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The Veteran's Affairs Office Advancement Of Health Care For Women Veterans With Post Traumatic Stress Disorder

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THE VETERAN'S AFFAIRS OFFICE ADVANCEMENT OF HEALTH CARE FOR
WOMEN VETERANS WITH POST TRAUMATIC STRESS DISORDER

by

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B.S., Southern Illinois University, 2005

A Research Paper
Submitted in Partial Fulfillment of the Requirements for the
Master of Public Administration.

Department of Political Science
In the Graduate School
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RESEARCH PAPER APPROVAL

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Introduction

Throughout its course in history, the United States (U.S.) military has been primarily a male dominated field. While women served in the military, their role in the past was extremely limited and segregated. Due to their minority status, the interests of female veterans were overshadowed and/or overlooked. Over time, female roles in the military have slowly expanded and improved as more women have chosen careers in the service. By 2008, the number of women serving in active duty increased to 200,000 which is about eight percent of the total number of veterans (U.S. Department of Veteran Affairs, 2007) and they made up approximately eleven percent of the veterans returning from military operations in Afghanistan and Iraq (U.S. Department of Veteran Affairs, 2007).

The increasing ranks of women have required the U.S. military and, subsequently the Department of Veterans Affairs (VA) to expand their services for women (Benedict, 2009). Figure 1 shows a comparison of the percentage of occupation classifications that are available to women and the percentage of positions currently held by women in the separate service branches for 2002. In the Air Force and the U.S. Coast Guard women were allowed to serve in ninety-nine percent and one hundred percent of occupations respectively. In both branches women occupied the maximum positions allowed to them. While the Navy allowed women to serve in ninety-four percent of its occupations and women have filled only ninety-one percent of those titles. The Army and the Marine Corps had the largest deviation between occupations open to women and the number of filled positions. Figure 1 shows that less than ten percent of job classifications were prohibited to women.

A consequence of having more women serve in recent conflicts such as Operation Iraqi Freedom (OIF) and the Operation Enduring Freedom (OEF) has been that a greater number of the soldiers returning to the U.S. with post traumatic stress disorder (PTSD) are women. The National Center for PTSD defines post traumatic stress disorder as “an anxiety disorder that can occur after you have been through a traumatic event which includes combat exposure, sexual or physical assault, natural disasters, or serious accidents” (U.S. Department of Veteran Affairs, 2007, p. 1).

Officially, women soldiers are restricted from direct combat roles and instead installed in combat support positions. Fighting in Iraq, however, is an “urban warfare” style. With this style there are no front lines, instead entire regions are combat areas. This means that, although women are serving in noncombat support units (such as transport, logistics, and medical), they have similar rates of PTSD as men in combat units (Hoge, 2010).

According to the Department of Veterans Affairs, between 2002 and 2006, some 20,000 men and 6,000 women soldiers were diagnosed with mental health issues (Meagher, 2007). Officials for the VA cautioned that only about ten percent of combat veterans choose to seek medical help which leads them to believe that their numbers represent only a small fraction of the soldiers suffering from the disorder (Meagher, 2007). The receipt of medical assistance can be additionally challenging, however, for female veterans with PTSD. VA resources for PTSD are tailored for the symptoms and treatment of male veterans. Women face additional burdens beyond PTSD. While overseas in Iraq and Afghanistan women endure not only combat trauma but also military sexual trauma (MST) including unwanted sexual behaviors or attention (U.S. Department

of Veteran Affairs, 2007). The Veteran's Affairs Office has a growing problem because a considerable number of women veterans are returning from combat with PTSD or MST and little resources are available to treat them (Benedict, 2009). This research seeks to determine whether the VA has been giving proper attention to this rising problem.

The VA has begun to take steps to address these problems stemming from the increase in women veterans. In general, the VA has created training programs, performed research surveys, and increased health care services dedicated to women (Benedict, 2009). More specifically for women's health including PTSD, they have improved the Women Veterans Health Strategic Health Care Group and employed Women Veterans Program Managers at VA facilities throughout the country. The VA also supported the passage of a key piece of legislation, the "Caregivers and Veterans Omnibus Health Services Act of 2010". Finally they conducted the "Department of Veterans Affairs Advisory Committee on Women Veterans Report in 2010". Detailed explanations of these changes and how they are improving assistance for women veterans will illustrate the VA's commitment to helping former servicewomen with PTSD.

The Increased Exposure of Women in Combat

Women in the military work at defying stereotypes especially those that make them appear to be too fragile for military duty (Paulson, 2010). In traditional military culture, a woman is often viewed as naïve and useless rather than as a competent soldier. This makes it difficult for female soldiers to gain acceptance.

Women were first allowed to serve officially in the U.S. Military in 1901, when the Army Nurse Corps was founded. It was not until 1948, that Congress passed the Women's Armed Services Integration Act which allowed women to serve in regular

forces during peacetime (Manning, 2005). The Act contained many conditions for women serving. For example, the act provided that women not make up more than two percent of the total arms forces. It also stated that they were forbidden from serving on navy vessels or combat aircrafts (Manning, 2005). One of the main reasons why women could not serve near a battlefield until after World War II, except for nurses, was the worry that they would be a sexual distraction to men. As a result of keeping women from battlefield frontlines, they were not issued weapons until after Vietnam (Benedict, 2009).

