National Center for PTSD

2003 Volume 12 (1) ISSN-105-7168

CLINICAL QUARTERLY

Menlo Park/Palo Alto * Boston * Honolulu * West Haven * White River Junction

PTSD AND TELEMENTAL HEALTH: UPDATES AND FUTURE DIRECTIONS

LESLIE A. MORLAND, PSY.D., CHRISTOPHER FREUH, PH.D., KATHLEEN PIERCE, PSY.D., & SARAH MIYAHIRA, PH.D.

Many veterans in need of specialized PTSD services live in remote geographical regions such as tribal reservations, or rural areas of the Pacific Islands, where services are not easily accessible. Further, veterans with PTSD often use self-isolation to reduce stimulation, hyperarousal, and interpersonal conflict and consequently may be more likely to locate in remote rural areas with low population density. Historically, difficulties with access to care in remote areas have resulted in a lack of specialized PTSD services or limited specialized service provision with tremendous financial, travel or personnel burden. For example, the Department of Veterans Affairs medical center located in Oahu, Hawaii provides services to veterans in a large geographic area that includes the Hawaiian Islands, Guam, the Northern Mariana Islands, and American Samoa. Approximately 4.6 million square miles of water separate these islands, and approximately 123,000 veterans live in this region. Over one third of veterans receiving mental health services from the Hawaii VA are diagnosed with PTSD. This is a significantly higher percentage than is found in other VA medical centers (1).

The major benefits of telemedicine are expanding access to care and bypassing travel that may be disruptive or too costly.

To meet the needs of these veterans, the VA often flies clinicians to remote destinations to provide specialized mental health services, and flies veterans to the Honolulu Ambulatory Care Center on the island of Oahu to receive specialized care. The high cost of air travel and human resources, increased airport security, and scheduling difficulties all present significant barriers to providing necessary care. Telemental health seems to be a promising solution to this access problem, with clear advantages for the veteran and the provider.

Telemental Health: What is it?

Telemedicine is the use of electronic communications and information technology to provide and support health care when distance separates the participants (2). The major benefits of telemedicine are expanding access to care and bypassing travel that may be disruptive or too costly. Telemedicine often refers to the provision of health services via remote video teleconferencing (VTC) technology. VTC equipment sends real-time audio and video data. This technology is synchronous and affords face-to-face interactions. In telemedicine, the specialties of radiology, dermatology, and pathology have used VTC technology to provide medical care psychological services, cognitive testing and general psychiatry. Despite the high utilization of telemental health, this technology is

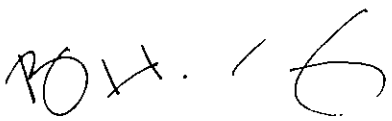
Continued on page 3

Inside this issue

FROM THE EDITOR...

Clinical innovation to help deliver the best possible mental health services to veterans suffering from PTSD, has long been a defining characteristic of VA behavioral health services. Another hallmark of VA PTSD clinical-related work has been its widespread adaptation and incorporation into community-based services for non-veteran victims of trauma. For example, many of the assessment and treatment protocols developed to help veterans (e.g., PCL and the CAPS), have (with slight modification) become widely used to help victims of community-based trauma including most recently, victims of 9/11. This issue of the Clinical Quarterly features the efforts of two groups of research practitioners whose work with veterans exemplify clinical innovation and the potential for helping trauma victims globally.

Leslie Morland, Christopher Frueh, Kathleen Pierce, and Sarah Miyahara have undertaken an innovative approach to care that could potentially change how mental health services are delivered when access to care is problematic. The outcome of their pilot study to evaluate the efficacy of video teleconferencing technology (telemental health) as applied to PTSD services holds promise to veterans who might not otherwise receive treatment, and possibly to quarantined communities/survivors resulting from catastrophic bio-terrorism. VA and non-VA science/clinical practitioners Amy Naugle, Kathryn Bell, and Meliisa Polusny have been collaborating to prevent the sexual revictimization of women. Through their efforts to understand the variables associated with revictimization, they have been able to explain why previously held strategies of prevention are ill-founded. The clinical implications of their work clearly have importance to the development of improved health care services provided to women veterans by mental health and primary care practitioners, but also to community health care services provided to non-veteran women who may benefit from learning about risk-reduction strategies or receiving treatment for sexual revictimization.



Bruce H. Young, Editor-in-Chief

NATIONAL CENTER FOR PTSD

Executive Director
Matthew J. Friedman, M.D., Ph.D.
VAMC/ROC White River Junction Vermont
05009

Education and Clinical Laboratory Division
Fred Gusman, M.S.W., Director
VAMC, Palo Alto, California 94304

Behavioral Science Division
Terence Keane, Ph.D., Director
VAMC, Boston, Massachusetts 02130

Women's Health Science Division
Patrica Resick, Ph.D., Director
VAMC, Boston, Massachusetts 02130

Pacific Islands Division
Fred Gusman, M.S.W., Chief of Operations
Honolulu, Hawaii 96813

Neuroscience Division
John Krystal, M.D., Director
VAMC, West Haven, Connecticut 06516

Northeast Program Evaluation Center
Robert Rosenheck, M.D., Director
VAMC, West Haven, Connecticut 06516

Clinical Quarterly Staff

Editor-in-Chief Bruce H. Young, L.C.S.W.
Managing Editor Josef I. Ruzek, Ph.D.
Executive Editor Fred D. Gusman, M.S.W.
Associate Editors Eve B. Carlson, Ph.D., Ilona Pivar, Ph.D., & Robyn Walser, Ph.D.
Assistant Editor John Aboytes, B.A.
Design & Production Bruce H. Young

Please feel free to contact us at the Education Division: FTS 463-2673/2494; commercial number 650-493-5000 ext. 22673/22494; or E-mail: ncptsd@bruceyoung.net
Please address all correspondence to: Editor, National Center for PTSD Clinical Quarterly, VA Palo Alto Health Care System, 795 Willow Rd (352E117), Menlo Park, CA 94025

still considered an untapped opportunity for many psychologists, social workers, and counselors because psychiatry has delivered the bulk of telemental health services (3).

Readjustment Counseling Service (RCS), in collaboration with Veteran's Healthcare Association (VHA) has been providing telemedicine primary and specialty care services to veterans located in rural locations where accessibility to services is limited. Although formal outcome data have not been collected at these sites, anecdotal reports suggest strong support by veterans, local providers, and remote clinicians. Sites such as the Vet Center at Logan, WV have been providing telemental health care to veterans by psychiatrists located at the closest VA hospital, two hours away in Huntington, WV. Additional sites include Cleveland, OH; Greenville, NC; and Santa Fe, NM where veterans are receiving routine care at local Vet Centers via VTC from remote VA hospitals. Although many of the services provided at these sites are for combat veterans with PTSD, a few sites are offering telemental health specialty PTSD services beyond medication management.

Surprisingly, when compared to the control in-person group, the remote clinician noted that there appeared to be a greater sense of camaraderie and cohesion among the VTC group participants.

While preliminary research on feasibility and reliability of the VTC modality for general clinical assessments and care, and favorable levels of patient and clinicians satisfaction (4) have been established, little is known about the clinical effectiveness and acceptibility of VTC for treatment of specific disorders like PTSD. Although most would agree that telemental health may present a more convenient and more economic way to provide or supplement specialty care services to remote veterans, research is still needed to determine the quality and clinical effectiveness of these services.

