Psychological Health Issues Affecting Women Service Members and Veterans

Oct. 23, 2014; 1-2:30 p.m. (EDT)

Presenters:

Elspeth Cameron Ritchie, MD, MPH
Chief Clinical Officer
Department of Behavioral Health
Washington, D.C.

Jennifer Strauss, Ph.D.
Women's Mental Health Program Manager
Mental Health Services
Department of Veterans Affairs
Washington, D.C.

Moderator:

Maj. Demietrice L. Pittman, Ph.D.
U.S. Army, MS
Clinical Psychologist, Deployment Health Clinical Center
Bethesda, Md.

Webinar Details

- Live closed captioning is available through Federal Relay Conference Captioning (see the “Closed Captioning” box)
- Webinar audio is **not** provided through Adobe Connect or Defense Connect Online
  - Dial: CONUS **888-877-0398**; International **210-234-5878**
  - Use participant pass code: **3938468**
- Question-and-answer (Q&A) session
  - Submit questions via the Q&A box

Resources Available for Download

Today's presentation and resources are available for download in the "Files" box on the screen, or visit **www.dcoe.mil/Training/Monthly_Webinars.aspx**

Continuing Education Details

- DCoE's awarding of continuing education (CE) credit is limited in scope to health care providers who actively provide psychological health and traumatic brain injury care to active-duty U.S. service members, reservists, National Guardsmen, military veterans and/or their families.

- The authority for training of contractors is at the discretion of the chief contracting official.
  - Currently, only those contractors with scope of work or with commensurate contract language are permitted in this training.

- All who registered **prior** to the deadline on **Thursday, Oct. 23, 2014,** at 3 p.m. (EDT) and meet eligibility requirements stated above are eligible to receive CE credit or a certificate of attendance.

Continuing Education Details (continued)

- If you pre-registered for this webinar and want to obtain a CE certificate or a certificate of attendance, you must complete the online CE evaluation and post-test.

- After the webinar, visit http://continuingeducation.dcri.duke.edu to complete the online CE evaluation and post-test, and download your CE certificate/certificate of attendance.

- The Duke Medicine website online CE evaluation and post-test will be open through **Thursday, Oct. 30, 2014,** until 11:59 p.m. (EDT).

Continuing Education Details (continued)

- Credit Designation – The Duke University School of Medicine designates this live webinar for:
  - 1.5 AMA PRA Category 1 Credit(s)
- Additional Credit Designation includes:
  - 1.5 ANCC nursing contact hours
  - 0.15 IACET continuing education credit
  - 1.5 NBCC contact hours credit commensurate to the length of the program
  - 1.5 contact hours from the American Psychological Association (APA)
  - 1.5 NASW contact hours commensurate to the length of the program for those who attend 100% of the program

Continuing Education Details (continued)

- ACCME Accredited Provider Statement – The Duke University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

- ANCC Accredited Provider Statement – Duke University Health System Department of Clinical Education & Professional Development is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's (ANCC's) Commission on Accreditation. 1.50 ANCC nursing contact hours are provided for participation in this educational activity. In order to receive full contact-hour credit for this activity, you must attend the entire activity, participate in individual or group activities such as exercises or pre/post-tests, and complete the evaluation and verification of attendance forms at the conclusion of the activity.

- IACET Authorized Provider Statement – Duke University Health System Clinical Education & Professional Development is authorized by the International Association for Continuing Education and Training (IACET) to offer 0.15 continuing education credit to participants who meet all criteria for successful completion of authorized educational activities. Successful completion is defined as (but may not be limited to) 100% attendance, full participation and satisfactory completion of all related activities, and completion and return of evaluation at conclusion of the educational activity. Partial credit is not awarded.

  Duke University Health System Clinical Education & Professional Development has been approved as an Authorized Provider by the International Association for Continuing Education &Training (IACET), 1760 Old Meadow Road, Suite 500, McLean, VA 22102. In obtaining this approval, Duke University Health System Clinical Education & Professional Development has demonstrated that it complies with the ANSI/IACET 1-2007 Standard, which is widely recognized as the standard of best practice in continuing education internationally. As a result of Authorized Provider status, Duke University Health System Clinical Education & Professional Development is authorized to offer IACET CEU's for its programs that qualify under the ANSI/IACET 1-2007 Standard.