During the Vietnam Conflict and the Panama crisis of 1989, rules began to loosen even more for women. The new rules resulted in the reclassification of military jobs into complex categories that allowed women to provide combat support while still maintaining the ban from ground combat (Benedict, 2009). This put women into battlefields and frontline combat without officially acknowledging the fact. In the Vietnam Conflict, there were 7,500 female soldiers in combat support roles and 41,000 in the Gulf War (Paulson, 2010). During the first Gulf War, women soldiers became prisoners of war for the first time since World War II. By 1993 President Clinton pressed the Pentagon to open more military positions to women (Benedict, 2009). This allowed women to serve in several branches of combat aviation and on all military ships except submarines. The second half of the 1990s saw women serving in dangerous military deployments such as Haiti, Bosnia, and Somalia (Benedict, 2009). Since World War II, Operation Iraqi Freedom has had the largest number of female soldiers fighting in a military conflict. As of 2010, over 100,000 women have served in Operation Iraqi Freedom (Paulson, 2010).

Figure 2 shows the number of women serving in U.S. military conflicts from the Spanish-American War until Operation Iraq Freedom. The number of women in military conflicts has not been a steady increase over time. Instead, women's presence in war goes through a cycle of increasing and decreasing over time. During the Spanish-American War, 1,500 women served in the military. Since that war the number of women in conflicts continually increased until it peaked during World War II with 400,000 women. Females in war declined in Korea and Vietnam and reached the lowest point in Grenada with only 170 women. During the conflicts in Panama and Desert Storm, the number of women again increased. In Operation Iraqi Freedom, the number of women reached 100,000. This up and down pattern shows women have not been a continuous presence in military conflicts. Because their numbers have not steadily increased in wars, the Department of Defense and the VA have not perceived battle trauma in women as a growing problem. The significant increase of women in Operation Iraqi Freedom and the changing roles for women are the primary reasons why women's PTSD is gaining attention.

Changing Roles for Women in the Military

Women soldiers have become indispensable to the military yet they are still officially banned from ground combat (Benedict, 2009). The ban on women in ground combat has proven extremely difficult in the Iraq War. The battle zones are entire towns, roads, and base camps. This type of guerilla warfare forces women into combat even if their job titles prohibit it. Part of the reason there are now more women in direct combat is because the U.S. military lacks troops, so they are placing women in jobs that are similar to those of all-male infantry and armor divisions (Benedict, 2009). Women are

flying helicopters, manning machine guns on top of tanks, and raiding buildings, all in direct combat.

As women become more visible in combat, there becomes an increase in hostility from their male comrades. Many men resent women for intruding on the masculine role of being a warrior, one of the few roles still primarily controlled by men (Benedict, 2009). The military culture will often view women as weak and passive creatures that are not reliable in battle (Benedict, 2009). Not all military men see women soldiers in a negative light, but many do.

Today, women make up only a small percentage of the U.S. military. Figure 3 illustrates the number and percentage of women serving in the different branches of the U.S. Arms Services as of 2010. Despite the increase in the number of women in the military, they still only make up around fourteen percent of all active troops, seventeen percent of Reserve, and fifteen percent of National Guard troops. With a total of 76,193 women, the Army has the largest number of women in service. Yet, the Air Force has the highest percentage of women at 19.2%. Females make up less than a quarter of the total number of active service members in all the branches. The reserve branches have only slightly higher percentages of women than the active duty branches. Women often serve in a squad with hardly any other women or none at all (Benedict, 2009). Women soldiers find themselves isolated and alone especially with the military's traditional hostility toward females. These factors force women to have an even more difficult experience coping with war. An army specialist from Montana serving in Iraq stated, "I was the only female in my platoon of fifty to sixty men" (Benedict, 2009, p. 3). These feelings of

being vulnerable and anxious increase the likelihood of a female soldier suffering from PTSD (Benedict, 2009).

Reservists and National Guard

Female reservists may have turned out to be especially at risk for PTSD because they did not imagine they would actually be facing combat in Iraq (Paulson, 2010). As one Army Specialist stated:

“I joined the Army reserve initially to help pay for college. I did not mind the weekend drills every month...I never thought seriously that I would have to go to Iraq” (Paulson, 2010, p. 26).

With the start of the Iraq War, there were 188,592 National Guard and reserve troops on active duty (Holmstedt, 2007) representing the largest reserve call-up since the Gulf War in 1991. Most reservists join with the plan of working one weekend a month and two weeks a year in exchange for money and receiving help with a college education. They often forget that their part-time commitment has the possibility of becoming a full-time job in dangerous war zones (Holmstedt, 2007).

In 1995 reservists were required to perform two million days of work; currently that number has increased to fifteen million days (Holmstedt, 2007). For many reservists and National Guard soldiers, the initial shock is how long they will be gone during their duty. When reservists become active, they spend four to eight weeks in training. After that training is complete, they go to Fort Polk, Louisiana, for advanced training in an environment similar to Iraq (Paulson, 2010). Depending on the unit rotation schedule, reservists would either deploy to Iraq or be placed at a military base in the U.S. to wait until they are deployed. The time that the reservists and National Guard spend training

and preparing to deploy does not count towards their overall time required for a tour of duty (Paulson, 2010). A one year tour in Iraq or Afghanistan might actually be a year and half or two years away from their home.

The majority of reservists' soldiers assume the role of military police while in Iraq (Paulson, 2010). Numerous reservists and National Guard described their time in Iraq as being similar to a peacekeeping mission; very few are placed in a combat company. For many of them, the trauma of the war was not the dangerous and deadly combat experiences but the prolonged time and distance away from their home and families. Scores of the "weekend warriors" became so entrenched in being active soldiers that they became unable to relate to their civilian lives back home (Paulson, 2010).