Telemental Health and PTSD: Pilot Research PTSD

For veterans with a history of trauma exposure, assessment of PTSD psychiatric or psychological symptoms is the first step to getting appropriate treatment. The accuracy of a PTSD diagnosis is important for both treatment implications and benefit claims. To date only one study has systematically evaluated the use of VTC to conduct assessements with veterans (5). In this study, 20 Vietnam veterans residing on the neighbor island of Hawaii who sought services at the VA Community-Based Outpatient Clinics in Hilo and Kona completed comprehensive PTSD evaluations administered via VTC from a remote clinician on the island of Oahu. The assessment protocol consisted of a combination of online self-report measures, a structured interview, and the Clinician Administered PTSD Scale (CAPS). Findings from this study suggests high satisfaction across the veterans, remote clinicians, and referring providers (5). Veterans were satisfied with assessments – the majority (80%) reporting moderate to high comfort levels. The referring providers reported to being very open to the VTC modality. Although the remote clinicians reported a slight preference for in-person interviews, the use of VTC was found to be acceptable, as remote clinicians indicated that they were able to establish rapport and perform an accurate diagnostic evaluation from a remote location.

Data on clinical outcomes from telemental health applications for treatment of PTSD are significantly lacking, with no randomized clinical trials (RCTs) completed to date. In an early case study with veterans suffering from PTSD, patient satisfaction and feasibility were demonstrated in a single session of group therapy conducted using VTC technology (6). More recently, investigators found that an 8-week manualized PTSD coping skills group was well received by veterans, clinic staff, and the remote group clinician (7). Comparison of VTC to an in-person control group revealed no significant difference between the two groups on measures of satisfaction and information retention. Surprisingly, when compared to the control in-person group, the remote clinician noted that there appeared to be a greater sense of camaraderie and cohesion among the VTC group participants.

Some anecdotal findings from these pilot studies indicate that remote clinicians experience more anxiety with the VTC group than the conventional 1:1 due to the awareness of the potential for technical difficulties. In addition, clinicians reported having less visual acuity with the VTC group, making it more difficult to observe and monitor facial expression and body language, which has the potential to be problematic when tracking an agitated veteran with PTSD. However, the clinicians reported that over time the VTC modality became less anxiety provoking.

There is still a great deal we need to know about how, when and with what patient population we can apply this new technology. However, based on these early pilot studies VTC appears to be a promising technology that can afford skills training and assessment from a distance for veterans with PTSD. Some logistic and clinical considerations and cautions are addressed below based on our clinical and research experiences with implementing and applying this technology for the care of veterans with PTSD.

Logistical Considerations

Using VTC for clinical work requires planning and preparation. It is important to consider logistics such as preparing the room and the equipment and having technological back-up support. The convenience and privacy of the room must be considered. In addition, a phone line should be available in the room in case the VTC equipment becomes disconnected. Stationary chairs are preferred to avoid excessive body movement. Additional aspects of the room to consider include the lighting and setting up the equipment in a manner that optimizes the clinical setting. Proper lighting is important to optimize the clarity of the image and allow for the clinician to be sensitive to any non-verbal communication. When using the VTC, there are visual adjustments to be made to improve comfort for those involved. To increase symmetry, or perceived power between the participants, each participant should appear about equal in size on the monitors. It is recommended that the visual field capture as much of the patient as possible, but at minimum a patient's head, shoulders, and arms.

At this early stage of VTC technology, disruptions and loss of transmission are realistic possibilities. Technical difficulties, e.g., hardware malfunctions, connectivity failures, poor or erratic audio and video quality, can occur frequently and disrupt the transmission and ultimately the clinical process. Should any of the VTC equipment fail during a session, it is imperative to have a telephone available at each point and available technical support on call for each VTC contact to help troubleshoot. At the remote site where technicians may not be available, it is important to have someone who can follow technical instructions by phone. The phone can be used in the interim until the problem is resolved. If the problem cannot be resolved, the phone will be the primary modality through the end of the session. Although this may not be ideal, it offers a modest alternative.

Clinical Considerations

Clinicians looking to integrate telemedicine into their practice must receive training and practice on using the equipment in order to feel comfortable and not allow the technology to distract from the clinical process. Clinicians report more comfort with VTC after several repeitions of working with it. A clinician's comfort with using VTC will directly relate to the veteran's comfort and likely the overall success of implementing a telemedicine program. Although telemedicine technology is advancing rapidly, it is important to note that it may be human factors that hinder the successful implementation of such programs. It is critical that clinicians are comfortable with the modality and not lose the traditional empathic warmth of mental health care. There may be some resistance to using telemental health by clinicians and veterans; some may fear that telemedicine might dehumanize clinical care.

Depending on equipment setup and transmission quality, it may be difficult to see the entire body of the veteran (clenched fists, shaking legs), or with comparable sensitivity, assess emotion breathing rate, etc. Although this makes a VTC clinical interaction more challenging for the clinician, there are tools that can aid in this process, such as the Subjective Units of Distress (SUDS), a scale from 1-100 that allows the patient to identify and report to the clinician how he or she is feeling in the moment. During the VTC session, the SUDS can be used by the remote clinician to track the veteran's emotional response to the session, guide adjustments in the session, or intervene with relaxation interventions such as deep breathing techniques. This technique can be helpful in compensating for the clinician's decreased sensitivity and perception when using the VTC modality.

It is important to talk with the veteran prior to the first VTC interaction. Topics to help orient the veteran to VTC can include a discussion of how the equipment works and what to do if equipment fails. Confidentiality and privacy concerns should also be openly discussed. In all, the risks and benefits of conducting the session via VTC should be weighed up front. Alternate or the lack of alternate methods of assessment and treatment should be included in the discussion. This provides the veteran with a rationale for having sessions via VTC and can serve to increase his or her comfort, satisfaction, and cooperation.

Finally, the need for clinical back-up services should not be understated. Some preliminary guidelines can be proposed at present. As a general rule, VTC sessions without an in-the-room clinician should not be attempted with patients who are emotionally unstable or volatile, due to the distance from the remote clinician and the potential for technical difficulties. Remote services to emotionally unstable or volatile patients are only suggested when the specific service cannot be provided by the on-site clinician (i.e., psychiatry or specialty PTSD services). It is optimal when a member of the clinical team can be assigned to sit in on the consultations with patients via VTC. If the on-site provider already has rapport with the patient, this can help to establish safety and ease from the onset of the consultation. Of course, many rural sites lack the staff to provide this in-the-room coverage. In such cases, it is essential that a clinical staff member at minimum be on-site during any VTC consult, to act as technical and clinical back up. If there is no one at the remote site to cover this function, one should carefully consider whether a VTC consultation is advisable.

Clinical Cautions

Given the novelty of VTC equipment, interacting with a new veteran through VTC without a referral is not recommended. There should be some form of screening or orientation prior to the VTC session. For example, at minimum the veteran should be screened for emotional stability (i.e., psychosis, volatility, suicidality, etc.) in order to determine if a VTC consult is appropriate, and if so, what level of safeguards should be in place (i.e., clinician in the room). How the patient perceives a VTC interaction can be unpredictable. Clinical emergencies pose a challenge. Suicide threats, violence, and other harmful behaviors are difficult to manage through VTC. Although careful screening

of VTC patients should reduce this risk, situations such as this are bound to arise from time to time. Again, with these types of consults, it is important to have a clinician on-site with the patient during the VTC session. The referring and remote clinicians should have direct access to each other as necessary. In addition to providing emergency back- up services, having a clinician on-site in the room might help veterans feel more secure and comfortable during difficult times.