Continuing Education Details (continued)

- NBCC: Southern Regional Area Health Education Center (AHEC) is a National Board for Certified Counselors and Affiliates, Inc.(NBCC)-Approved Continuing Education Provider (ACEP™) and a cosponsor of this event/program. Southern Regional AHEC may award NBCC-approved clock hours for events or programs that meet NBCC requirements. The ACEP maintains responsibility for the content of this event. Contact hours credit commensurate to the length of the program will be awarded to participants who attend 100% of the program.
- Psychology: This activity complies with all of the Continuing Education Criteria identified through the American Psychological Association (APA) Continuing Education Requirements.
- NASW: National Association of Social Workers (NASW), North Carolina Chapter: Southern Regional AHEC will award contact hours commensurate to the length of the program to participants who attend 100% of the program.

Questions and Chat

- Throughout the webinar, you are welcome to submit technical or content-related questions via the Q&A pod located on the screen. **Please do not submit technical or content-related questions via the chat pod**.
- The Q&A pod is monitored during the webinar; questions will be forwarded to presenters for response during the Q&A session.
- Participants may chat with one another during the webinar using the chat pod.
- The chat function will remain open 10 minutes after the conclusion of the webinar.

Webinar Overview

Women represent more than 15 percent of those serving in today's U.S. military. Education and awareness of women's health issues are key factors in maintaining current operational readiness. An increase in the presence and engagement of women in the military has resulted in an equally rapidly growing population of women veterans, projected to reach 15 percent of the total U.S. veteran population by 2035 (National Center for Veteran Analysis and Statistics, 2011). This presentation will describe relevant research findings and clinical guidelines to inform best practices for meeting the unique needs of this population.

Current research findings indicate many women in the deployed environment hesitate to seek medical care when they have a health concern related to their genito-urinary or reproductive health. Issues around pregnancy and breastfeeding lead to occupational health concerns. Although important gender differences exist, similar to their male counterparts, women may develop mental health difficulties such as posttraumatic stress disorder and depression related to combat and/or military sexual assault.

- At the conclusion of this webinar, participants will be able to:
  - Review the effects of combat on psychological health
  - Explain the rigors of maintaining proper nutritional and gynecological health in a deployed environment
  - Communicate issues around sexuality and motherhood with service members
  - Describe gender differences in the effects of military service on mental health and well-being
  - Identify the components of gender-sensitive clinical care

Elspeth Cameron Ritchie, MD, MPH

- Chief Clinical Officer, Department of Behavioral Health, District of Columbia
- Retired from the Army in 2010 after holding numerous leadership positions within Army Medicine to include Psychiatry Consultant
- Trained at Harvard, George Washington, Walter Reed, and the Uniformed Services University of the Health Sciences; completed fellowships in forensic and preventive and disaster psychiatry
- Professor of Psychiatry at USUHS and Georgetown University
- Internationally recognized expert with a unique public health approach to the management of disaster and combat mental health issues; assignments and other missions to Korea, Somalia, Iraq, and Cuba.
- More than 200 publications, mainly in the areas of forensic, disaster, suicide, ethics, military combat and operational psychiatry, and women's health issues. Major publications include the Military Medicine Textbook on "Combat and Operational Behavioral Health", "The Mental Health Response to the 9/11 Attack on the Pentagon", "Mental Health Interventions for Mass Violence and Disaster", "Humanitarian Assistance and Health Diplomacy: Military-Civilian Partnership in the 2004 Tsunami Aftermath", and the series in 2013 on the Use of Complementary and Alternative Medicines for the Treatment of PTSD in military service members.
- Senior editor on the forthcoming: "Forensic and Ethical Issues in Military Behavioral Health", "Women at War", and "Post-Traumatic Stress Disorder and Related Diseases in Combat Veterans: A Clinical Casebook."

Jennifer Strauss, Ph.D.