Understanding Combat Post Traumatic Stress Disorder

Over the years, American society has created a set of moral or ethical codes. Many of these codes, such as do not kill another human person, do not willingly harm another person, do not overtake or destroy another person's property, and do not set yourself above society by creating your own authority have become governing laws. Raising American children with this belief system in public schooling and religion engrains in them a sense of right and wrong. With these beliefs, Americans become adults and choose to become soldiers. Fighting in a war, they are forced to reevaluate their moral code and often times must replace it with another more simple code, kill or be killed (Holmstedt, 2009).

American soldiers in Operation Iraqi Freedom are faced with many difficult tasks. They are required to kill hostiles when in danger, physically restrain suspects, overtake

buildings, and create rules or regulations to ensure safety. For soldiers fighting in a combat war zone, the choices they must make in order to stay alive often contradict the ethical and legal beliefs taught to them. This fact alone could create emotional turmoil within a person. Soldiers must also handle the pressure of being in a dangerous place and must remain aware that they could die and others are dying around them. All these factors create an environment for post traumatic stress disorder to occur (Cantrell, 2005).

PTSD creates an “impairment of the person’s ability to function in social or family life, including occupational instability, marital problems, family discord, and difficulties in parenting” (Meagher, 2007, p. xxi). Other mental issues such as depression, anxiety and/or a crisis of faith can accompany PTSD (Meagher, 2007). PTSD is very similar to prolonged severe stress. This type of stress creates physical changes to the body that are unremitting such as an increase in blood pressure and heart rate, changes in hormone levels, or elevation of adrenaline (Hoge, 2010). Soldiers deployed for extended periods of time develop severe stress which causes their bodies to adjust to daily higher levels of stress. Once they return from the combat zones, it is difficult for soldiers to bring their physical reflexes back down to a normal level for a noncombat environment where the stress is much lower (Hoge, 2010).

Description of Combat Post Traumatic Stress Disorder

Post traumatic stress has been present in combat as far back as 380 BC. A Spartan commander at the battle of Thermopylae Pass released soldiers from combat because he saw they were mentally exhausted from previous battles (Bentley, 2005). In 1678, Johannes Hofer used the term “nostalgia” for men in mercenary armies that suffered from episodes of fever, disturbed sleep, melancholy, and constant longing of home (Meagher,

2007, p. 14). Symptoms of combat stress were observed during the Napoleonic and American Civil War but it was during the Russo-Japanese War in 1904 that a psychological treatment was used for combat stress. A system of “forward treatment,” in which physicians would evaluate and treat traumatized soldiers close to the front lines of battle was applied. It was assumed, however, that the farther soldiers were removed from the battle, the more difficult it was for them to return (Meagher, 2007).

New challenges for treating combat fatigue and stress came after the Vietnam War. Veterans began seeking help, for their trauma, months and years after their original combat exposure. The medical doctors and psychologists were unsure of how to treat these veterans, on both a physical and psychological level, due to the large range of symptoms and the lack of consistent data on combat stress (Meagher, 2007). Finally, in 1980, the *Diagnostic and Statistical Manual of Mental Health Disorders* added to its third edition a definition for Post-Traumatic Stress Disorder. This addition gave researchers an official name and definition to not only study the disease but to also find a treatment (Meagher, 2007). With the wars in Iraq and Afghanistan occurring, psychologists and doctors are again seeing a large tide of veterans returning home with symptoms of PTSD. As of 2006, nearly 150,000 veterans were discharged from services in Iraq and Afghanistan. Of these veterans, one-in-four have filed disability claims, over half of which concern mental health issues which includes PTSD (Meagher, 2007).

Differences in Male and Female Symptoms for PTSD

The classification of PTSD is based on a specific set of symptoms that have gone on for at least one month (Hoge, 2010). The most common symptom associated with PTSD is re-experiencing the trauma through flashbacks, nightmares, and obsessive

thoughts. These symptoms make the veterans feel as if they are actually reliving the traumatic situation again (Hoge, 2010). There are many different things (e.g., the smell of gasoline, the sound of screeching tires, or the flash of fireworks), for example, that can trigger a flashback. One soldier explained, “I’m jumpy when I hear thunder, door slams, and fireworks. Much like in Iraq, when I heard incoming” (Hoge, 2010, p. 33). Hyper-sensitivity is another frequent symptom for PTSD. This causes victims to be overly alert and hyper-defensive. One soldier that came back from Iraq drove in the middle of the road for weeks after she returned home. This impulse grew out of the fear that she would hit an improvised explosive device (IED) (Holmstedt, 2009, p. 186). Physical changes, such as weight loss, nervous twitches and phantom pain can also occur in victims. While all of these symptoms are general indicators for PTSD in both men and women, researchers have found that many symptoms are more gender specific (U.S. Department of Veteran Affairs, 2007).

Men diagnosed with combat PTSD will more often have difficulty dealing with anger control and irritability (U.S. Department of Veteran Affairs, 2007). This leads them to frequent episodes of violence or rage. Male soldiers also suffer more from insomnia. When they encounter sleep, they often experience nightmares (Hoge, 2010). Another common symptom for men is problems with memory or concentration and focus (Hoge, 2010). While in a combat zone, men work at a faster and more intense pace that forces them to make instinctive or reactionary decisions. When returning to civilian or non-combat duties, male veterans have a more difficult time working at a slower and focus driven pace. Probably the most significant symptom by men veterans with PTSD is

that the majority of them turn to alcohol and drug abuse to cope (U.S. Department of Veteran Affairs, 2007).

