men and women) report that overt sexual harassment did not occur, and that

gender integration of military troops is perceived to have a relatively small effect. However, their study highlights a complex set of contradictions reflecting more covert incidents that may be better quality of life indicators about how women are getting along during their OEF/OIF deployments. A number of specific mental health concerns come to the forefront.

Sexual Trauma

Jeffreys (2007) presents an argument that female troops face double jeopardy. On one hand they are subject to the wartime dangers of being killed or wounded by the enemy, on the other hand they endure the possibility of rape by male colleagues. She further notes that the masculine nature of warfare encourages misogynist attitudes that the increased presence of women has yet to mitigate. In a recent study, 15.1% of women and .7% of men deployed in OEF and OIF reported military sexual trauma (MST) (Kimerling et al., 2010). Those reporting such history were more likely to receive a mental health diagnosis. Evidence is accumulating that sexual trauma that happens as part of military service is more significant as a predictor of mental health issues than is such trauma experienced pre or post deployment (Street, Vogt, & Dutra, 2009). They also cite research documenting that compared to civilian women; military women report a greater experience of both child abuse and child sexual abuse. In addition, the prevalence of sexual harassment in military cultures is an additional stressor also related to mental health diagnosis. Women veterans upon return may also be viewed as not “real veterans” having faced danger and thus not receive the recognition and support afforded to male colleagues. Thus gender specific exposure to assault and harassment is becoming well documented as strongly related to subsequent mental health diagnosis.

Post-Traumatic Stress Disorder (PTSD)

PTSD, although not as strongly associated with suicide as depression, is more related to suicide ideation and attempts than any other anxiety disorder – even after accounting for confounding resulting from other mental health and sociodemographic factors (Karney et al., 2008). Additionally, veterans with simultaneous mental health concerns (comorbidity) have more severe symptoms, need more specialized treatments, have poorer outcomes and experience more disability in social and occupational functioning. A study sponsored by the Veterans Administration (VA) found those with comorbid depression and PTSD had more severe depression, lower social support, more suicide ideation, and more frequent primary care and mental health care visits than did individuals with depression only. These researchers suggest that in additional to traditional interventions for specific conditions, early interventions are likely to have meaningful indirect and long-term benefits concerning developing a supportive environment and coping strategies (Joining Forces America, 2008). One study, comparing women to male veterans of the OEF/OIF theaters of operation, note that women: are younger, less likely to be employed and more likely to have a major mental health concern (Gamache et al., 2003).

Alcohol Abuse

Alcohol and drug use disorders often occur with a diagnosis of PTSD and this has been documented over time with combat veterans of Vietnam (Karney et al., 2008). Alcohol becomes a form of self-medication. Gradus, Street, Kelly, and Stafford (2008) found evidence of an association between sexual harassment and harmful alcohol use among women. Hankin, Skinner, Sullivan Miller, Frayne, and Tripp (1999) found those experiencing sexual assault were two to three times more likely to meet screening criteria for alcohol abuse and that 60% of those screening positive reported receiving no mental health treatment. For active duty service members, accessing treatment for substance abuse will

result in an automatic report to the commanding officer. Williamson and Mulhall (2009) identify this lack of confidential access to treatment as a significant barrier.

Homelessness

Women veterans are found to be three to four times as likely as non-veteran women to be homeless (Washington, Yano, McGuire, Hines, Lee, & Gelberg, 2010). MST, disability, and screening positive for anxiety disorder or PTSD were associated with homelessness in this study. Perl (2009) identifies mental health issues, disrupted social networks, and employment difficulties as increasing the difficulty with which women veterans readjust to civilian life, and thus could be risk factors for homelessness. She notes that similar to male veterans, research has shown that women veterans are more likely to be homeless than women who are not veterans. However, women are estimated to make up fewer than 4% of the total veteran population seeking VA homeless services. These programs may lack adequate facilities for female veterans, particularly women with children. Washington et al. (2010) describe services as a patchwork that many times may lack attention to the privacy and other gender specific needs of women particularly those with children.

Family Life

In or out of the military, traditional gender prescribed roles and expectations result in differential distributions of labor, as well as add to role overload and role conflict for women (Hays & Erford, 2010). For women troops, pervasive sex role social expectations are also likely to generate compounding influences in family situational conflicts that result in circular causality producing more negative family relationship consequences. For example, non-traditional work schedules, short deployment notice and longer deployments for women are likely to disrupt routines, create unique child care challenges, and generate or increase stress from role strain and role conflict in families (Psychology Career Center, 2010a; Department of Defense, 2009).

Given the nature of contemporary military life and the seriousness of the mental health issues discussed previously, family life may be compromised for women both during and after their active service. Female troops currently are experiencing the majority of military divorces with marriages failing at nearly triple the rate of male service members (Williamson & Mulhall, 2009). The use of National Guard and Reserve units in the post 9-11 conflicts also complicates family life since these troops often do not live near military facilities that house support services (Ginzburg, 2009; Psychology Career Center, 2010b). Themes identified in a qualitative study of reserve units returning from deployment (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008) indicated boundary ambiguities surrounding safety, redistribution of roles and responsibilities and rejoining the family.

Kelly, Herzog-Simmer, and Harris (1994) found that women facing deployment reported more parenting stress and single mothers indicated more separation anxiety and less family cohesiveness and organization. In particular, younger families have more difficulty adapting (Faber et al., 2008). Disorders such as PTSD and depression are connected to problems with maintaining intimate relationships as well as intimate partner violence and increased divorce rates (Karney et al., 2008). These stresses, particularly with lack of intervention, can ultimately extend through children into the next generation. Thus, the effects may continue well beyond an individual service member's experience (Karney et al., 2008).

