Women Who Served In Our Military: Provider Perspectives
Written Video Transcript

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It's hard on the families. It's hard on the children. It's hard on spouses that stay back here. Because then [00:03.00.00] you're finally just getting back into the swing of things and then (you happen) to have to leave again.

I was always sad, I was always crying. I was depressed. The only thing I would do was go to work and come back home. I didn't like weekends [00:03.20.00] because I would have to spend the weekend by myself. So, I guess I would always want to be at work. At least there I didn't have to think about what was going on.

We all have always jokingly said (we medics) are kind of like the worst people of all because we're the last ones to take care of ourselves. [00:03.40.00] But we do seek it out. [00:04.00.00]

Like the women you just met we owe a great deal to all women who have served in our country's military. All have made personal sacrifices. Hello, I'm Jane Pauley and today I'm at the Women In Military Service Memorial at the entrance to Arlington National Cemetery. At this honored site we pay tribute to all women [00:04.20.00] who have gallantly served our nation. Our military sisters have played crucial roles in our history. They've nursed the wounded, built military equipment, kept supplies moving, flown air transports and performed many other jobs. And they continue to be a vital link today. The exhibit on display here [00:04.40.00] at the memorial is called Faces of the Fallen. Each portrait is a man or woman who has given their life for Operation Enduring Freedom or Iraqi Freedom. A reminder that so many have made the ultimate sacrifice. There is no way to adequately express our gratitude to [00:05.00.00] our brave veterans, both men and women. But we should begin by saying thank you.

The war on terror in Afghanistan and Iraq has reshaped our view of women in today's military. More than 60,000 women have been deployed overseas. [00:05.20.00] Particularly in Iraq military personnel, both men and women, find themselves in combat situations. And with no clear frontlines danger is always near.

In this war we have had more women serve in the military than ever before. Their jobs are diverse: leadership roles, [00:05.40.00] roles in combat, support services, health care, the whole nine yards.

Women are there, they're carrying an M-16, they're driving a truck on a convoy that's hit with a rocket-propelled grenade, they're receiving small arms fire. They're being wounded. [00:06.00.00] They're in live combat with enemy forces.

People are exposed to death and danger, to rocket attacks, mortar attacks. Everybody who watches the news knows what they're exposed to. In addition it can be slightly different for a woman over there. [00:06.20.00] She can be feel vulnerable because there may be fewer of her. She may feel targeted by the other side. So, women do have some unique stresses. But most of what they face is pretty much the same as men as far as danger.

We're going to have women who have suffered and experienced [00:06.40.00] similar type of injuries as their male counterparts, such as traumatic brain injury. We have women right now in Walter Reed and some of the other military facilities around the country who've experienced amputations or become blinded by explosive devices. And so I think that over the history of time our perception and the actual role [00:07.00.00] of women in the military has certainly been changed in the last few years.

From our early days women have played a vital role in supporting or serving our nation's military efforts. During the American Revolution [00:07.20.00] some women disguised themselves as men because women weren't allowed to fight. During the Civil War women were hired as nurses and cooks and other jobs supporting the troops.

I have a great quote, and it was from 1862. It was a Union General (Shields) to secretary of war, [00:07.40.00] in 1862. And he said, "I can retake the Shenandoah Valley but you must send men to keep it. The women will take it if we don't." So, that was way back in 1862, so imagine when you talk about women in the military and their history, we go back centuries.

Women have served in a variety [00:08.00.00] of roles. As an example, Dr. Mary Walker served as an army surgeon during the Civil War. Dr. Walker is the first and only woman to have been awarded the Congressional Medal of Honor. At the turn of the 20th century the Army Nurse Corps and Navy Nurse Corps were established. But World War I [00:08.20.00] appears to have been a turning point in the history of women in the military. Women became an official part of the military. It was the first war in which American women served overseas, and many were decorated with combat medals. More than 35,000 served in roles ranging from nurses to telephone operators [00:08.40.00] to clerks. Ten times that many women were recruited in World War II when women began to take on larger missions, flying airplanes and serving overseas. This war saw the first female officers. More than 200 military women of the Women's Army Corps [00:09.00.00] and Women Air Force service pilots died in action overseas, 88 were held

as prisoners of war. Up to that point women were recruited only during times of war and then released from service. But in 1948, Congress passed legislation allowing women to serve on a permanent basis. [00:09.20.00] Now women for the first time could make a career in the military. The majority of women sent to Korea during the Korean conflict and to Vietnam during the Vietnam War were nurses. However, during the Vietnam War the military opened up many other positions to women. [00:09.40.00] In 1970, Anna May Hayes, head of the Army Nurse Corps, became the first female brigadier general. But the biggest gains for women came with the all volunteer force in 1973. Since then the ranks of active duty women have jumped from nearly 3% of the force [00:10.00.00] to more than 15% today. More women saw action in Desert Storm., nearly 35,000 served in the Persian Gulf. Women flew reconnaissance and search and rescue missions, drove convoys over the desert and were close to enemy positions. And in the 21st century women continue to serve around the world, [00:10.20.00] playing a prominent role in Operation Enduring Freedom and Iraqi Freedom. [00:10.40.00]

I feel like I could talk for a straight week about everything that happened over there and no matter what I could say, no matter all the pictures I took and the diary I kept and everything, there is no substitute for actually being there. I mean there's no way to capture the experience. And people back here, [00:11.00.00] if they haven't been there, they just don't understand.