Female soldiers tend to suffer a different set of PTSD symptoms. They suffer increased levels of anxiety, show more signs of hyper-vigilance, and will have episodes of panic attacks when feeling overwhelmed. Avoidance is another common symptom. Females will avoid situations or people which remind them of traumatic events. A person attacked in a vehicle during combat, for example, may avoid driving or riding in a car. Avoidance can also cause victims to simply not speak of or refer to the traumatic incidents (U.S. Department of Veteran Affairs, 2007). Women will use distraction-based coping techniques to bury their pain and memory of the event rather than working through the problem. One female soldier, after returning from Iraq, got married, moved into a new apartment, and began furnishing her new home within the first seventy-two hours of landing in the U.S. (Holmstedt, 2009). This was her way of distracting herself from the emotional upheaval occurring inside. Avoidance causes women to have trouble feeling emotions both positive and negative. Female veterans suffering from depression are often diagnosed with PTSD after seeking treatment (National Center for PTSD, 2010).

By observing men and women veterans returning home to their different social roles, one can see such differences in PTSD symptoms. Because of the stressors of combat life, many female soldiers have trouble transitioning back to civilian life (National Center for PTSD, 2010). Many roles and responsibilities within society and culture are gender-specific. This is partly due to tradition but also due to natural

preferences. Roles such as the breadwinner and warrior are traditional models for men, but traditional roles for women are homemaker and caregiver (Paulson, 2007).

In the last twenty years, both in the military and civilian life, these traditional roles have crossed over genders with the rise of working mothers and single parent homes. This change in roles becomes more prevalent for women during combat where they are constant warriors. After taking on the role of being a “warrior” for a lengthy period of time, some women find it difficult to return to the caregiver role that was undertaken naturally before the war, but has to be forced now (Paulson, 2007). One female soldier described how she became distant and less affectionate than her old self after returning from Iraq. While playing the warrior role in Iraq, she had created a cold and detached attitude to handle the stressors of combat. Her actions consequently led to problems in her marriage (Holmstedt, 2009).

Women also struggle with taking on the “mommy role” and may find more conflicts with their children (National Center for PTSD, 2010). Some women come back unable to handle the noise and upheaval that accompanies children. They also struggle with changes in household dynamics such as, when the father becomes the primary authority and caregiver in the mother’s absence (Benedict, 2009). These types of role changes are a reason women veterans need PTSD treatments and programs that are gender specific (National Center for PTSD, 2010). Professional health care providers treating PTSD to veterans are accustomed to helping men with their role changes from warrior and soldier to the roles of father or breadwinner which is easier to readapt. The roles allow for a sense of authority and distance (Paulson, 2007). Female veterans need

professionals that understand the steps necessary to reconnect the soldier (that kills and shouts orders) to the mother (that gives hugs and kind words).

Better Understanding Women Veteran's Health Care

When discussing the topic of VA health care services for women, it is important to consider that this is a very young field of study. Although women have been officially present in the military since 1901, it was not until the 1980s that the military and health care establishment began to address issues of women's health care stemming from serving in combat zones. In 1982, the VA appointed the first Women Veterans Advisory Committee to evaluate any deficiencies in VA health care for women. As a result, the VA founded the Women Veterans Health Program in 1985. Throughout the late 1980s, the VA performed studies on services available to women but little became of the findings (Women Veterans Health Care, 2010).

A significant step came in 1992, when the Veterans Health Care Act became law and funds were specifically provided for gender specific services (e.g., reproductive health care and sexual trauma care). In 1993, the VA created a guideline requiring Women Veterans Coordinators to be available at facilities throughout the nation. This guideline became the current Women Veterans Program Managers (Veterans Health Administration, 2007).

The next wave of interest in VA health care for women didn't occur until after 2005 as the first female soldiers began returning from Afghanistan and Iraq needed medical services. VA hospitals are seeing an increase in women veterans treated for PTSD and military sexual trauma (MST) (Benedict, 2009). As of 2010, women made up about eight percent of the total U.S. veteran population (see Figure 4). This may appear

as a small percentage of the total number of veterans, but this eight percent is approximately 1.5 million women (U.S. Department of Veteran Affairs, 2007). This is a considerable demographic that requires health care specific to the needs of women.

Caregivers and Veterans Omnibus Health Services Act of 2010

In order to better understand the unique symptoms of women in the military to combat more general political pressure and to address the health care needs of veterans, Congress passed the “Caregivers and Veterans Omnibus Health Services Act of 2010”. Title II of the legislation, Women Veterans Health Care Matters, requires that the Secretary of Veteran’s Affairs create a program to give advanced medical training and certification for mental health specialists that are supplying treatment and counseling to female veterans (Senate Bill 1963, 2010). Specifically, professionals must receive training in treating female veterans with PTSD and MST. Health care professionals receive opportunities for continuing education in the mental health field (Senate Bill 1963, 2010).

Along with health care training, the Secretary must annually present a report to Congress detailing the services and treatments available to female veterans (Senate Bill 1963, 2010). The report breaks down data gathered throughout the prior year on matters such as the number of mental health care specialists and medical providers participating in the certified program. The report further evaluates the effectiveness of training and continuing education courses provided to professionals working in VA facilities. The report also assesses whether health care professionals are meeting the needs of the female veteran population requiring services for PTSD (Senate Bill 1963, 2010). The report will further show the number of female veterans that received treatment from a health care

professional certified by the program. Finally, the report should include a list of any recommendations for improving the program or treatment of women veterans with MST and PTSD (Senate Bill 1963, 2010).