- Women's Mental Health Program Manager at the Office of Mental Health Services, Department of Veteran Affairs
- Assistant Professor of Psychiatry and Behavioral Sciences at Duke University
- Contributes to VA policy recommendations and their implementation and oversight, as related to women Veterans' mental health
- Authored more than 30 journal articles and book chapters, and received independent research funding from the Department of Veteran Affairs, National Institute of Mental Health, and the Department of Defense
- Graduated from Emory University with a Bachelor's of Arts degree and received MS and PhD degrees from the University of Miami
- Areas of interest and content expertise include women's mental health, posttraumatic stress disorder (PTSD), military sexual trauma (MST), the development of self-management interventions and strategies for increasing individuals' collaborative involvement in the treatment process, and the integration of complementary-alternative techniques and evidence-based therapies
- Member of the American Psychological Association, the North Carolina Psychology Association and the Society for Clinical and Translational Science

Medical and Psychological Issues for Female Service Members

Elspeth Cameron Ritchie, MD, MPH,
Chief Medical Officer
Department of Behavioral Health,
Washington, DC

Disclosure

- The views expressed in this presentation are those of the presenter and do not reflect the official policy of the Defense Department or the U.S. government or Wash DC.
- I have no relevant financial relationships to disclose
- I do intend to briefly discuss the off-label/ investigative (unapproved) use of commercial products or devices on slide 24.

Objectives

Review the effects of combat on psychological health.

Explain the rigors of maintaining proper nutritional and gynecological health in a deployed environment.

Communicate issues around sexuality and motherhood with service members.

Outline

- Credentials
- Garrison vs field vs deployment vs combat
- Medical Issues
- Psychological Issues
- Focus on sexual assault

My credentials

- **Experience**
  - 24 years active duty
  - Deployments to Korea, Somalia, Iraq, Cuba
  - Mental health and Women's health issues at Health Affairs 1999-2003
  - Psychiatry Consultant, work at OTSG 2005-2010
- **Publications on Women's Health Issues**
  - Reactions to Rape: A Military Forensic Psychiatrists Perspective. Military Medicine, Aug 1998
  - Issues for Military Women in Deployment. Military Medicine, Dec 2001
  - Breastfeeding in the Military. Part I: Information and Resources Provided to Servicewomen. Military Medicine, October 2003.
  - Breastfeeding in the Military. Part II: Resource and Policy Considerations. Military Medicine, October 2003.
  - Sexual Abuse and Female Recruits, 2006,
  - Women in Combat, Psych Annals, April, 2014.
  - Women at War. Oxford University Press, in press.

Special Issues for Female Service Members

- Reproductive
  - Pregnancy
  - Breastfeeding
- Musculoskeletal
  - Stress fractures
- Deployment Health
  - Urinary tract infections
  - Dehydration
  - Menstruation
- Psychological reactions
  - Evacuations from theatre for PTSD
  - Treatment for PTSD
- Sexual assault

Reproductive Issues

- Pregnancy (garrison)
  - Physical training
  - Deployment
  - Exposure to toxins
- Breast-feeding (garrison, field)
  - Maintenance of breast feeding
  - Exposure to petroleum products
- Motherhood (garrison, field, deployment, combat)

Musculoskeletal issues

- Heavy personal equipment
  - Kevlar helmets
  - Body armor
- Stress fractures
  - Pelvic
- Special issues for recruits
- Personal strength

Deployment Health

- Genito-urinary issues
  - Lack of clean bathrooms
  - Bombs by the side of the road
  - Fluid restriction
  - Dehydration
- Menstruation
  - Regulating
  - Suppressing
- Birth control

Deployment vs Combat

- Women in deployment
  - "Issues for Military Women in Deployment" Bathrooms, pregnancy, breast-feeding, home front problems
- Women in combat
  - Women's Health Task Force report from Afghanistan Bathrooms (see next slides)
  - Body armor
  - Home front issues
  - PTSD
  - TBI

Naclerio, Stola, Trego, & Flaherty, 2011

Women's Health Task Force

- Issues women face while in austere environments that AFFECT their health
  - How to urinate in the field
  - Maintaining urogenital hygiene
  - Managing menstruation in field environment
  - Managing lactation in the field
  - Improper fit of uniform

Naclerio, et al., 2011

Women's Health Task Force

- Dealing with female health issues in an austere environment
  - Levels of care / providers
  - Menstrual dysfunction
  - Urogenital infections
  - Access to birth control
  - Unintended pregnancy