Like many men and women in the Army reserves, Cheryl received the word to report for duty in a hurry. One moment she's at work in a software company, the next moment she gets a e-mail to report to active duty, in her case in three days. [00:11.20.00]

I had to stop mail and arrange for my car to be stored and my rent to be paid automatically and you know just try to pack. They didn't give me a packing list, so basically I was just going through everything going, "Well, will I need this, will I need that? I don't even know where I'm going."

Cheryl and four other women were separated from their original unit and were sent first [00:11.40.00] to Kuwait, then on to Iraq. She describes the constant threat that all troops faced.

Well, besides the constant threat to your life, because every day that we went outside the wire we were in danger, even if we were at a so-called friendly person's house [00:12.00.00] or a school or a police station, our mere presence there could make that place a target. So, we always had to be on guard.

And the living conditions could be unbearable.

I knew it was going to be hot. I had no idea that a human being could survive such heat, especially with all the gear that we had to wear. [00:12.20.00] You know, we had to keep our sleeves down, had to wear our flak vest everywhere. It's incredibly hot. It would routinely get up to 130, 140 in the summer.

Another problem Cheryl faced as a military woman was the chain of command. To Cheryl it seemed that the intent was to prove that women were not cut out [00:12.40.00] for the military.

Many times I felt set up for failure when given tasks, because I remember one guy actually put me in charge of a tent detail not because he knew I could do it, but because he knew I couldn't. It seemed to me that they were trying to prove that a woman really couldn't make it out there. [00:13.00.00]

Cheryl proved them wrong. She completed her service staying over a year in Iraq. However, like many men and women, when she came back home problems she had ignored in country emerged.

I couldn't face it, I couldn't even get up in the morning. I couldn't, [00:13.20.00] I couldn't sleep in my bed, you know. I was just a wreck. And I went to my civilian doctor and he, you know, said, "Well, just go home and try to take it easy."

But her despair, depression and anxiety would not go away. Cheryl next made an appointment at an army medical center.

So, I went to the military hospital [00:13.40.00] and saw a specialist there that I was told is strictly dealing with returning OIF, OEF veterans. And sat in his office and pretty much sat there crying the whole time. And he handed me a book and told me to take it home and read it. And when I asked about any follow up he said he didn't think it would be necessary, just go home and read the book. [00:14.00.00]

But again, Cheryl wouldn't give up. After more searching she came across the vet center online, the Web site for readjustment counseling service through the VA. She was able to get the resources and help she needed. She made those all-important first steps [00:14.20.00] of reaching out and getting reconnected. She's now involved in individual counseling and group sessions at the local vet center.

You know, when you break your leg you need a doctor, you need someone to put a cast on you. When you go through trauma sometimes you need somebody who can, you know, kind of put that mental cast on you until you're strong enough again. [00:14.40.00]

For all military men and women an important aspect of training is to persevere despite hardship, despite pain and suffering, despite the odds. [00:15.00.00] However when military men and women return from deployment, minimizing, denying or pushing on through distress or physical problems can be counterproductive in the long term. Skilled interventions can often help to minimize or even resolve post-deployment issues or problems. [00:15.20.00] For providers it's important to understand military women's unique contributions and challenges, battlefronts that many women fought and some continue to fight. Until World War II women served without rank. And in the military

no rank means little authority. [00:15.40.00] Females were given desk jobs or food service or became nurses. Women often felt their work went unrecognized. Even today, although women may be promoted in the military, or become officers, many experience a definite glass ceiling. Many women feel they were not given the recognition, respect and credibility [00:16.00.00] commensurate with their roles and responsibilities. And sometimes today military women still feel treated differently.

I was waiting for my appointment and this lady nurse came and asked all the male veterans if they had got their flu shot and she just ignored me. And I was like, [00:16.20.00] "Excuse me," and I was sitting right there with them. And she's like, "Oh, are you a veteran?" I said, "Yes." She's like, "Oh, I'm sorry." But I mean it shouldn't have taken for me to say anything for her to acknowledge me. All she had to do was ask the question.

A recent report by the American Journal of Industrial Medicine reveals that among female veterans nearly three in ten [00:16.40.00] reported sexual assault during their military careers. And it appears to occur more frequently, and to a greater degree, when only a few females are part of the unit. Sexual assault remains a threat for many women in the military. Many don't report an assault for fear of making matters worse. [00:17.00.00] They fear reprisals such as demotions, lack of promotions, escalation of the abuse, ridicule, or even discharge.

Sometimes they will say that their experience afterwards was far worse than the rape itself. Simply because they didn't get acknowledged or validated [00:17.20.00] as far as the rape goes.

For example, the effects of trauma within the military have shown that the impact is even greater than those people traumatized in the general community. And that may be because the military [00:17.40.00] is seen in such a symbolic way. Many of the people are attracted to the paternalistic structure, and the promises for something better. The trauma then becomes a betrayal of that.

Women in the military often feel they have to prove themselves that they can handle a job [00:18.00.00] as well as a man. Part of this relates to being in a male dominated field, countering old beliefs about women's ability to perform certain jobs.

As female officer I was the only female lieutenant. And it was a little different for that reason. I didn't feel like I could ever show feelings or weakness. [00:18.20.00] I had to kind of just be on my own. Didn't want anybody to see any weakness, because I wanted to prove I was worthy of being there.