Section 203 of the “Caregivers and Veterans Omnibus Health Services Act of 2010” requires that a pilot program be carried out through the Readjustment Counseling Service of the Veterans Health Administration. The goal is to evaluate the possibility of creating a treatment program, in group retreat settings, for women veterans who are recently separated from service after a prolonged deployment, particularly a combat zone deployment (Senate Bill 1963, 2010). The pilot program is intended to provide female veterans with information on the reintegration into family and civilian life, financial and occupational counseling for employment outside of the armed services, and information on counseling for stress and conflict resolution. The purpose of the pilot program is to establish whether or not supplies, skills, and information can help women veterans better adjust to life outside of a combat zone and are willing to accept care for mental health issues (Senate Bill 1963, 2010). Performing the pilot program will occur over two years with a report that contains the program findings and results to be submitted to Congress no later than 180 days after the completion of the program. The legislation also requires a comprehensive study of the difficulties faced by female veterans receiving health care from the VA (Senate Bill 1963, 2010).

The Act, which promotes training for MST and female PTSD shows that the federal government recognizes that women veterans returning from OIF and OEF have unique disorders and a different approach is necessary. Moreover, it is important to treat these women before the increase in the number of women (seeking treatment) elevates

this potential crisis (Senate Bill 1963, 2010). By performing pilot programs, studies, and evaluations, the VA can obtain the information to provide the best possible treatments for female veterans (Senate Bill 1963, 2010).

Upgrading the Women Veteran Health Strategic Health Care Group

The Women Veteran Health (WVH) Strategic Health Care Group is one of the VA's initiatives to promote women's health. In 2007, the VA office promoted the Women Veteran Health program to a Strategic Health Care Group within the Office of Public Health and Environmental Hazards (Women Veterans Health Care, 2010). The VA upgraded the program when they observed an increase in female veterans returning from combat with both physical and mental health problems.

The program's mission is to be a leader in providing quality health care for women veterans (Women Veterans Health Care, 2010). To execute their mission, the WVH Strategic Health Care Group works to make sure all women veterans seeking health care receive services with a basic set of standards. This includes providing complete primary care by a capable and concerned health care provider, making sure that patients receive the correct care, and the patients receive treatment in a health care facility with privacy, safety, and sensitivity to the needs of women veterans (Women Veterans Health Care, 2010). The program also ensures that the veteran's hospitals have the most current health care equipment or skills to ensure that the female veterans receive quality health care comparable to services provided to male veterans (Women Veterans Health Care, 2010).

For women veterans suffering from PTSD, the WVH Strategic Health Care Group provides assistance for mental health screenings and evaluations (Women Veterans

Health Care, 2010). The WVH then directs the patient into contact with comprehensive treatment programs that match the needs of the patient and coordinates with their location. The WVH is working to increase the availability and number of sites for woman-only inpatient treatment units (Women Veterans Health Care, 2010). Inpatient treatment facilities for men and women are rare throughout the nation, usually requiring a veteran to travel outside of his/her home state to receive counseling. The WVH works at providing special services to women seeking treatment for military sexual trauma. Additionally, the VA provides free confidential counseling and treatment for conditions related to MST (Women Veterans Health Care, 2010).

Advisory Committee on Women Veterans Report in 2010

Another vital step that the Veterans Affairs Office has taken to improve the health care for women veterans was the establishment of the “Department of Veterans Affairs Advisory Committee on Women Veterans Report 2010.” The report describes strategic initiatives to address relative and important issues faced by women veterans and design programs that meet their specific needs. The VA office is aware of the unprecedented challenges it faces as more women veterans are seeking help and benefits through the VA facilities. The report outlines ten detailed recommendations along with supporting rationales to improve the ongoing plans and programs which manage the health care needs of female veterans (Department of Veterans Affairs, 2010). The report also provides the Department of VA responses to the recommendations. Development of the recommendations came from data and information gathered from services and individuals such as Veteran Service organizations, Department of Labor, House and Senate Congressional Committees and women veterans. Of the ten recommendations, three of

them discuss the VA's need to improve on mental health care for women with PTSD and MST (Department of Veterans Affairs, 2010).

The first recommendation was that the VA should establish more gender-specific health treatment programs for women Veterans, such as women-only PTSD programs and Military Sexual Trauma (MST) programs. The Advisory Committee on Women Veterans (ACWV) found that many female veterans were uncomfortable participating in treatment programs along with male veterans (Department of Veterans Affairs, 2010). Also, the absence of a female specific PTSD program caused women to either seek treatment outside of the VA or to forgo treatment altogether. Of the nineteen VA medical facilities evaluated, none had female-only inpatient treatment units. The majority of the facilities had mixed gender or male only residential programs. The report states that "the establishment of more gender specific programs would better facilitate the recovery of female veterans who have been traumatized due to their combat experiences or who have experienced MST" (Department of Veterans Affairs, 2010, p. 9). The increase of women in combat and facing traumatic events causes a growing need to expand gender specific treatment programs (Department of Veterans Affairs, 2010).

The VA reported that they appreciated the need for mental health programs specific to women veterans. Yet, the VA stated that they supported mixed gender programs because they foster gender respect. Moreover, they help patients to confront fears or assumptions about the opposite sex while maximizing efficient use of resources (Department of Veterans Affairs, 2010). In residential programs that have mixed gender facilities the VA maintains safety by requiring separate units for sleeping and bathroom facilities. Veterans who feel that they strongly need a single gender treatment program

can request a gender specific facility which is available as a nationwide resource for all veterans. The PTSD and MST Support Team, started by the VA, monitor the number of patients and the number of waitlisted patients for these single gender programs (Department of Veterans Affairs, 2010). The VA is concerned that, as the number of women veterans increases, the number of waitlisted patients will increase. To meet the needs of all veterans, the creation of additional treatment programs is necessary.