At the current time, it is not recommended that trauma-focused type interventions (e.g., exposure therapy) or trauma focused type treatments be provided utilizing VTC. The possibility of intense emotional distress abreaction is high with this type of treatment, and management of the content and affect of a session would apt to be very difficult when providing remote services. Since the purpose of providing remote services hinges on the lack of adequate or specialized services in a distant site, it would be imprudent to open up an individual's traumatic experiences without having solid clinical backup. If that level of clinical service were available, it would be a better practice to allow the on-site clinicians to do process or trauma- focused work with the PTSD patients.

Future Directions

At this point more research is necessary to fully understand the various clinical, technical, and ethical issues that relate to applying telemental health to PTSD. We are at a very early stage in the development of protocols for assessing and treating PTSD through telemental health. More rigorous comparisons between VTC and traditional in-person interactions are necessary to appreciate the impact of VTC on the process of mental health care. In particular, randomized controlled trials are needed to support the efficacy and effectiveness of VTC with veterans and other populations. Furthermore, future research studies should build upon previous findings to maximize practical information and minimize trial-and-error. Although there is a great need for more research, this fact should not impede or preclude current use of VTC for certain applications. By bridging the distance between clinician and patient, telemedicine has the potential to profoundly influence the delivery of PTSD-related services to the many remote veterans with PTSD who have been previously unable to access specialty care.

References

1. Department of Veteran Affairs. (2000). Honolulu VAMROC Vista System Report.
2. Field, M. (1996). ed Institute of Medicine. Telemedicine- A guide to assessing telecommunications in health care. Washington, DC: National Academy Press.
3. Mahue, M. (2001). E-Health, telehealth & telemedicine: A guide to startup and success. Lanham, MD: Lexington Books.
4. Frueh, B.C., Deitsch, S.E., Santos, A.B., Gold, P.B., Johnson, M.R., Meisler, N., Magruder, K. M. & Ballenger, J.C. (2000). Procedural and methodological issues in telepsychiatry research and program development. Psychiatric Services, 51, 1522-1527.
5. Miyahira, S., Morland, L.A., Pierce, K. S., & Wong, M. (in progress). Assessing PTSD using telemedicine in the Pacific Islands.
6. Deitsch, S.E., Frueh, B.C., & Santos, A.B. (2000). Telepsychiatry for post-traumatic stress disorder. Journal of Telemedicine and Telecare, 6, 184-186.
7. Morland, L.A, Pierce, K., & Wong, M. (under review). Telehealth and PSTD psychoeducation groups in the Pacific Islands: A feasibility study.

Dr. Leslie A. Morland is a clinical psychologist at the NCPTSD Pacific Island Division located in Honolulu, HI. Clinical and research research interests include developing guidelines for provision of clinical services to trauma victims in rural locations using telehealth technology. Additional interest includes examining the relationship between trauma, PTSD and female reproductive health in the Pacific Islands.

Dr. Christopher Frueh received his doctoral degree in clinical psychology from the University of South Florida in 1992. He is currently Associate Professor at the Medical University of South Carolina, and staff psychologist at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina. He is presently principal investigator on 5 NIH-funded research grants, including one to study the use of videoconferencing for providing treatment to veterans with PTSD.

Dr. Kathleen S. Pierce is a clinical psychologist currently working for the state and in the private sector in Oahu, HI. She was recently affiliated with the National Center for PTSD Pacific Island Division located in Honolulu, HI. Clinical and research interests include exploration of Native Hawaiian traditional healing practices, as well as culturally appropriate service delivery to trauma survivors living in rural locations using telehealth technology.

Dr. Sarah D. Miyahira is currently the Director for Intramural Research at the Pacific Telehealth and Technology: A DoD/VA Joint Venture and the former Acting Director of the NCPTSD Pacific Islands Division. Her professional and research interests include the application of innovative technologies in behavioral health and medical interventions, PTSD assessment and treatment, ethnic minority mental health, and research ethics.

October 9 Is National Depression Screening Day

Participating Clinicians Can Earn Continuing Education Credits

This year's National Depression Screening Day (NDSD) – held on October 9 and co-sponsored by the National Center for PTSD – offers a concise, easily comprehensible questionnaire that screens patients for post-traumatic stress disorder along with depression, bipolar and generalized anxiety disorder. By striving to build mental health resiliency during stressful times, the program offers solutions to the 54 million Americans, and their communities, who suffer from mental health disorders.

New this year, clinicians interested in conducting an NDSD event can receive three continuing education credits for completing a self-education component. Details can be found at www.mentalhealthscreening.org.

NDSD can provide the gateway to treatment for veterans and others – such as loved ones of overseas troops, or victims of terrorist attacks – who may be suffering from PTSD or other mood or anxiety disorders.

Registered sites receive an Event Planning Guide that includes tips on program implementation and sample publicity materials. Kits also include screening forms with scoring instructions and referral guidelines, diagnostic aids, clinician's guide, videos, posters and educational materials for diverse audiences. Sites that service low-income or uninsured populations can register for a discounted Public Sector Kit.

Last year, screenings took place at roughly 6,000 sites nationwide, including hospitals, mental health clinics, colleges, primary care offices and in public settings. To download registration materials, go to www.mentalhealthscreening.org/reg or call (781) 239-0071 for more information.

NATIONAL CENTER FOR PTSD CLINICAL TRAINING PROGRAM

The Education and Clinical Laboratory Division for the National Center for Post Traumatic Stress Disorder at the Palo Alto CA VAMC, in collaboration with the VA Employee Education System, offers a Clinical Training Program (CTP). The training program is approved for 30 Category 1 CEUs for physicians, psychologists, social workers, and nurses.

Each year we welcome many mental health professionals from across the United States and from around the world. Most clinicians who enroll in the program have a working knowledge about treating the effects of trauma and PTSD and are looking to upgrade their clinical skills. The CTP offers a broad range of educational activities, including:

* **Lectures**
* **Clinical consultation**
* **Clinical observation of group treatment**
* **Group discussions facilitated by staff**

Specific training topics include warzone trauma group treatment, treatment of women veterans, treatment of sexual assault related PTSD, relapse prevention, cross cultural treatment issues, assessment and treatment of families, disaster mental health services, cognition and PTSD, assessment of PTSD, and psychiatric assessment.

Training programs are scheduled for a minimum of one week, though longer programs are available if the applicant can justify an extended stay. Programs are scheduled nine times per year, on the second or third week of the month.

Funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or VA Employee Education System.

For more information, or to request an application, please email:
Josef.Ruzek@med.va.gov
or telephone FTS 700-463-2673; commercial number 650-493-5000, ext. 22673.

NEW DIRECTIONS

Matthew J. Friedman, M.D., Ph.D.
Executive Director, NC-PTSD

It is with great pleasure that I announce that Patricia Resick, PhD, has accepted an appointment as Director of the National Center's Women's Health Sciences Division (WHSD) at the Boston VA Medical Center. She is currently Professor of Psychology and Director, Center for Trauma Recovery at the University of Missouri-St. Louis.

It has taken a number of years to find someone of Dr. Resick's stature to fill this key leadership position within the National Center. During the interim, Marie Caulfield, PhD, and Lynda King, PhD, have done an excellent job maintaining the forward momentum of WHSD, initially generated by Jessica Wolfe.