We must also keep in mind each veteran's personal background. Is there prior history of trauma? For example, veterans may have suffered physical [00:18.40.00] or sexual abuse in childhood, or have been a victim of domestic violence. Other considerations include

whether the veteran has lived in poverty or in crime-ridden areas, factors often associated with violence.

A couple studies have pointed out that women who are younger, women who may be enlisted [00:19.00.00] as opposed to officers, not in leadership roles, and have childhood trauma, sexual trauma backgrounds, are twice as much, twice as likely to be assaulted and raped in the military. So, we're often seeing patients with that kind of background.

A veteran's general background and life experiences [00:19.20.00] and developmental stages also have to be considered, such as whether a woman is a new parent or has just retired. Other factors may include religion, ethnic or cultural affiliations, and race. Some of our female clients may have experienced racism or prejudice. [00:19.40.00]

With African-American females seeking help in our facility, her symptoms may not be that much different than her sister coming in seeking services. What might be different though would be her attitude about seeking care. There may be a little more suspiciousness, [00:20.00.00] a little more wariness about the institution.

And a woman's final front may be a life threatening trauma experienced in a war zone or elsewhere in her military career. The result of trauma has left many veterans with a challenge: to manage their own war within. [00:20.20.00]

Before my experience in Desert Storm I believe I would have been able to handle it and never have gotten in that situation. But afterwards I just ... I didn't have it in me to stop that situation. And looking back now I can see what [00:20.40.00] happened throughout those years, and what just built up and built up and built up. I can see that now after going through treatment. But I couldn't see it then.

I felt very numb when I came back. Very emotionally dead. So, it took a few months to kind of unwind from that, and realize [00:21.00.00] it's okay to show now you feel and say how you feel. And you don't have to prove anything to anybody.

A history of factors such as these fronts can complicate a woman's emotional, psychological and physical functioning during her military career. They can also compromise her readjustment to civilian life. [00:21.20.00]

Soldier's heart, shell shock. That's what combat stress reactions used to be called. With an increasing number of women facing combat many veterans and active duty personnel return from war only to experience [00:21.40.00] their own war within. About 20% to 25% of the women who served in the Vietnam war, and the first Gulf War, were reported to have post-deployment adjustment issues. This number is expected to rise in those deployed in recent wars. So, what is normal [00:22.00.00] adjustment and how do we know when a veteran's psychological or physiological functioning may be outside a normal range?

The symptoms range from minor anxiety to depression to panic attacks to adjustment disorders to [00:22.20.00] PTSD. So, there's a wide variety of symptoms that occur and reactions that occur.

I might argue that almost everybody has some readjustment problems who have been off to war. But when we're talking about somebody who may qualify for a mental disorder, PTSD, depression, substance use, that would be a small number. Again, 20%, 25% [00:22.40.00] or thereabouts.

Common responses to traumatic stress include acute stress disorder, symptoms that occur within a month of the trauma, to include being easily startled or being hyper vigilant and experiencing problems falling or staying asleep. Other common reactions include [00:23.00.00] depression, general anxiety and panic attacks. There's also adjustment disorder, symptoms in a number of these areas that make it difficult to adjust to civilian life and post-traumatic stress disorder, or PTSD. These symptoms last more than one month and include emotional numbing, [00:23.20.00] heightened arousal, sleep onset and maintenance problems, nightmares, feeling isolated and alone and having intrusive memories of the traumatic event. PTSD commonly occurs after traumatic military experiences such as firefights [00:23.40.00] and other combat situations, or seeing someone gravely injured or dead, being held as prisoner or being tortured, body handling or being the victim of military sexual assault.

Females consistently have been proven to have PTSD at at least twice the rate as males [00:24.00.00] for reasons we don't understand. But the point is we need to pay special attention to females, particularly those who are exposed to trauma, either sexual trauma or combat trauma, because they're at much greater risk for having a problem of a PTSD sort that (are males) and develop special screening and attentive health care interventions [00:24.20.00] for them.

When the symptoms of stress occur immediately after a traumatic event they're known as acute stress disorder. But if they continue longer than a month they meet criteria for PTSD. They're called chronic when they've lasted for six months or longer. But, it's not unusual for PTSD [00:24.40.00] to appear with a delayed onset months or even years after the event.

The likelihood of having a problem, PTSD or otherwise, is very much dependent upon the dose of trauma. The more intense, the longer the duration or the more severe the trauma the more likely you are to have PTSD [00:25.00.00] or depression or some other related mental health problems. So, as health care practitioners we need to know what experiences people have had, how long they were in country, how much they were exposed to death and dying and the horrors of war, because that will be a very good predictor.

Now we have a more complex pictures of PTSD in women veterans. Where previously the bulk were [00:25.20.00] suffering from PTSD because of sexual or physical abuse, or

severe illness or life threatening accident. Not that those problems have gone away, but we're now seeing women who have the same sort of combat trauma in every way as men veterans.

This is the [00:25.40.00] first time we're really seeing large numbers of women in combat. And we don't exactly know what to expect. We don't know what the long term psychological consequences are going to be. However, we are doing research on that and we're following women, both in the battle field and after they get back home to see how they do.

The big thing that we noticed [00:26.00.00] is that the soldiers going through an incident, the National Guard had often known each other for a long time, and just a lot of stress on the level of family type stress, friend type stress, fellow soldier stress. The combat losses were much more traumatic because of the relationships [00:26.20.00] of the soldiers.