The increase and expansion in the number and status of women included in active initiatives, and National Guard and Reserve personnel during the OEF and OIF has brought new attention to the unique experience of women in military service. The literature indicates that some challenges associated with being in the military are uniquely connected to gender, and have a disproportionately negative impact on women. The table in the Appendix identifies resources and stressors associated with women in military

service. The table summarizes and compares data and themes reflecting circumstances and concerns of women veterans at predeployment, deployment and postdeployment.

Implications for Counselor Education

Mental health professionals are critically needed. Williamson and Mulhall (2009) report that mental health care systems in the DoD and the VA have been slow to respond to a growing mental health crisis. In particular, professionals are often not available to active duty troops and to veterans especially in rural areas. In their conclusions and recommendations Tanielian, et al. (2008) pointed to the need to increase the cadre of providers who are trained and certified to deliver proven (evidence-based) care so that capacity is adequate for current and future needs. Training in these evidence-based approaches will also be needed for existing providers. In particular, they noted the need for the development of a certification process to document that providers have the skills to implement high-quality therapies for specific conditions. They recommend expanding existing training programs for all mental health workers to including training in specific therapies related to trauma and to military culture. The American Psychological Association (2007) articulates specific guidelines for counseling girls and women that consider the influence of gender in terms of social context and power. These guidelines align with both multicultural and social justice advocacy competency standards that under-grid what Hays and Erford (2010) and Day (2008) identify as consciousness raising approaches to therapy that address structural and systemic inequities associated with gender, as well as support advocacy at both macro and micro level intervention levels.

Although the VA has adopted qualification standards for licensed mental health counselor positions, it will take time for counselors to be fully integrated into the VHA system (Barstow & Holt, 2010). Continued advocacy by professional groups will be critical to ensure that counselor positions are

posted and that counselors are hired. The initial hires will undoubtedly be under scrutiny in terms of recognition of counselors as mental health providers and counselor's perceived ability to provide services.

The military services do not have military occupational specialties for counselors. The profession needs to consider advocacy for such specializations as an additional area for professional recognition. Social workers are the largest group of mental health practitioners; for example, in the Army and Air Force, they are 33 and 38 percent, respectively, of the mental health provider workforce. Each of the Services embeds mental health professionals into operational line units. For instance, a Marine Corps program called the Operational Stress Control and Readiness Program, or OSCAR, integrates mental health teams at the regimental level (Gaskin, 2007). The Army embeds a behavioral health officer and an enlisted mental health specialist to increase division mental health assets, which include a division psychiatrist and a senior noncommissioned officer. Williamson and Mulhall (2009) however point to the difficulty of accessing mental health professionals while deployed in a combat theatre. Providers who understand the military culture, and the social context in which mental health problems might develop, can form an alliance of trust and recognition of the professional credential that can continue following discharge from the active military service (Burnam et al., 2008).

The Council for the Accreditation of Counseling and Related Educational Programs (CACREP) in the 2009 standards has adopted a 60 hour standard for Clinical Mental Health counselors. This will involve the transitioning of current Community Counseling programs to the new model. Additional emphasis on diagnosis, treatment planning, and working with trauma has been included with the additional hours. Graduates of these programs should be better positioned to meet the needs as outlined by the VA. However, an emerging question would involve how specifically to train those already in practice to work with military populations and to understand military culture. Mental health

professionals currently believe that their professional community is underprepared to help this population (Joining Forces America, 2008). Another question would involve the gender specific needs of women. These are complex issues that extend to the families that veterans return to as well as those that they establish post deployment. Mental health services will likely be needed by many throughout their lives. Hopefully with increased research and emphasis as well as a larger pool of mental health providers, those who have served the nation and their families will receive the help they need to continue that service in civilian life.

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Appendix: Military Status, Stressors and Resources of the Women of OEF/OIF

<table>
<tr><td colspan="2">Pre-Deployment : Women represent 15% of active duty and 17% of National Guard and Reserve personnel</td></tr>
<tr><td>Resources/ Protective Factors:
Individual/family resources and stability
14.1 years of education on average
54% are married</td><td>Stressors:
Individual/family instability
Limited access to resources
Socio-cultural and demographic variables
Gender, Race, SES etc…</td></tr>
<tr><td colspan="2">Deployment: Variables impacting mental health outcomes include duration, number, timing of deployments</td></tr>
<tr><td>Resources:
Systematic
Department of Defense (DoD) oversight
Defense Advisory Committee on Women in the Services (DACOWITS)advisory review
Personal
Rank
Male gender
Vigilance</td><td>Stressors:
Unit and combat assignments
more than 1 or exceeding 12 months increases likelihood of mental health concerns; gender minority status
12.65% of OEF/OIF deployments
OEF/OIF women reporting harassment similar to general population
OEF/OIF women reporting assault : 39% sexual, 23% physical
Military sexual trauma (harassment &assault can produce trauma) increases the risk of mental health problems by 59%
Lack of confidentiality in reporting results in fear for safety and career
Lack of mental health care specialists</td></tr>
<tr><td colspan="2">Post Deployment: Active military service time is an additional risk factor added to socio-cultural and demographic stressors</td></tr>
<tr><td>Resources :
Marital status
African American family and community support for returning veterans is identified as significant in counter acting stress
Primary care physicians provide early intervention opportunities</td><td>Stressors:
Gender role conflict and role strain
Bias and lack of gender based programming
Marital status (single)
Age - youngest women veterans (18-24) are at the greatest risk for mental health concerns
Exponential compounding
most frequent OEF/OIF veterans seeking VA health care are Black & single
Women veterans are up to four times as likely to be homeless than non-veteran women and male vets
Marriages of female troops are failing at almost three times the rate of males</td></tr>
</table>