Dr. Resick has an international reputation as a clinical scientist in the field of traumatic stress. She has dedicated her career to furthering our understanding and developing effective therapeutic interventions to address the catastrophic psychological impact of interpersonal aggression as exemplified by rape, domestic violence, and childhood sexual abuse. For over 20 years her research has helped us understand the devastating consequences of sexual assault: how it affects one's view of oneself; how it promotes psychopathology and social maladjustment; how it may distort perceptions of one's environment; and how such distortions promote maladaptive thoughts, feelings, and behavior patterns. More importantly, she has taken the insights gleaned from these studies and created therapeutic interventions designed to correct such dysfunctional behavior. Here is where she has emerged as a world leader who has been a mentor for the rest of us. She has developed her own treatment approach, Cognitive Processing Therapy, designed it for both individual and group therapy contexts, and written a comprehensive treatment manual to guide clinicians. But that is only the beginning.

During the past 14 years, Dr. Resick has put her theories and therapy manual through their paces by testing them in rigorous and elegant treatment outcome studies. Her scientific papers are a joy to read because they are lucid, conceptually-driven accounts of well-designed treatment trials that have repeatedly demonstrated the efficacy of Cognitive Processing Therapy. It is important to recognize that this is extremely difficult research to carry out. I should also emphasize that Dr. Resick's therapeutic approach represents one of only a handful of effective treatments for sexual assault and interpersonal violence which affect so many American women and men in the course of their lifetime.

Dr. Resick is an excellent lecturer, mentor, and role model as a clinician scientist. The esteem that she has earned from an international community of scholars, researchers, and therapists is indicated by her appointment to editorial boards, scientific study sections, leadership positions in scientific organizations, and invitations for lectures and visiting professorships. Noteworthy appointments in specific professional organizations include: the Association for the Advancement of Behavior Therapy (of which she is President-elect), the International Society for Traumatic Stress Studies (of which she was recently vice president), the American Psychological Association (Divisions 9, 12, & 35), the American Psychiatric Association (DSM-IV PTSD Working Group), and the National Organization of Victim Assistance. She has also played prominent roles in both VA and NIMH research activities.

Her distinction as a scientist is attested by her success in obtaining research support in an increasingly competitive funding environment as well as by her prolific record of published articles in peer reviewed scientific journals and chapters in books.

Despite her heavy clinical, research, and teaching responsibilities, Dr. Resick has maintained a strong sense of social responsibility exemplified by her participation in numerous national, state and local organizations dedicated to assisting victims of sexual assault and interpersonal violence. Such humanistic commitment has been officially noted by the Missouri House of Representatives which passed a resolution congratulating and recognizing her for outstanding victim assistance on behalf of victims of crime. She has also received many other honors in recent years.

In summary, Dr. Resick is one of those extraordinary people who really has made a difference. Her creative innovations have generated new hope among the victims of rape and interpersonal violence by providing important new tools to the therapists who seek to help them. She has accomplished this while maintaining a determination to improve the world through social action without losing her warmth, humor, or zest for life. We are extremely pleased that she has joined the National Center and look forward to working with her closely in years to come.

NATIONAL CENTER FOR PTSD EDUCATION, TRAINING, & SUPPORT SERVICES

PTSD Assessment Library

Available upon request are selected instruments from our library of assessment and program evaluation tools (with accompanying articles), together with templates describing over 100 trauma-related measures courtesy of Beth Stamm, Ph.D., and Sidran Press. Telephone (650) 493-5000 ext. 22477.

PTSD Article Library

A helpful set of key articles on aspects of PTSD is available to VA or Vet Center clinicians free of charge. Telephone (650) 493-5000 ext. 22673.

PTSD Video Library

The Menlo Park Education Team maintains a small videotape lending library exploring topics related to PTSD diagnosis, evaluation, and treatment. Videotapes may be borrowed free of charge. Telephone (650) 493-5000 ext. 22673.

PTSD Program Liaison and Consultation

The Menlo Park Education Team can help VA health care professionals locate needed resources. Services may include assistance in locating relevant articles, locating resource persons, or problem-solving. Staff are available to consult in the areas of PTSD Diagnosis and Treatment, Program Development and Design, Women and Trauma, Relapse Prevention, and with other PTSD-related concerns. Telephone (650) 493-5000 ext. 22977.

National Center for PTSD Web Page

The NC-PTSD Home Page provides a description of activities of the National Center for PTSD and other trauma related information. The world wide web address is: *http://www.ncptsd.org*

PILOTS Database

PILOTS, the only electronic index focused exclusively on the world's literature on PTSD and other mental health consequences of exposure to traumatic events, provides clinicians and researchers with the ability to conduct literature searches on all topics relevant to PTSD. *http://www.ncptsd.org/PILOTS.html*

NC-PTSD Research Quarterly

The *Research Quarterly* reviews recent scientific PTSD literature. Telephone (802) 296-5132 for subscription information.

Disaster Mental Health Training and Consultation

NC-PTSD staff provide disaster mental health training, including presentations and one/two day trainings sponsored by host agencies. Consultation regarding program development and other related technical assistance is available. Telephone (650) 493-5000 ext. 22494 or email: *ncptsd@bruceyoung.net*

Conferences and Training Events

The Menlo Park Education Team provides consultative support for the development of training in PTSD. Services include assistance in finding faculty and designing program content. Telephone (650) 493-5000 ext. 22673.

WOMEN AND TRAUMA: A CLINICAL FORUM

Annabel Prins, Ph.D.
NC-PTSD

Clinical considerations in working with lesbian survivors of hate crime

Annabel Prins, Ph.D.& Claire Sandringham, M.S.

To date, large-scale epidemiological studies on the prevalence of trauma have not included hate crime as a specific traumatic event category (1). Similarly, studies on the psychological impact of trauma have generally excluded information on the sexual orientation of its participants (2). These are unfortunate omissions for two reasons. First, because hate crimes appear to be particularly traumatizing and second, because the "minority stress" associated with being gay, lesbian, or bisexual may significantly exacerbate responses to traumatic events (3,4). In this column, we will explore the prevalence and nature of traumatic experiences among lesbians with a specific focus on victimization experiences. We will then examine the psychological impact of bias-related events (i.e., hate crimes). We conclude by considering aspects of the recovery environment among lesbian women and exploring both positive and negative factors associated with recovery from a hate crime.

Research in this area has encountered significant methodological problems in clearly defining lesbian status and the nature of victimization experiences. However, the evidence seems to suggest that lesbians, when compared with heterosexual women, report more experiences with physical and sexual abuse in childhood or adolescence. Tjaden et al., (1999) found that 59.5% of lesbians and 35.7% of heterosexual women reported a history of physical abuse (5). Sexual abuse prior to age 18 was reported by 16.5% of lesbians and 8.7% of heterosexual women. It is not unreasonable to believe that these experiences may be related to gender-role nonconformity or to the coming out process (6). For example, in a sample of young adults, Pilkington and D'augelli (1995) found that 18% had been physically assaulted by a family member with clear and explicit references to their sexual orientation (7).