I think for a lot of soldiers it's going to be a big adjustment coming back to the lifestyle that we have here compared to what we had in Iraq. Because they were on the go all the time. So, I think there is a big adjustment for those soldiers. And I think one of the things is that adjustment comes slowly. [00:26.40.00]

Experts say the best way to find out if there are adjustment issues is to first build rapport, then ask some basic questions to see if your female clients are having problems.

How are you sleeping? Do you have trouble getting to sleep? Perhaps even more importantly, after you get to sleep [00:27.00.00] are you awakened, anxious and restless and sweaty and upset? And I also ask them whether they're having disturbing dreams. Because difficultly sleeping and having problems with nightmares are seen as more normal [00:27.20.00] variants of the human experience.

Are they having difficulty readjusting to their work? Are they having difficulty in their marriage or with their parenting. All of these areas can, can reflect problems in adjusting that may have to do less with—we think less in terms of a does a person have a diagnosable mental health condition [00:27.40.00] and more in terms of how are you doing, how's your life going, what can we do to help?

It's confusing when you have PTSD. You may think that you're going crazy, but you're not. The symptoms of PTSD is a response by your body and your brain to overwhelming pressure and stress. [00:28.00.00] This can happen to anyone, even the strongest person.

As providers it's important to reassure the veteran that what she may be experiencing is a normal reaction to trauma. Avoid mental health diagnostic labels such as major depressive disorder, or post-traumatic stress disorder until a formal diagnosis has been confirmed. [00:28.20.00] This can be particularly relevant to recent veterans, active duty, National Guard or reserves who have served in Operation Enduring Freedom, Iraqi Freedom, because they could be redeployed.

There are those veterans who are still active in the National Guard or the reserves or are seeking [00:28.40.00] employment with the police or the fire department, who feel that if they have a formal diagnosis of post-traumatic stress disorder this will impair their career. In those veterans I'm more circumspect about making a formal diagnosis by DSM-IV criteria, at least for a while.

Many guard and reserve [00:29.00.00] members and veterans do have some concerns about stigma, related to inheriting, if you will, a mental health diagnosis or seeking care from a mental health practitioner. There are fears that this will somehow hurt them in their career pursuits or advancement up the ranks if they're still in the guard and reserve.

As a clinic what we're moving more towards is more general descriptors. [00:29.20.00] For example, what's the soldier here for? It's post-deployment adjustment. Maybe we're talking about combat stress. Tell you what, I (V code) an awful lot until later on in terms of phase of life. Anyone coming back from a deployment is going through a phase of life issue. Perhaps I run the risk of being imprecise, [00:29.40.00] but I can always talk to a provider through confidential e-mail or mostly on the phone or in person if there's really an issue to talk about there.

Most veterans returning from a combat zone deployment don't want to see themselves as having [00:30.00.00] a psychiatric problem because of the heroic service they perform for their country.

It's best to honor our service men and women by treating them with respect. Be mindful of the stigma issue in your treatment. And since you may be seeing [00:30.20.00] more women exposed to combat in your practice, it's also important to recognize women's challenges on the home front as well. [00:30.40.00]

In some ways I'm still dealing with the isolation or the whose roles are what. Still have to struggle with that. My husband kind of became Mr. Mom while I was gone. He quit his full-time job, moved the kids up here to Washington, [00:31.00.00] got them started in school, and didn't find a full time job until after I got back.

Leeann spent 14 months as first lieutenant and convoy commander with the National Guard in Iraq, a year she and her family will never forget. Leeann was part of the first wave of soldiers that moved in Iraq as the war began. [00:31.20.00] After completing her duty with the National Guard Leeann now works for the Veterans' Benefits Administration, but her memories of being thrown into a war zone are still vivid.

We don't have a luxury of separate quarters. In Kuwait there were a number of rapes and it was a little scary [00:31.40.00] at the sleeping arrangements at Camp [31:42] when we first arrived. I slept with a knife. Did not feel at all safe, 500 people crammed into a warehouse.

At first living conditions were also difficult. No latrines, no showers, no chow hall. They lived on prepackaged food rations [00:32.00.00] also known as MREs. Temperatures could soar to 130, and in winter fall to freezing. And sandstorms blocked the sun. Immediately she had to learn to drive trucks and lead convoys through dangerous Iraqi streets. But nowhere, not even in her own force, [00:32.20.00] did she feel safe.

Sexual harassment of course is ongoing. It's what you make it, I suppose. You tell somebody that's inappropriate and knock it off, they do. But that's always a constant in any kind of male-dominated field. [00:32.40.00]

Meanwhile, back in Seattle, Leeann's husband Sam, and children Crystal and Samuel, managed the home front.

Life will go on, but you can't stop your whole life just because of one thing's going wrong. Like we had to move on [00:33.00.00] and we still had to do school. It's not like we could drop out of school, "Oh my mom is away. I can't go to school any more." Life does go on, and you kind of have to deal (without). It's all right to be sad.

(Just think it was like) kind of put distance from us and mom. [00:33.20.00]

And even more distance, like you would get so tired of each other.

Back on the warfront Leeann continued with her own challenges while living in constant fear leading convoys.

That was very difficult. We did have an incident where driving through a town and a kid probably about 15, 16, 18, [00:33.40.00] came running up to the side of the Humvee and reached through the open window and groped me. And laughed.

After all these challenges one of Leeann's hardest struggles came when she arrived back home from the war 14 months later.

I felt very isolated when I came back, like I didn't fit in the family any more [00:34.00.00] in some ways. They could do without me. [cries] So, it was hard when I came back.