The next recommendation (from the report) called for the VA to establish a training program to educate new and current employees about the changing roles of women in combat, PTSD symptoms, and MST sensitivity (Department of Veterans Affairs, 2010). VA employees need to understand the issues that women veterans encounter when seeking health care and benefits. They must recognize that female symptoms and responses for PTSD and MST are different from their male counterparts. Health care professionals need to be alert to address these issues. The Advisory Committee on Women Veterans believes that this training is a vital element for providing female veterans with accurate health care and it becomes a necessity as more women veterans are seeking help (Department of Veterans Affairs, 2010).

The VA supported the recommendation for more awareness training on women veterans. The VA explained that various divisions in the VA department are addressing the issue with different training programs. The Human Resources and Administration has created four courses addressing women veterans' issues available through the VA Learning Management System. They are working to design more training classes on the subject (Department of Veterans Affairs, 2010).

The Veterans Benefits Administration included a section on sensitivity to women veterans claiming MST and PTSD in its employee training program. In November of 2010 the new section was implemented to the training program (Department of Veterans Affairs, 2010). The Veterans Health Administration (VHA) is continually improving educational training for employees in order to increase awareness of women's roles both in combat and non-combat situations and diagnoses of PTSD and MST. The VHA understands that health care providers are a crucial element for this training and has created a Mini-Residency Program in Women Veterans Health to refresh the primary caregivers' knowledge of women's health issues. The training also shows them how to handle these issues in a sensitive manner (Department of Veterans Affairs, 2010). Since 2008, this two and a half day program has been offered at nine facilities across the country. The VHA is continually creating new videos, online training guides, as well as providing information sessions to increase training for serving women veterans. The video entitled "You Served, You Deserve" enhances awareness for all health care staff on women's role in the military. All new employees are required to watch the video at orientation. (Department of Veterans Affairs, 2010).

The third recommendation in the ACWV report is for the VA to generate a strategy to reverse the high turnover rate of full time Women Veteran's Program Managers (WVPM), and develop a succession plan to ensure continuity of care for women veterans (Department of Veterans Affairs, 2010). VA facilities are having difficulty retaining full-time women veteran's program managers. The high turnover rate resulted from a lack of consistent services provided to women veterans and a lack of proper training for the managers (Department of Veterans Affairs, 2010).

The VA acknowledged that the turnover rates for WVPMs can cause challenges in providing care and services to women veterans (Department of Veterans Affairs, 2010). The gaps, when these positions are vacant, create lapses in time for appointments. The VA reported that it would work to reduce the turnover rate for WVPMs by updating the orientation program to include a mentor component to ensure support and correct training throughout the orientation process (Department of Veterans Affairs, 2010).

The ACWV report continued on to list other recommendations for women veterans such as childcare services and substance abuse treatments (Department of Veterans Affairs, 2010). The report proves that while the VA has previously addressed issues for women veterans, they have many alterations and improvements to make before female veterans have all necessary services and treatments available to them.

Women Veterans Program Manager

Today, every VA facility in the U.S. has a Women Veterans Program Manager (WVPM). This position began with the Veterans Health Care Act of 1992, which requires that a veteran health care official in different regions serve as a coordinator for women's services (Veterans Health Administration, 2007). Today each Veterans Health care facility must have a WVPM on staff to implement and assist in services for women veterans. A WVPM is responsible for: acting as an administrative resource for patients and officials, maintaining female specific services and equipment, reviewing physical environment for potential privacy and safety deficiencies, and partnering with the local Operation Iraqi Freedom contacts to ensure women veterans have access and knowledge of quality health care (Veterans Health Administration, 2007).

While the position of WVPM is useful, it is still an area where the VA is failing to provide proper support for women veterans. As the job duties previously discussed, the program manager is required to perform a large range of duties (Veterans Health Administration, 2007). Many of the managers work alone with few to no associates or assistants. Hence, the position requires managers to maintain a focus on women veterans issues despite the lack of support. This may overtax the abilities of the manager and result in poor quality services for the patients (Veterans Health Administration, 2007).

Such high expectations also make the position difficult to fill because it requires both a medical health care professional and administrative social work experience. In the Advisory Committee on Women Veterans Report, a recommendation was given that the VA addresses the rising issue of high job turnover rate for the program managers (Department of Veterans Affairs, 2010). From 2005 to 2007, the position had an annual turnover rate on average of 22 percent throughout the nation. In 2008 to 2009, the average rate jumped to 42 percent (Department of Veterans Affairs, 2010). This large turnover rate makes it difficult for the VA to treat patients regularly and counsel them on services available to them. The VA acknowledged that the turnover rate for WVPMs is a problem but has yet to find a way to solve the issue (Department of Veterans Affairs, 2010).

Conclusion

Women first served in the military to support troops outside of combat. Gradually, the military has given women a larger role to play in combat operations. Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) greatly expanded the role of women in combat. Today, female soldiers serve in the middle of

battle zones and experience war from a new perspective. With this new role comes the mental stressor of fighting in combat and learning to live with the traumas of war in its aftermath (Benedict, 2009).