Lesbians are also more likely than heterosexual women to have experienced physical and sexual assault as adults (5). For example, Tjaden et al., (1999) found that 25.3% of lesbians and 10.3% of heterosexual women reported a sexual assault after the age of 18. Herek and his colleagues report that 16.6% of lesbians in their sample had experienced a physical or sexual assault that was clearly motivated by hatred related to sexual orientation (3). Most of these assaults were identified as hate crimes based on verbal statements made by the perpetrator. A good example of this is provided by a lesbian whose love letters were found by a Sergeant in the Army:

"The sergeant....called me into his office and told me to explain the letters. When I refused,, he grabbed me by the collar and threw me up against the wall and told me he wasn't going to have any dykes in his company. He took me outside and said get in the jeep. Took me to the top of a [mountain]. Got out, pushed me against the side of the jeep and said he was going to show me what a real man could do. Said he was sick of all these lesbians. He said what I needed was a real man to bring me out of this gay shit". (8)

Lesbians who have experienced a hate crime related to their sexual orientation are more likely than lesbians who have experienced a similar but non-biased related crime to report more severe (but not different) symptoms of distress, including PTSD symptoms (3). Lesbian survivors of hate crime also appear to have longer lasting psychological distress (approximately 5 years) than lesbians of non-biased crimes (approximately2 years). Several hypotheses can be generated as to why these crimes may be particularly traumatizing. First, hate crimes are more often committed by multiple perpetrators and are more likely to involve physical injuries that require medical care or hospitalization. Second, the experience of a hate crime may have a profound effect on self-identity and the coming out process. For example, hate-related victimization experiences may delay the coming out process due to fear of further violence. Herek and his colleagues found that hate crime survivors reported more vulnerability and fear of future crimes and less belief in the benevolence of others than lesbian and gay men of similar but non-biased crimes (3). Third, acceptance of the cultural myth that sexual abuse causes lesbianism may result in the survivor questioning her same-sex attractions and being open about her sexuality (6).

Certainly, hate crimes related to sexual orientation are less likely than other crimes to be reported to law enforcement authorities (9). The most obvious reason for non-disclosure and non-reporting is fear of secondary victimization (i.e., further mistreatment by others, including the police) and/or concern about the negative consequences of one's sexual orientation being publicly revealed (9). Despite significant changes in the past 10 years, most adults in the US still hold negative attitudes and beliefs about homosexuals. Herek (1994) found that higher levels of sexual prejudice were evident among individuals who were older, less educated, living in the US South or Midwest, and rural residents. Furthermore, sexual prejudice is positively correlated with authoritarianism, political conservatism, and fundamentalist religious beliefs (10). These may be important contextual features in the decision to disclose experiences of hate crimes to the police and/or health care providers.

As suggested here, there are many considerations to be taken into account when evaluating the optimum recovery environment for lesbian survivors of hate crime. One important aspect involves careful assessment of sexual identity and extent of previous disclosure regarding sexuality/sexual orientation. Furthermore, in specific settings, disclosure of homosexual behaviors can lead to harassment, job loss and the risk of further hate crime victimization. One veteran's experience is captured in a recent study by Herek and his associates (9). *"We were in a foreign country and we were in the military. When in the military you don't go to the police and say, 'Oh, they harassed us because we are gay".*

Closely related to this aspect of the recovery environment is the extent of social support available to the survivor. This is particularly significant for lesbians recovering from a hate crime, partly due to the self-doubt and questioning often generated by an attack related to their sexual orientation.

Finally, there are various considerations to be made about those involved in the recovery environment of the survivor, especially those directly involved in the treatment process. One obvious factor concerns the gender, and possibly even sexual orientation, of the treatment provider. Furthermore, given societal trends related to sexual prejudice and the commonly held myths about sexuality and the nature of hate crimes, it is essential for treatment providers to evaluate their own biases and continually assess the impact of these biases on the recovery environment of the survivor.

References

1. Breslau, N., Kessle, R.C., Chilcoat, H.D., Schultz, L.R., Davis, G.C., Andreski, M.A. (1998). Trauma and Posttrauamtic Stress Disorder in the community. Archives of General Psychiatry, 55, 626-632.
2. Kessler, R.C. (2000). Posttraumatic stress disorder: The burden to the individual and society. Journal of Clinical Psychiatry, 61, 4-14.
3. Herek, G.M., Gillis, J.R., & Cogan, J.C. (1999). Psychological sequelae of hate crime victimization among lesbian, gay, and bisexual adults. Journal of Consulting and Clinical Psychology, 67, 945-951.
4. DiPlacido, J. (1998). Minority stress among lesbians, gay men and bisexuals: A consequence of heterosexism, homophobia, and stigmatization. In G.M. Herek (Ed.), Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals (pp.138-159). Thousand Oaks, CA: Sage Publications.
5. Tjaden, P., Thoeness, N., & Allison, C.J. (1999). Comparing violence over the life span in samples of same-sex and opposite-sex cohabitants. Violence and Victims, 14, 413-425.
6. Balsam, K.F. (2003). Traumatic victimization in the lives of lesbian and bisexual women: A contextual approach. In T.L. Huges, C. Smith, and A. Dan (Eds.), Mental Health Issues for Sexual Minority Women: Redefining Women's Mental Health (pp. 1-14). New York: Harrington Park Press.
7. Pilkington, N.W., & D'Augelli, A.R. (1995). Victimization of lesbian, gay, and bisexual youth in community settings. Journal of Community Psychology, 23, 33-56.
8. Herek, G.M., Cogan, J.C., & Gillis, J. R. (2002). Victim experiences in hate crimes based on sexual orientation. Journal of Social Issues, 58, 319-339.
9. Berrel, K.T. (1992). Antigay violence and victimization in the United States: An Overview. In G.Herek and K. Berrill (Eds.), Hate Crimes (pp. 19-45). Thousand Oaks, CA: Sage.
10. Herek, G. (2000). The psychology of social prejudice. Current Directions in Psychological Science, 9, 19-22.

CLINICAL CONSIDERATIONS FOR TREATING SEXUALLY REVICTIMIZED WOMEN

Amy E. Naugle, Ph.D., Kathryn M. Bell, M.A., & Melissa A. Polusny, Ph.D.

The phenomenon of sexual revictimization among women who seek psychological services presents a unique and complex set of issues for clinicians. In this article, we provide an overview of the research on sexual revictimization and its related psychological consequences, as well as offer assessment and treatment suggestions for therapists working with sexually revictimized women.

Overview of Sexual Revictimization

Definition and Prevalence

Sexual revictimization generally refers to the relationship between experiences of childhood sexual abuse (CSA) and subsequent sexual victimization as an adolescent or adult. Research across a variety of samples and studies consistently has demonstrated that women with a CSA history are at significantly greater risk for experiencing sexual assault or other unwanted sexual experiences later in life (1-3). For example, Wyatt, Guthrie, and Notgrass (4) found that 56% of female CSA survivors reported adult sexual assault compared to 21% of nonabused subjects. In a study examining the relationship between CSA and revictimization among a sample of 1,887 female Navy recruits, the data suggested a significant relationship between CSA and adult sexual assault (5). After controlling for childhood physical abuse, rape was reported among women who had experienced CSA almost 5 times more frequently than among women with no CSA history. In one study investigating risk factors for sexual assault, Koss and Dinero (6) found that 66% of the women who reported rape or attempted rape also had prior childhood sexual experiences. Only the variables indicating past traumatic experiences improved predictions over base rates for identifying rape victims. Furthermore, results from a study on female veterans (7) indicated that more than half of women who were physically or sexually abused or raped during childhood also reported abusive experiences during adulthood, both during and outside of militaryservice.

> Revictimized women do not generally present for treatment with an articulated goal of dealing specifically with revictimization issues.
>
> Rather, they present because they are depressed, anxious, having problems in relationships, drinking excessively, or some complex combination of these and other problems.

The Impact of Sexual Revictimization

Sexual assault has been associated with a number of physical, psychological, and interpersonal difficulties. These difficulties include anxiety, PTSD, depression, anger, self-injurious behavior, substance abuse, somatization, sexual dysfunction, and distrust of others (3). The severity of these problems becomes even greater among women who have had multiple victimization experiences (8). Revictimized women scored higher on the Trauma Symptom Checklist (TSC; 9) than women who reported only one type of victimization experience (10), indicating the presence of more trauma-related symptoms. Moreover, Follette et al. (8) offer evidence for the cumulative impact of multiple victimization experiences. Women who identified multiple types of victimization experiences reported increasing levels of post-trauma symptoms. According to Cloitre, Scarvalone, and Difede (11), revictimized women are also more likely to attempt suicide and experience problems in areas such as intimacy and trust than either women who had never been sexually victimized or women who had been sexually assaulted only.