Family loyalty and support are at the top of the list for active duty deployed. Through it all Leeann says her husband and family have been very supportive, [00:34.20.00] her lifeline.

A lot of heart to heart talks with my husband. I also was fortunate to go to Camp (Chaperelle) which is a joint VA hospital, VHA and (Jackamaw) Nation retreat. It's a wonderful facility where they have PTSD veterans come and share their stories. And it was a time of healing [00:34.40.00] for combat veterans.

In addition, Leeann met with a private counselor for a few sessions to sort out her feelings. Yet, through all her anguish Leeann also discovered her strength and courage.

If I can sleep in a tent on a hard cot for a year in the freezing cold and the 140 degrees, if I can jump in a vehicle with a weapon [00:35.00.00] that I barely knew how to shoot, if I can coordinate the actions and the trucks for over 100 soldiers, I can do anything that the VA asks of me. I can do anything that my family needs of me. It was a terrific experience despite all the hardships and the fear. [00:35.20.00]

Deployment brings major adjustment to those activated. It also brings major changes for family members when one or more parents are deployed. For example, when mom is deployed dad's role alters as well. If mom is a single parent [00:35.40.00] that brings its won set of problems. And sometimes grandparents have stepped in to help with childrearing. This disrupts family, work, school and relationships.

I think also the soldiers needs to truly understand that maybe they left a child that was a pre-teen and now the child's a teen. [00:36.00.00] And they think totally different, they look at the world entirely different. So, it goes back to patience again and good communication, trying to work that out. Sometimes a third party mediating some of those things is really, really helpful.

Recognize that children and teens may often act out in angry ways [00:36.20.00] or be very clingy, or even distance themselves emotionally and physically from the parent who went away.

Where we're seeing challenges when they come home is the child that seems the most adjusted obviously is the one who's not going to get much attention. Because oh, he's doing fine. But that's probably the one that is taking his [00:36.40.00] attention, his need somewhere else. And you have to remember don't let the reunion, don't let rebuilding family relationships, let these children slip out the back.

Marital difficulties are often a sign of adjustment issues. That's why the National Guard and the Army offer marriage enrichment weekends [00:37.00.00] for couples coming back from deployment. As providers you may want to involve the family in your own treatment of the veteran.

Both the Army and the other branches of the service have recognized where the advantage is for us for the guard and reserve that families are the key to readiness. So, in recognizing that they've thrown some [00:37.20.00] money at it that we didn't have before. The money allows us to provide resources at the level where the families are, not only on military installations but in their local communities.

Veterans often try many different approaches to cope with their stress-related symptoms. Too many turn to drugs or alcohol. Some may [00:37.40.00] seek healing through

religious counseling or culturally based treatments. Some veterans will go to a primary care physician for physical symptoms that are often stress related. But some medical centers, like the Seattle VA, have set up a deployment health clinic for new returning veterans where they can see a physician and mental health counselor [00:38.00.00] all in one place.

All Iraqi Freedom and Enduring Freedom veterans who come into our system go through that clinic, or nearly all. For primary care evaluation and checkup and treatment, as well as mental health screening and brief treatment in that setting, which is acceptable and sufficient for most of our returning veterans.

Medical physicians are essentially trained [00:38.20.00] to recognize and diagnose and treat physical diseases. That's our primary training really. At the same time primary care physicians, it's really our responsibility to consider the global health of the individual, perhaps even more than any other provider really. We have to think about how is this person in terms [00:38.40.00] of their mental health? How is it in terms of their family health and marital health?

The Primary Care PTSD Screen is a four item question set that can be used to screen a veteran for possible history of trauma and PTSD. The questions focus on current symptoms the veteran may be experiencing and can assist the [00:39.00.00] clinician in their decision regarding further mental health evaluation for the veteran.

Primary care practitioners need to be educated in some of the basic medicines that are useful in treating nightmares, sleep disturbance and of course depression and other PTSD symptoms. They can be trained to do this. But some primary care practitioners can actually be good healers themselves [00:39.20.00] in terms of providing some counseling. It doesn't always take a 50 minute hour to be effective.

The signature wound of this war may be traumatic brain injury. Folks who have been exposed to a blast have a concussion but don't come in reporting that. Therefore, the provider has to suspect it and screen for it. [00:39.40.00]

With our returning veterans in particular patience is going to be a real issue, and the VA's going to need to be very sensitive when they are called up. They're not going to want an appointment in a month, they're going to want to be seen probably that same day because it' a crisis issue.

Nice to meet you.

Nice to meet you.

However your practice is set up to see veterans [00:40.00.00] and active duty personnel know the signs of possible emotional or psychological problems in women.

Some of the symptoms that the primary care providers might look for are things like nightmares, things like panic attacks, chronic pain, difficulty [00:40.20.00] sleeping, isolation, substance use, those kinds of things to alert them that there might be a need for a referral to mental health.

Women who have experienced trauma often experience and present with somatic or physical complaints. They experience more eating disorders such as binge eating [00:40.40.00] and obesity. Gastrointestinal problems such as irritable bowel syndrome and constipation are common. Many also complain of gynecological problems such as fibroids and general pelvic pain, or joint pain such as fibromyalgia. Women are at heightened risk for mood, anxiety [00:41.00.00] and substance abuse disorders.

One of the most common comorbidities found in female veterans with PTSD is major depression. In fact, many of the female veterans that come into our facility carry with them the diagnosis of major depression, and may have had that diagnosis prior to being diagnosed with [00:41.20.00] PTSD because so many of the women have either not shared the details of their trauma or it was overlooked.