Naclerio, et al., 2011

Military Medical Culture and Women

- Military Medicine
  - Many women in medical roles
- Deployed hospitals relatively female friendly
- Further forward medical units often austere
  - May have very few women

Photo courtesy of COL (ret.) Elspeth Ritchie

Research on Mental Health of Deployed Women

- **Minimal Research**
  - **Most Mental Health Advisory Teams focus on men**
    - Mental Health Advisory Team II (2005) showed essentially equal rates in PTSD in women (12%) and men (13%)
    Millennium Cohort Study

- **Evacuations for Behavioral Health reasons**
  - Female PTSD rates in OIF OEF 2001 to 2013
  - Courtesy of Dr. Mike Carino, staff officer, Office of the Army Surgeon General
  - Army data 2003-2013

Female PTSD Percentages in OIF OEF from 2001 to 2013.

PTSD: Post Traumtic Stress Disorder

Theater: Iraq and Afghanistan

Evacuation: Air Medical Transport Out-of-Theater required

OEF: Afghanistan, Operation Enduring Freedom 7 October 2001--

OIF: Iraq, Operation Iraqi Freedom 19 March 2003--31 August 2010

OND: Iraq, Operation New Dawn 1 September 2010--18 December 2011

*PTSD case defined as either two (2) outpatient encounters on different days with ICD9 diagnostic code (any position) of 309.81; OR inpatient encounter with ICD9 diagnostic code (any position) of 309.81.

CY 2003-- CY 2013	Gender	
	Female	Male
Percent of Active Duty Army	**13.9%**	**86.1%**
Percent Deployed (OIF, OND, OEF)	**9.8%**	**90.2%**

	Gender				
	Female		Male		
	#	%	#	%	
Percent of all Soldiers Medically Transported Out of Theater	8,299	**12.7%**	57,181	**87.3%**	Female Soldiers represent a higher percentage of all Soldiers requiring Medical Transportation Out-of-Theater when comparing the Percent Deployed by Gender
Percent of all Soldiers Medically Transported Out of Theater with a finding for Behavioral Health Issues (non PTSD)	1,147	**16.3%**	5,891	**83.7%**	Female Soldiers represent a higher percentage of BH (non PTSD) Medically Transported Out-of-Theater when comparing the Percent Deployed by Gender
Percent of all Soldiers Medically Transported Out of Theater with a finding for PTSD	85	**9.0%**	857	**91.0%**	The percent of Soldiers requiring Medical Transportation Out-of-Theater, with a finding for PTSD, is representative of the Percent of Soldiers Deployed to Theater (OIF, OND, OEF) when comparing Gender
Diagnosed PTSD, not associated with Deployment	5,821	**38.0%**	9,499	**62.0%**	The percent of Female Soldiers who had a diagnosis for PTSD, not associated with a deployment, is significantly higher than their representative percentage of the Active Duty Army
Diagonosed PTSD, associated with Deployment History	8,508	**9.7%**	79,584	**90.3%**	The percent of Soldiers with a finding for PTSD, associated with a Deployment to Theater, is representative of the Percent of Soldiers Deployed to Theater (OIF, OND, OEF) when comparing Gender

	Gender	
	Female	Male
	Rate	
Soldiers Requiring Air Medical Transport Out-of-Theater	per 10,000 Soldiers Deployed	
Evacuation for Post Traumatic Stress Disorder (PTSD)	3.3	3.6
All Medical Evacuation Conditions	325.3	243.3
Behavioral Health Evacuation (non PTSD)	45.0	25.1

PTSD DSM IV Diagnostic Concept

- Traumatic experience leads to:
  - Threat of death/serious injury
  - Intense fear, helplessness or horror
- Symptoms (3 main types)
  - Reexperiencing the trauma (flashbacks, intrusive thoughts)
  - Numbing & avoidance (social isolation)
  - Physiologic arousal (“fight or flight”)
- Which may cause impairment in
  - Social or occupational functioning
- Persistence of symptoms

DSM 5 Definition of PTSD

- Removes Criterion A-2
- Additional criteria
  - Somatic reactions
  - Sleep
  - Depressive symptoms
  - Anger and irritability