Risk Factors for Sexual Revictimization

Although the relationship between CSA and revictimization has been demonstrated by a number of empirical investigations, no theory accounting for mechanisms mediating this association has been definitively supported. That being said, a number of situational variables and both victim and perpetrator characteristics have been identified as potential risk factors. One potential risk factor is the nature of the relationship between the victim and the perpetrator. For example, the majority of sexual victimization experiences occur in situations where the victim and perpetrator know one another (12, 13). In fact, some data suggest that women who are unsuccessful at resisting unwanted sexual advances are more likely to be involved in a steady dating relationship with the offender (14). Research has also suggested that higher levels of consensual sexual activity may lead to increased risk of sexual victimization (4, 15-17). Among female Navy recruits, Merrill et al. (5) found that women with a CSA history reported having a higher number of sexual partners than women without a history of CSA. This is important information for clinicians. Often one therapeutic goal is to empower sexually victimized women to utilize skills to prevent future assaults. Given that sexual victimization generally is perpetrated by a man the woman knows, the nature of the skills to be utilized are qualitatively different than what is needed in stranger rape situations. Simply instructing women to lock their doors and avoid walking alone at night are not sufficient for preventing the type of unwanted sexual experiences that typically occur. Therefore, incorporating interventions that focus on

teaching women skills to thwart stranger attacks or to protect themselves once an attack has ensued may be helpful, these strategies are not sufficiently comprehensive.

Some researchers have found that the use of alcohol or other drugs by both males and females in dating situations is also associated with increased risk for sexual assault (6, 18, 19). It has been argued that the use of alcohol or drugs reduces male inhibition against forced sexual activity and impairs a woman's ability to resist an attack once it occurs. In addition, alcohol use may impair a woman's ability to identify additional risk factors earlier on in social interactions that may lead to unwanted sexual activity. Alcohol use by women may contribute to misinterpretations of men's intentions as well as contribute to psychological barriers such as concern of embarrassment or fear of rejection that make it difficult to resist sexual advances (20). Some sexually victimized women may drink or use drugs in order to reduce distressing PTSD symptoms (21). Furthermore, alcohol intoxication that functions to decrease or dampen anxiety and discomfort may also reduce other internal experiences that otherwise serve as cues that something is amiss. Therefore, while substance use problems may or may not be the primary focus of treatment, it is crucial for clinicians to assess both the nature and function of a client's substance use.

Researchers have investigated whether trauma related symptomatology might increase women's risk for being revictimized. In a 10-week prospective study of 323 college women, Sandberg, Matorin, and Lynn (22) found that PTSD symptoms moderated the effects of previous victimization on subsequent sexual assault. Revictimization was more likely among women who reported high levels of PTSD symptoms. Research has also investigated the role of other psychological phenomena that may be related to the presence of PTSD symptoms, such as alexithymia. Cloitre (23) has suggested that victimized women who are more alexithymic, or have difficulties identifying and labeling feeling states, possibly as a result of chronic hyperarousal symptoms, may be at increased risk for revictimization. Within the context of acquaintance rape, an alextyhimic woman's difficulties identifying and labeling her feelings may contribute to sexual miscommunication as well as her "no" being minimized or disregarded by her partner.

In addition to the risk factors described above, there has been an emerging interest in identifying potential risk recognition and behavioral skills deficits that may be associated with increased risk for sexual victimization. Given the high rate of sexual assault among previously victimized individuals, researchers have attempted to explain why these individuals are at substantially greater risk. One possible explanation for why individuals with a CSA history are at greater risk for revictimization is that previously victimized women may have difficulty assessing whether a social or interpersonal situation is risky (24, 25). In addition to the risk-recognition hypothesis, Naugle (26) suggested that a prior victimization experience could result in an impoverished repertoire. That is, even if a woman could adequately identify danger or risk, she may still lack the requisite skills for effectively dealing with the situation. Preliminary research provides some support for this hypothesis. Using a set of videotaped scenarios depicting interpersonal situations that might be related to sexual assault risk, Naugle (26) found that women with a prior victimization history rated the vignettes as depicting more risk than did women who had not been sexually victimized. However, even though they rated the scenarios as being riskier, previously victimized women were more likely to acquiesce to the offers of the males in the vignettes than were non-victimized women.

Both the risk-recognition problems and skills deficits are not unrelated to the risk factors outlined above. Indeed, these deficits may be the result of chronic hyperarousal or emotional numbing that results from prior sexual abuse experiences (23). Such autonomic challenges may make it difficult for women to distinguish physiological changes that would normally signal a person to avoid or respond effectively to dangerous situations. Furthermore, alcohol intoxication and drug use are other factors that may impair judgment and interfere with use of effective skills.

It is important to recognize that research on risk factors for revictimization is correlational in nature. That is, we cannot say whether these particular skills deficits or psychological factors are causes of revictimization or whether they are consequences or outcomes of revictimization. Regardless of the direction of the relationship between risk variables and revictimization, clinicians are challenged to address these issues, among others, when working with individuals who have been revictimized.

Clinical Implications

In working with revictimized women, the overarching goals for the clinician are twofold. First, intervention strategies should be aimed at reducing psychological distress and improving quality of life. Revictimized women do not generally present for treatment with an articulated goal of dealing specifically with revictimization issues. Rather, they present because they are depressed, anxious, having problems in relationships, drinking excessively, or some complex combination of these and other problems. Therefore, this first goal of treatment involves decreasing the distress that may have resulted from being sexually victimized. A second goal is to specifically address risk factors for future revictimization and introduce skills to minimize risk.

Orienting the Client to Treatment

Working with sexually revictimized women inevitably will involve dealing specifically with the sexual traumas at some point in treatment. This exposure-based therapeutic work will require individuals to recall distressing events associated with the trauma(s). Given the emotionally distressing nature of this treatment component, sexually victimized clients may be reluctant to begin and follow through with treatment. In addition, childhood sexual abuse experienced by many women who present for treatment may have involved trusted adults who failed to provide protection and nurturance. These early experiences may result in clients being avoidant of close relationships, including the therapeutic relationship. Therefore, it is essential for the therapist to work early on in treatment to establish and maintain good rapport and trust with the client. Sexually revictimized clients may find it difficult to progress through certain components of therapy that are emotionally and physically draining.

The therapist may need to gently guide the client through treatment without forcing the client to complete steps prematurely. In order to maximize the likelihood that the client will successfully complete treatment, the therapist should make every attempt to set the client up for success when assigning new tasks for the client to complete. For instance, when learning new interpersonal skills, it may be useful to have the client practice these skills in settings where the client is likely to succeed before encouraging the client to use the skills in more challenging situations. It may also be helpful to discuss with the client the potential for setbacks when trying new skills outside of therapy. By preparing the client for possible relapses, the client may be less likely to discontinue therapy when a setback has occurred. Furthermore, it may be important for the therapist to periodically address behaviors that may be interfering with treatment progress. For example, a client may be hesitant to complete homework assignments that evoke negative emotions. The use of behavioral chain analyses may help the client understand how this avoidance of negative emotions has functioned as a coping strategy in the past and how the avoidant behavior may be preventing her from successfully meeting new goals.