It's important that we take the time, that we try to understand that there possibly will be different forms of expression, [00:41.40.00] different ways that emotions will come out. So, it's about not assuming that because we're so well experienced in treating combat stress and other illnesses that could be comorbid with these, but to look for the differences. Men and women are not the same. We all know that. But [00:42.00.00] literally we have to understand it and put it into our practice.

And especially for women who experienced military sexual trauma it can be very difficult to impossible to undergo a pelvic examination in treatment by an OB-GYN physician. Understandably, due to the nature of the OB-GYN exam and it's procedures [00:42.20.00] there are aspects that possibly remind the women of a traumatic time. Loss of control, being invaded, and losing integrity. Thus she avoids care.

Be ready to provide intervention oneself as a primary care provider. And of course be linked up with the appropriate mental health department. For example, vet centers [00:42.40.00] often times have female practitioners to specifically treat female sexual trauma. And many VA medical centers these days have a mandate to provide military sexual trauma screening and treatment.

Female sexual trauma is very real, but so is male sexual trauma. As providers realize that any client [00:43.00.00] who sees you could have experienced sexual abuse in the past.

Patricia volunteered for the service because she saw herself as a tom boy and joined the Army out of high school. But soon after she was sexually assaulted [00:43.20.00] by two men, including her boyfriend who was also an officer.

I was supposed to go with my boyfriend to his friend's house to eat Thanksgiving dinner. So, when we got there there was no Thanksgiving dinner. I mean didn't think anything of it. And then we started arguing [00:43.40.00] about I don't know what. And then they both came in the room and did what they did. And after that I mean I ... I wanted to go to the police but I thought it was, you know, who's going to believe me? I mean who am I? I'm a private, you know, and here they are NCOs. [00:44.00.00]

It took her several months to come forward and report it to police on base. Once she finally went to authorities no one wanted to press charges.

We went to the police, and the police told me that it couldn't be rape because it wasn't done in an alley or a dumpster. So, they dropped my case. [00:44.20.00] So, then I really felt, I mean, worthless because nobody was trying to help me.

Patricia says it was too hard being so close to the officer who raped her. So, eventually she left the Army and went home. But the pain continued. Her depression went on for many years until one primary care doctor [00:44.40.00] finally took note.

I came to the doctor for a checkup and she had—she asked me if I was depressed. I told her, yes. I had had problems with depression before but they had never done anything about it. So, they sent me here to mental health.

Patricia was diagnosed [00:45.00.00] with depression related to her military sexual trauma. That was over a year ago. Today Patricia is involved in a women's trauma group at the VA.

I mean it's bad to say, but I feel better when I know it's not just me. [00:45.20.00]

Patricia is a working mother and single parent of two children, Simone and Tiara. Some days are still very difficult.

Trying to be a good mother is very hard. There's days when I don't even want to get out of the bed. But I know I have to for them. They know there's something wrong with me. And they seem to understand, but [00:45.40.00] there's times when they don't. And I don't know how to explain it to them.

Through her treatment Patricia is learning that she doesn't have to be perfect to be a caring mother. She's also accepting herself more these days. [00:46.00.00]

It helps me to know that there's other people out there like me. That I'm not the only one, that I'm not really crazy. Actually without this treatment I don't think I'd be here today.

Treatment that's found to be most effective for treating sexual trauma and other trauma as well is exposure therapy, [00:46.20.00] which is essentially going back to the trauma and

reliving it in a very systematic way through the help of a therapist, and cognitive interventions or cognitive restructuring. Those are the two most effective therapies.

It's really important that practitioners make things very clear, sometimes very concrete. [00:46.40.00] That hey repeat things and ensure that the person understood what it is that they say. We often use in our treatment, "What did you hear me say?" as a phrase. Because it's really important. We may have all sorts of intentions, but you have to remember [00:47.00.00] that there's a lot of distraction also with PTSD. You know, there are intrusive thoughts, intrusive memories, whatever.

Let the whole story come out before they try to interpret what the soldier's saying, just let the soldier start from the beginning to end. Because a lot of things that the soldier may be coming in for are traumatic things, [00:47.20.00] things that may have happened to them from a fellow soldier possibly that they don't want—it's really hard for them once that soldier comes up to go to mental health.

Service men and women may be dealing with [00:47.40.00] anger about what they've experienced, or they may have what's known as survivor's guilt. They survived, but their buddy died, or the rest of their group died. Or they feel guilt about having taken another human life.

In group we see this remarkable sense of guilt that these incredible young men and women have that they didn't bring everyone back home. [00:48.00.00] And then there's a sense of guilt that certainly it doesn't pass the common sense test but it's emotional. And that is what it means for the soldier to have been injured, to have been wounded would be the better term.

In trying to connect I think there's a sense of isolation and feeling alone in their sense of guilt and anger [00:48.20.00] and frustration with all that. The reason I believe that group therapy is most useful for soldiers coming back from especially a traumatic experience of any kind is because soldiers are helping soldiers. And I believe that's Dr. Drew's coin that term, soldiers helping soldiers.

With racially, ethnically mixed groups, what I've noticed [00:48.40.00] is that the experience of having a cross culture group allows for everyone to have a voice to discuss their issues. What we found is that we start with the process of having a non-judgmental group that allows for everyone to feel they can bring forward their issues across their life [00:49.00.00] that have a cultural basis.