Male soldiers returning from Korea and Vietnam struggled with problems they faced from the traumas of combat. Now, women are in combat zones for the first time and must learn how to confront their suffering and seek help when they return. The VA is working to provide the help they need. When men returned from Korea and Vietnam, the doctors and psychologists did not know how to diagnosis combat PTSD. It was not until the men continued suffering for years after their return that medical professions began seeing their symptoms more systematically as a common problem. Today the medical community and the VA understand PTSD and the effects that combat can place on a soldier. The next step is to create treatments and therapy tailored for the symptoms of women and encourage female soldiers to seek help (Meagher, 2007).

The largest number of American women since World War II served in Operation Iraqi Freedom (OIF). Another 100,000 female soldiers are now returning from combat zones in Iraq and Afghanistan. Many of these women are showing symptoms of PTSD. Even though women still make up only about 10 percent of the combat troops, the affliction affects thousands of women veterans. Because women's symptoms for PTSD are different from men's, the VA hospitals are struggling to understand the needs for women's mental health care while trying to meet this large demand of returning soldiers (Meagher, 2007) .

The VA still has improvements to make for women's health care, specifically for PTSD and mental health. The VA is taking several measures to address shortcomings in

PTSD treatments for women. Congress passed the Caregivers and Veterans Omnibus Health Service Act, which requires the VA to create a program for health care professionals to receive training on the symptoms and treatments for women with PTSD. The Act also requires a pilot program created from the Veterans Health Administration. The pilot program will evaluate the possibility of female group retreat programs for mental health treatment and to provide women veterans with tools and information to ease the transition from combat back to civilian life.

Also, as a response to the growing number of women veterans returning from Iraq and Afghanistan, the VA decided to advance the Women Veteran Health (WVH) Program to a Strategic Health Care Group. The WVH provides women veterans' with assistance in the VA evaluation process for disability compensation. The Health Care Group also helps women veterans receive quality health care and works with VA hospitals and clinics to improve facilities and treatments for women.

The Advisory Committee on Women Veterans Report discusses positive initiatives that will enhance VA services for women but it is still at the recommendation stage. The report is only a preliminary step to making these problems a priority. The VA must decide which issues are of critical importance and need to be implemented into health care programs. It could be years before these recommendations become regulations and made available to women veterans.

Women Veterans Program Managers are making progress for women's health care but they need more supportive staff to help handle all of the duties. Incentives are necessary to induce job retention and lower the high turnover rate of the managers. Many female veterans do not know Women Veterans Program Managers are available or the

services they provide. The VA facilities need to inform female veterans of the program managers and the health care assistance they can provide. The number of inpatient PTSD treatment facilities for women only is another concern. There are currently only six inpatient programs for women throughout the nation (Benedict, 2009). The rising number of women returning with PTSD is severely straining the capacity of inpatient facilities and threatens to increase the number of women who will have to wait for treatment.

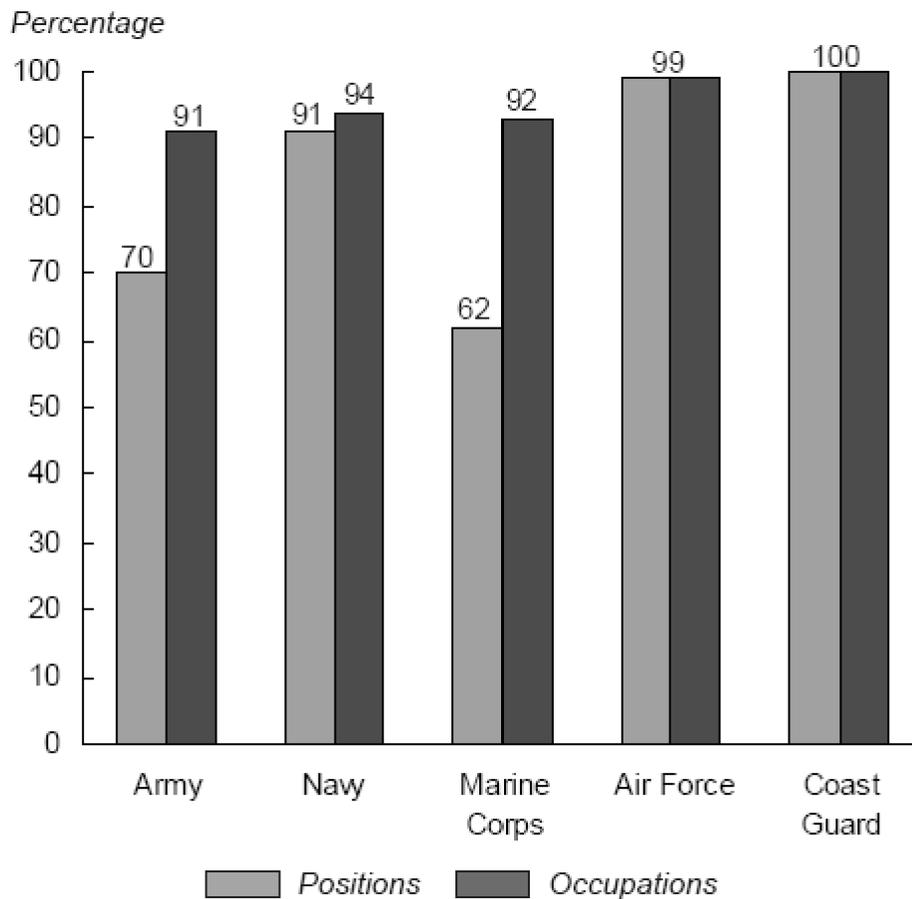
Female soldiers are still not receiving the same quality care for PTSD as their male counterparts. The evaluation of symptoms and available treatment plans are designed for men veterans. The VA needs to increase the number of female specific treatment programs, advance the research and training for health care providers in PTSD for women, and promote the services that are available to women.