Assessment Issues

Individuals who have been sexually revictimized may be at a higher risk for developing a number of Axis I disorders, including major depression, substance abuse/dependence, and post-traumatic stress disorder. Therefore, it is imperative that clinicians conduct a thorough assessment of the client's problems before proceeding with treatment. A combination of self-report measures (e.g., Beck Depression Inventory, 27; Brief Symptom Inventory, 28) and structured interviews (e.g., Structured Clinical Interview for Diagnostic and Statistical Manual-IV [SCID-IV], 29; Clinician Administered Interview for PTSD [CAPS], 30), as well as informal clinical interviews, can be used to assess the client's current symptomatology and overall level of functioning. Specific attention should be given to PTSD, depressive (including suicidal and self-injurious behaviors), dissociative, and substance abuse symptoms. An extensive clinical history should be conducted to gather detailed information on the client's traumatic experiences (including natural and man-made disasters) and the impact these experiences had on the client's life. In addition, the therapist should assess the client's current living situation and relationship status to determine the client's potential for sexual revictimization. Self-reported measures such as the Revised Conflict Tactics Scale (31) may be useful in assessing the client's current and past physical victimization history. Since victims of sexual assault may have an extensive medical history and are at a higher risk for somatization, the clinician should also conduct a thorough assessment of the client's physical health history. Additional information should be gathered regarding the client's coping strategies, history of interpersonal problems, and current level of social support. When developing a treatment strategy, the clinician should consider how the client's symptoms may be interacting with each other. For example, many sexually revictimized clients may use substances to help regulate and dampen their emotions. By teaching the client more appropriate ways to effectively regulate affect, the client may be less likely to rely on substances to cope with negative emotions. Given the transient nature of many of the symptoms experienced by sexually revictimized clients, it is recommended that the therapist reassess the client's symptomatology and risk for revictimization periodically throughout treatment.

...the first goal of treatment involves decreasing the distress that may have resulted from being sexually victimized. A second goal is to specifically address risk factors for future revictimization and introduce skills to minimize risk.

In addition, assessment strategies that identify specific discrimination and skills deficits may allow us to develop intervention and prevention strategies to teach women to better identify environmental cues that indicate potential danger. Moreover, identification of specific repertoire deficits may aid in intervention components designed to establish or strengthen the behavioral repertoires of survivors so that they can more effectively deal with high risk situations, while still establishing social behavior that allows for the pursuit of supportive intimate relationships.

Intervention Strategies

A number of empirically supported cognitive-behavioral interventions exist for treating specific psychological problems that may be associated with a revictimization history. For example, cognitive therapy (32) and behavioral activation (33) have been demonstrated to be effective for reducing levels of depression. Anxiety management techniques are useful for addressing symptoms of anxiety and panic (34), and so on. However, it may be constructive to consider implementing treatment strategies designed to address the unique problems and concerns of revictimized women specifically. Cloitre (23) has proposed one treatment model for revictimized women that combines prolonged exposure techniques with additional affect regulation and interpersonal skills.

The Skills Training in Affect and Interpersonal Regulation/ Prolonged Exposure (STAIR/PE; 23) treatment model was created to address the PTSD, interpersonal, and affect regulatory problems often experienced by sexually revictimized clients. The model contains two modules, which can be used separately or conjointly during treatment. Cloitre recommends that therapists consider using both components when the client is experiencing both significant skills-related deficits and PTSD symptoms. The STAIR component typically involves eight sessions that focus on teaching clients to successfully identify and label various feelings, tolerate aversive events and cope with negative affect, and effectively manage challenging interpersonal relationships through the use of self-control and assertiveness skills.

Cognitive-behavioral techniques are often used to encourage clients to monitor and rate their feelings, recognize and confront irrational thinking, and practice appropriate strategies for addressing difficult interpersonal situations. In addition, positive imagery and self-statements are often utilized to aid clients in regulating their emotions.

The second component included in Cloitre's treatment model involves the use of prolonged exposure to treat PTSD symptoms often experienced by sexually revictimized clients. Based on Foa's exposure treatment for rape victims (35), Cloitre's model recommends that the client be gradually exposed to the traumatic memories both in and out of session while continuing to be encouraged to use coping skills acquired in the STAIR component. However, PTSD symptoms of sexually revictimized clients have also been effectively treated through the use of techniques such as Cognitive Processing Therapy (36) and Eye Movement Desensitization and Reprocessing (EMDR; 37).

In addition to addressing psychological distress experienced by women who have been sexually revictimized, it is also essential that treatment focus on strengthening behavioral skills necessary to prevent future occurrences of unwanted sexual experiences. Given that revictimized women may have difficulty identifying and responding to interpersonal and environmental risk, it may be important to teach clients how to recognize high-risk situations. Furthermore, teaching specific skills for dealing with high-risk encounters may also be essential. For example, assertion and communication in interpersonal situations and around sexual negotiation may be particular areas to target in treatment. Teaching women to identify and express their own needs and preferences as well as how to be assertive in response to their partners' demands may help reduce incidence of sexual victimization. Revictimized women may benefit from therapy that resembles assertiveness training yet recognizes the complexity of the interpersonal relationships in which victimization occurs. Women may benefit from therapy focused on building relationship skills, strengthening personal values, and developing a sense of self worth that is less directly influenced by the presence of others or by one's accomplishments and failures.

While the assessment and intervention strategies described above are relevant to treating most sexually victimized and revictimized women, there may be unique issues involved in working with female veterans and military personnel. Women who are currently enlisted in the military may face risk factors for victimization that are specifically related to their military involvement. For example, the disproportionate ratio of males to females in some branches of the military may contribute to a sexualized environment for women. Women in the military may have to withstand both more overt as well as more subtle forms of sexual coercion than other women. Such issues may make it difficult for enlisted women to come forward when they encounter unwanted sexual experiences, especially when perpetrated by their male peers. Reports of sexual assault may not be taken seriously and making such claims may result in continued harassment by the assailant as well as by other male military personnel. Therapy may be the only safe arena for female military personnel to talk about their experiences. However, these women may not initially trust the privacy and safety of the therapeutic environment and may be reticent to disclose information even to a therapist. Additional reassurance and time may be required to do the demanding therapeutic work described above.

Conclusion

Working with sexually revictimized women necessarily involves the clinician communicating with the client about graphic details of rape and other traumatic experiences. This aspect of treatment may be personally distressing for many clinicians, and may result in changes in their own worldview. Additionally, McCann and Pearlman (38) have suggested that clinicians doing trauma work may experience "vicarious traumatization", or traumatic stress reactions that occur after hearing accounts of victimization during therapy. Clinicians may find themselves experiencing intrusive recollections of details of their clients' trauma histories revealed during exposure work, avoiding situations that are perceived as dangerous, as well as experiencing strong emotions such as sadness, anger, and disgust (36). Moreover, these reactions may influence clinicians' in-session behavior in ways that make treatment ineffective or even harmful. For example, clinicians who are distressed by hearing about details of clients' victimization history may avoid processing these details in therapy. Focusing on skill deficits that may increase a client's risk for revictimization without also validating how prior victimization may have interfered with the development of effective skills may be perceived as blaming and judgmental. The therapeutic relationship is an important tool that allows clinicians to model and reinforce a more effective behavioral repertoire for successful living and prevention of further victimization. Given this, it is important that clinicians utilize appropriate supervision and consultation, as well as personal therapy if indicated, to remain effective and empathic in their work with revictimized women.