For women who have experienced trauma, they are—they tend to want to do individual therapy primarily. And as most people do, I believe, because it's very difficult being in the group setting. However, I believe that some of the group therapies, some of the strategies that are most effective for PTSD [00:49.20.00] offered in a group setting are very effective or probably more effective than an individual. Because they get the chance

to share an experience that they had to essentially go through alone, they get to share that with other people as well.

There's a lot of distrust. So, what's important is that [00:49.40.00] they learn that when they come in there they're in charge to some degree. Because we're dealing with veterans, women, who have had many experiences where they were powerless and had no control over situations. So, I like to let them know that whenever they're uncomfortable that that's fine. And we can stop right there. [00:50.00.00]

Clinicians should keep in mind that a female client may not want to be in a co-ed group. It's not avoidance behavior, it just makes sense. For example, most women, particularly those with military sexual trauma, feel more comfortable sharing these issues with an all female group with a female [00:50.20.00] clinician.

With nightmares and other symptoms of combat stress or trauma, medications are often prescribed. Research and clinical experience supports the use [00:50.40.00] of antidepressants such as Zoloft and other SSRIs, as well as anti-anxiety medications. Also consider a new approach for treating symptoms of PTSD with the anti-hypertensive drug (crisasin).

I discovered working with combat veterans that the sleep [00:51.00.00] disruption and nightmares of combat situations appeared to be an adrenaline rush phenomenon. Fortunately we have medications that were initially developed to treat high blood pressure that block the excessive norephrine response.

Dr. Raskin says they've been giving [00:51.20.00] this medication to new returnees and to women veterans with good results. But he cautions providers to prescribe lower initial doses, especially for women. Otherwise there is a hypotensive effect.

There's one caution in using (crayasin). For the first three nights one takes this medication you have to give the lowest dose, [00:51.40.00] one milligram, because there is what's called a first dose excessive blood pressure lowering response if you take too much right away. If you start low and increase slowly by a milligram or two every week, until you get to an effective dose, there are rarely any problems with adverse effects, hypotension [00:52.00.00] or otherwise.

I think it's important to provide ongoing education to this population. Not just at the first visit when starting the medication but at every visit talk about your expectation for dosing. Talk about how long you believe the veteran would need to be on the medication. And when you expect that the benefits from treatment will show itself. [00:52.20.00]

We have to remember that the same kinds of interventions that we provided for many years for men might not necessarily fit for women. There's new research, there's new types of medications. So, really what it calls for is for us to educate ourselves, and as

well to listen to [00:52.40.00] these women so that we can better understand how we can serve them.

In the military you're trained to keep going, to stay on mission, despite adversity, stress or even wounds. In fact these are critical to maintaining a fighting force. It's no wonder then that combat medics are often the last to reach for [00:53.00.00] help themselves.

In 1992 Penny began her military career with the Navy. As a recruit she attended the first integrated male/female boot camp. [00:53.20.00] A few years ago she left the Navy for the National Guard. Little did she know was a medical specialist with the guard she would be sent to Iraq, face to face with life and death.

We know what is available more than the typical soldier, sailor or airman does. And we're more likely to seek that out [00:53.40.00] in our own personal private times versus when we're not—and we have always jokingly said we medics are kind of like the worst people of all because we're the last ones to take care of ourselves. But we do stick it out.

As a captain and deputy brigade surgeon Penny's job in Iraq was to help the National Guard [00:54.00.00] plan for medical emergencies while in theater.

I always said there's the war fighter side and then there's the medical planning side that the medical service corps officer brings together to be able to explain to the combat arms folks how they're going to actually medevac somebody if somebody does get injured.

Penny is also [00:54.20.00] an environmental specialist who tested the air, water and soil in Iraq for contamination.

More importantly we look at preparing the soldiers to go into any kind of a medical threat environment, which we did have some concerns with malaria as well as [54:36] over there with regards to pest control operations. [00:54.40.00]

In today's war front, more people are surviving multiple serious injuries because of quicker access to improved medical care and better body armor. Most survive, some do not. Medics are no different from many others who served in combat. They often wish they could have done more. [00:55.00.00]

Every emotion probably from the medical professional's perspective comes out. Post-treating, post any kind of major mass-cal event. Of course if there are any fatalities or lost soldiers or sailors or airmen they of course want to [00:55.20.00] feel that they or they think that they should have done more or could have—would have should have could have is a term that we sometimes use.

Despite more chaplains and combat stress teams available in Iraq Penny chose not to reach out for this type of counseling following the incidents.

For me personally, one of the reasons is [00:55.40.00] I'm always anticipating the next circumstance or evolution that's coming so I don't—it's kind of like a process again of being a medical professional that we all have to go through in order to feel spiritually as well as mentally back in the game. [00:56.00.00] And by staying engaged or staying constantly involved and not taking that downtime it's easier that way.

On the other hand, when she noticed her unit being affected Penny said she'd point out to her commander that the troops needed some downtime after an incident. And she recommends that VA and other medical providers decompress [00:56.20.00] as well.

One of the ways practitioners can help themselves is by having their own internal work organization that will be able to again recognize as a team. And be able to also feel confident that they can go and talk to their colleagues when and if circumstances that they've experienced [00:56.40.00] from a confidential case basis as well—that they can also seek out services and support that they need as well.

Civilian soldier Penny has now returned to her job as an environmental specialist in her local public health department. Now she plans for very different [00:57.00.00] kinds of attacks.