To date, the VA has been working to adapt its treatments and facilities to treat women with PTSD. Many of the initiatives currently underway promise future improvement. However, the growing number of women returning from current deployments threatens to seriously compromise these efforts if the concerns addressed here continue to go unnoticed. The VA is aware of the need for advancement and they are making good progress to improve health care for women veterans.

It would be beneficial in the advancement of women's health care for the VA to make certain changes. First, the VA needs to adopt an exit procedure in which veterans are required to complete a series of psychological evaluations to determine their mental health state. These evaluations should start during a veteran's final month in service before they are officially released from duty. Follow-up evaluations should be

mandatory six months after the release. Secondly, the VA should also improve the Women Veterans Manager Program by providing supportive staffing to the manager position. The VA is facing an instability problem because they have a low job retention rate for the managers. The VA can significantly improve this problem by provided the managers with assistant staff to allocate the workload and increase service time with the veterans.

Positions Currently Held by Women and Occupations Currently Available to Active-Duty Women by Branch of Service, 2002 (in percentages)



Source: U.S. Department of Defense, Office of the Assistant Secretary of Defense, Public Affairs News Release No. 449-94, July 29, 1994.

Figure 1. Positions Currently Held by Women and Occupations

History of Women Serving in U.S. Military Conflicts

Women in Military Conflicts	
Spanish-American War	1,500
World War I	35,000
World War II	400,000
Korea	50,000
Vietnam	7,500
Grenada	170
Panama	770
Desert Storm	41,000
Operation Iraqi Freedom	100,000

Source: U.S. Department of Defense,
Office of the Assistant Secretary of Defense, 2010

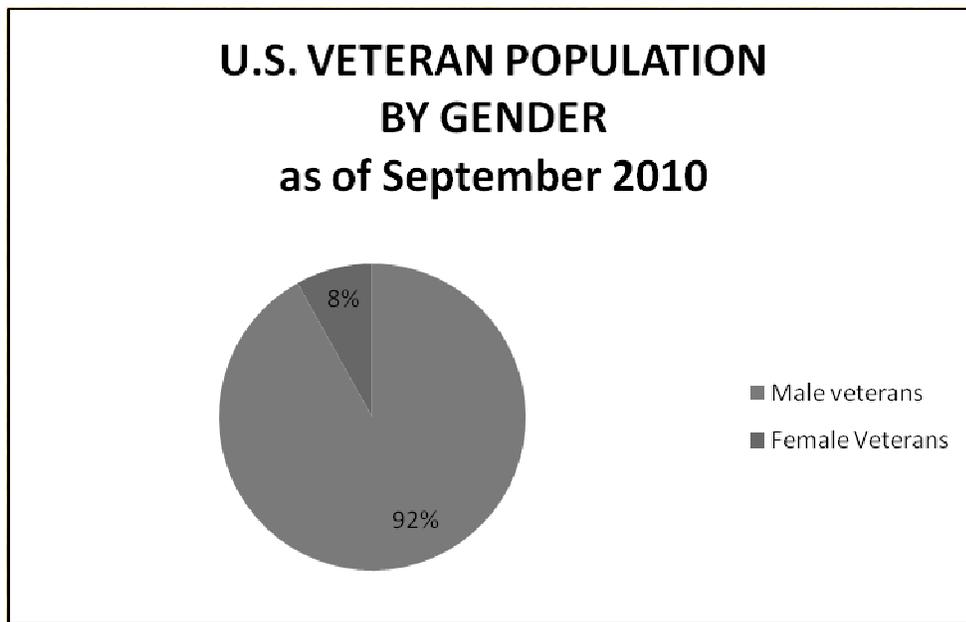
Figure 2. History of Women Serving in the U.S. Military Conflicts

Active Women Serving in the U.S. Arms Services
Data as of Sept. 30, 2010

Active Duty				Reserve & National Guard			
	Women	Total	%Women		Women	Total	%Women
US Army	76,193	566,045	13.5%	USAR	62,334	284,184	21.9%
US Marine Corps	15,257	202,441	7.5%	USMCR	5,423	97,087	5.6%
US Navy	52,546	328,303	16.0%	USNR	19,761	102,348	19.3%
US Air Force	64,275	334,196	19.2%	USAFR	29,113	110,674	26.3%
Total	208,271	1,430,985	14.6%	Reserve Total	116,631	594,293	17.7%
				USARNG	52,356	366,902	14.3%
				USANG	19,826	107,676	18.4%
<i>(More than 90% of all career fields in the armed forces are now open to women)</i>				National Guard Total	72,182	474,578	15.2%

Source: U.S. Department of Defense,
Office of the Assistant Secretary of Defense, 2010

Figure 3. Active Women Serving in the U.S. Arms Services



Source: Department of Veterans Affairs, Veterans Health Administration, Office of
Prepared by the National Center for Veterans Analysis and Statistics

Figure 4. U.S. Veteran Population by Gender

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APPENDIX

APPENDIX A

LIST OF ACRONYMS

ACWV	Advisory Committee on Women Veterans
IED	Improvised Explosive Device
MST	Military Sexual Trauma
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PTSD	Post Traumatic Stress Disorder
US	United States
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
WVH	Women Veteran Health
WVPM	Women Veteran's Program Manager

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