References

1. Breitenbecher, K. H. (2001). Sexual revictimization among women: A review of the literature focusing on empirical investigations. Aggression and Violent Behavior, 6, 415-432.
2. Messman, T. L., & Long, P.J. (1996). Child sexual abuse and its relationship to revictimization in adult women: A review. Clinical Psychology Review, 16, 397-420.
3. Polusny, M. A., & Follette, V. M. (1995). Long term correlates of child sexual abuse: Theory and review of the empirical literature. Applied and Preventive Psychology, 4, 143-166.
4. Wyatt, G. E., Guthrie, D., & Notgrass, C. M. (1992). Differential effects of women's child sexual abuse and subsequent sexual revictimization. Journal of Consulting and Clinical Psychology, 60, 167-173.
5. Merrill, L. L., Newell, C. E., Thomsen, C. J., Gold, S. R., Milner, J. S., Koss, M. P., & Rosswork, S. G. (1999). Childhood abuse and sexual revictimization in a female Navy recruit sample. Journal of Traumatic Stress, 12, 211-225.
6. Koss, M. P., & Dinero, T. E. (1989). Discriminant analysis of risk factors for sexual victimization among a national sample of college women. Journal of Consulting and Clinical Psychology, 57, 242-250.
7. Coyle, B. S., Wolan, D. L., & Van Horn, A. S. (1996). The prevalence of physical and sexual abuse in women veterans seeking care at a veterans affairs medical center. Military Medicine, 161, 588-593.

8. Follette, V. M., Polusny, M. M., Bechtle, A. E., & Naugle, A. E. (1996). Cumulative trauma effects: The impact of child sexual abuse, adult sexual assault, and spouse abuse. Journal of Traumatic Stress, 9, 15-25.
9. Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. Journal of Interpersonal Violence, 4, 151-163.
10. Gold, S. R., Milan, L. D., Mayall, A., & Johnson, A. E. (1994). A cross-validation study of the Trauma Symptom Checklist: The role of mediating variables. Journal of Interpersonal Violence, 9, 12-26.
11. Cloitre, M., Scarvalone, P., & Difede, J. (1997). Post-traumatic stress disorder, self, and interpersonal dysfunction among sexually revictimized women. Journal of Traumatic Stress, 10, 435-450.
12. Koss, M. P., Dinero, T. E., Seibel, C. A., & Cox, S. L. (1988). Stranger and acquaintance rape: Are there differences in the victim's experience? Psychology of Women Quarterly, 12, 1-24.
13. Russell, D. E. H. (1984). Sexual exploitation: Rape, child sexual abuse, and workplace harassment. Beverly Hills, CA: Sage.
14. Amick, A. E., & Calhoun, K. S. (1987). Resistance to sexual aggression: Personality, attitudinal, and situational factors. Archives of Sexual Behavior, 16, 153-163.
15. Abbey, A., Ross, L. T., McDuffie, D., & McAuslan, P. (1996). Alcohol, misperception, and sexual assault: How and why are they linked? In D. M. Buss & N. M. Malamuth (Eds.), Sex, power, conflict: Evolutionary and feminist perspectives (pp. 138-161). New York: Oxford.
16. Gidycz, C. A., Coble, C. N., Latham, L., & Layman, M. J. (1993). Sexual assault experience in adulthood and prior victimization experiences. Psychology of Women Quarterly, 17, 151-168.
17. Mayall, A., & Gold, S. R. (1995). Definitional issues and mediating variables in the sexual revictimization of women sexually abused as children. Journal of Interpersonal Violence, 10, 26-42.
18. Muehlenhard, C. L., & Linton, M. A. (1987). Date rape and sexual aggression in dating situations: Incidence and risk factors. Journal of Counseling Psychology, 34, 186-196.
19. Norris, J., & Cubbins, L. A. (1992). Dating, drinking, and rape. Psychology of Women Quarterly, 16, 179-191.
20. Norris, J., Nurius, P. S., & Dimeff, L. A. (1996). Through her eyes: Factors affecting women's perception of and resistance to acquaintance sexual aggression threat. Psychology of Women Quarterly, 20, 123-145.
21. Ruzek, J. I., Polusny, M. A., & Abueg, F. R. (1998). Assessment and treatment of concurrent posttraumatic stress disorder and substance abuse. In In V. M. Follette, J. I. Ruzek, & F. R. Abueg (Eds.), Cognitive-behavioral therapies for trauma (pp. 226-255). New York: Guilford.
22. Sandberg, D. A., Matorin, A. I., & Lynn, S. J. (1999). Dissociation, posttraumatic symptomatology, and sexual revictimization: A prospective examination of mediator and moderator effects. Journal of Traumatic Stress, 12, 127-138.
23. Cloitre, M. (1998). Sexual revictimization: Risk factors and prevention. In V. M. Follette, J. I. Ruzek, & F. R. Abueg (Eds.), Cognitive-behavioral therapies for trauma (pp. 278-304). New York: Guilford.
24. Naugle, A. E., & Follette, W. C. (1994, November). An empirically derived functional analytic conceptualization of revictimization. Paper presented at the annual meeting of the Association for the Advancement of Behavior Therapy, San Diego, CA.
25. Wilson, A.E., Calhoun, K.S., & Bernat, J.A. (1999). Risk recognition and trauma-related symptoms among sexually revictimized women. Journal of Consulting and Clinical Psychology, 67, 705-710.
26. Naugle, A. E. (1999). Identifying behavioral risk factors for repeated victimization using video-taped stimulus materials. Unpublished doctoral dissertation, University of Nevada, Reno.
27. Beck, A. T., Steer, R. A., & Brown, G. K. (1996). Beck Depression Inventory-Second Edition manual. San Antonio, TX: The Psychological Corporation.
28. Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. Psychological Medicine, 3, 595-605.
29. First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1997). Structured Clinical Interview for DSM-IV Axis I Disorders-Clinician Version (SCID-CV). Washington D. C.: American Psychiatric Press.
30. Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Charney, D. S., & Keane, T. M. (1997). Clinician-administered PTSD Scale for DSM-IV. Journal of Traumatic Stress, 8, 75-90.
31. Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised conflict tactics scales (CTS2). Journal of Family Issues, 17, 283-316.
32. Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). Cognitive therapy of depression. New York, NY: The Guilford Press.
33. Martell, C. R., Addis, M. E., & Jacobson, N. S. (2001). Depression in context: Strategies for guided action. New York: W. W. Norton.
34. Barlow, D. H. (2002). Anxiety and its disorders: The nature and treatment of anxiety and panic (2nd ed.). New York: Guilford.
35. Foa, E. B., & Rothbaum, B. O. (1998). Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. New York: Guilford.
36. Resick, P. A., & Schnicke, M. K. (1993). Cognitive processing therapy for rape victims. Newbury Park, CA: Sage.
37. Shapiro, F. (2001). Eye movement desensitization and reprocessing: Basic principles protocols, and procedures (2nd ed.), New York: Guilford Press.

Amy E. Naugle, PhD, is Assistant Professor in the Department of Psychology at Western Michigan University. Dr. Naugle's research and clinical interests focus on the psychological, behavioral, and interpersonal outcomes associated with a history of sexual trauma.

Kathryn Bell is a doctoral student in clinical psychology at Western Michigan University. Her primary research and clinical interests are centered on understanding and treating adult sexual and physical victimization.

Melissa A. Polusny, PhD, is staff psychologist at the Minneapolis Veterans Affairs Medical Center, and Assistant Professor in Psychiatry at the University of Minnesota. Dr. Polusny's research and clinical interests include acceptance theory, long term correlates of sexual trauma including revictimization, disaster mental health issues, and the impact of trauma exposure and emotion regulation on health outcomes.