I believe I'm doing well. It was interesting the first time I was at a public event with my colleagues from work it was a little overwhelming at first because everybody thinks I'm a hero. And I guess in some retrospect I'm a little humble when it comes to that. I feel [00:57.20.00] knowing my job and feeling comfortable in what it is that I do for both my state as well as the country. I went, did my job and came home. So, I'm glad to have done that safely. [00:57.40.00]

Women like Penny are the every day heroes who may need our help. Many women go undiagnosed for problems related to trauma or combat stress. A recent study found that over 80% of women veterans visiting a VA primary [00:58.00.00] care clinic have experienced trauma. Of those 44% sexual trauma including military sexual trauma. Yet women are often the last to seek treatment. Female trauma experts say women often avoid taking care of themselves. They're either too busy caring for others, or they choose [00:58.20.00] busyness to avoid their problems. Either way the results are the same. Trying to keep, to keep going despite distress.

Many women generally are hesitating about coming into the VA system. First of all they're all had the experience of being in a male dominated [00:58.40.00] environment being in the military. And for the most part that experience has not been a positive one. Those feelings about the military get transferred to their thoughts about what it would be like to seek services at the VA.

The VA Office of Seamless transition ensures the [00:59.00.00] smooth transfer of returning Operation Iraqi Freedom and Operation Enduring Freedom veterans from DOD

to VA. Many VA medical centers, vet centers, and all VA regional offices have outreach efforts underway.

For the first time in history the VA is providing two years of free health care [00:59.20.00] for combat veterans from countries that are part of the global war on terrorism, primarily Iraq and Afghanistan. And this two years of free health care is from the date of separation from active duty. So reservists are qualified for this program as well, and National Guardsmen.

About 45% of deployment overseas to Iraq is composed of guard and reserve, [00:59.40.00] which represents a larger percentage than ever before. So the VA understands now that we can go out to these guard and reserve units, do aggressive outreach by educating family members, not just soldier and veterans, but family members about mental health problems, also providing them with social services, housing, financial problems, [01:00.00.00] health insurance issues.

Former Navy commander and psychologist Mike (Colson) knows first hand the urgent need to reach returning veterans early. As Seattle Vet Center's outreach coordinator for the northwest, Mike meets with male and female soldiers as they return from deployment [01:00.20.00] on and off military bases.

The great thing about being a clinician and a provider and an outreach guide in the 21st century is there are many avenues to help people. These young people are very smart. They're wired, they're connected. And I get a chance to refer them to people who I know [01:00.40.00] and who I trust and allow them that connectivity within the system. I referred seven people on the phone yesterday just by talking to them while I was driving from one place to another, one event to another. That's the VA that I know. [01:01.00.00]

Dr. (Colson) believes it's vital for everyone in the VA to do our part, to reach out. It may possibly save a life. For Mike this is all too real and personal. He recently lost his nephew to suicide. The young veteran had been deployed to Iraq and was a recent returnee. [01:01.20.00]

I've lost family members. I have three serving active duty members. All of us have served in Iraq. I'm the fourth. And one of those young men, my nephew, is dead as a direct result of his good and effective military service. Not in country but out of country by his own hand. So the issue is, is it life and death? [01:01.40.00] Well, it is for my family. And is it life and death for other people's families? Absolutely.

This is the time now for those of us clinicians in the VA and in other institutions and agencies and for the veterans to come together. What we don't want to see is another population, another era lost to chronicity [01:02.00.00] and other complex comorbidities. Remember we don't want to see these men and women struggling 20 and 30 years from now.

We need to continue building bridges with our female veterans. Communicate in a way [01:02.20.00] that fosters being understood. Clinical experience and veterans' input suggests VA providers consider the following in treating female clients. Women veterans have experienced combat on many fronts. Offer basic respect, sincerity and courtesy [01:02.40.00] and a sense of hope. Ask questions and listen attentively and patiently to responses. Allow your female clients to teach you. Keep in mind patient confidentiality. If appropriate, avoid charting potentially stigmatizing diagnoses. [01:03.00.00] Find out about your client's personal historical background and current family and work status. Ask about the veteran's military experiences, especially those that were traumatic. Convey a sense of collaboration, both provider and veteran working toward a common goal, [01:03.20.00] helping her to minimize or resolve mental distress or physical symptoms. And consider implementing a number of treatment approaches, medical, behavioral, psychosocial and cultural for adjustment issues or physical issues. Time is of the essence. [01:03.40.00] Do your part to reach out. I'm no expert, but I'm a veteran too of sorts. In my autobiography, Skywriting, I wrote about being diagnosed with bipolar disorder at the age of 50. I'd always known it as manic depression, a mood disorder in which people experience mostly normal functioning [01:04.00.00] with periods of extreme high or low moods. I'd gone my whole life unaware I had any vulnerability to bipolar until the symptoms became painfully obvious. For me, the easiest part is talking about it publicly and without shame. Our veterans should feel no shame or stigma [01:04.20.00] from their psychological wounds from war. They served this nation proudly. Our country's heroes are in your hands. Early interventions can often prevent long-term problems. Reach out, not only to women who served in prior wars and eras, but to those who serve in this new generation [01:04.40.00] of wars. All have sacrificed for our country. Each one's experience is different. For some trauma was a very real part of their military experience. As providers you have the tools that could alleviate much mental and physical distress and even save lives. Welcome home our military sisters, [01:05.00.00] reach out and give them the best care possible. [01:05.20.00]

[end of audio]