Evidence Based Approaches for PTSD

- Psychotherapy
  - Cognitive behavioral therapy
    - Cognitive processing therapy
  - Prolonged exposure
- Pharmacotherapy
  - SSRIs

New and Innovative Approaches

- Other Pharmacotherapies
  - 2nd Generation Antipsychotics
- Integrative therapies
  - Acupuncture
  - Stellate ganglion block
  - Yoga
  - Canine therapy
  - Technology
    - Virtual reality

Evidence Based Approaches for PTSD: Psychotherapy

- “Manualized” therapies have been shown effective in research trials. The two most common are 1) Cognitive behavioral therapy (and a variant called cognitive processing therapy) and 2) Prolonged exposure.
- These are usually delivered by psychologists and social workers. Most are readily available in military and Veteran’s Affairs settings.
- A computer variation of prolonged exposure is called “virtual reality.” This may be self-administered via computer. “Virtual Iraq,” is simulated on the computer screen.

Psychopharmacology

- Pharmacotherapy evidence based approaches: include the SSRIs sertaline (Zoloft) and paroxetine (Paxil). Those two are FDA approved. However other SSRIs are commonly used for PTSD.
- Sexual side-effects may be a problem, especially for young male service members.
- Second generation (atypical) anti-psychotics are often used both for depression and PTSD, to augment other antidepressants. While controversial, clinicians find low doses useful. For example, quetiapine (Seroquel) is commonly used for trauma induced nightmares at low doses of 25 to 50 mgs. However these medications may cause unacceptable weight gain, so use sparingly.
- Prazocin, a blood pressure medication, is also used to decrease nightmares. It is prescribed at a lower dose than for blood pressure.
- Bupropion (Wellbutrin) is often well tolerated without the weight gain.

Sleep medications

- Insomnia is extremely common in PTSD. Improving sleep is critically important to recovery.
- Consider standard sleep medications, such as Trazodone 100 mgs (warn re priapism). Zolpidem (ambien) is often used. Warn about interactions with alcohol, other sedating medications.
- Avoid benzodiazapines, especially alprazolam (Xanax) because of the short half-life.

Innovative Approaches

- Complementary and Alternative or Integrative therapies are anecdotally very helpful but not yet evidence based. They are Available at some military, veterans affairs and civilian facilities.
- Acupuncture probably has the best evidence base for use in PTSD
- Stellate ganglion block is an Anesthetic technique for pain seems to relieve PTSD symptoms.
- Other strategies include yoga, marital arts and other physical techniques, meditation and/or mindfulness and canine therapy.

Clinical pearls

- The following are not currently FDA approved, but are options that some clinicians have noted success when using/combining:
  - If there is sexual dysfunction from SSRIs, add bupropion (Wellbutrin).
  - If PTSD related anxiety, try propranolol (Inderal).
  - Again quetiapine and prazocin are helpful to decrease nightmares.
  - Combine medication, psychotherapy and innovative approaches.

Co-morbidities

- The following are all very common with PTSD: substance use, depression and physical injuries with associated pain (including TBI).
- Unfortunately, after Vietnam, too many veterans slid into unemployment and homelessness.
- Many states are developing action plans to try to prevent that deteriorations. These focus on health care, employment, housing, education and the criminal justice system.

What is TBI?

- Traumatic brain injury (TBI) is a disruption of function in the brain resulting from a blow or jolt to the head or penetrating head injury.
- Not all blows to the head result in injury
- TBI can be caused by:
  - Falls
  - Motor vehicle and motorcycle crashes
  - Assaults
  - Explosions
  - Sports injuries
- The severity of injury may range from “mild” (a brief change in mental status or consciousness) to “severe” (an extended period of unconsciousness or amnesia after the injury). TBIs can also be penetrating

DoD Definition for TBI

Traumatic brain injury (TBI) is a traumatically-induced structural injury and/or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event:

(1) Any period of loss, or a decreased level, of consciousness.

(2) Any loss of memory for events immediately before or after the injury.

(3) Any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.).

(4) Neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient.

(5) Intracranial lesion.

- External forces may include any of the following events: the head being struck by an object, the head striking an object, the brain undergoing an acceleration/deceleration movement without direct external trauma to the head, a foreign body penetrating the brain, forces generated from events such as a blast or explosion, or other force yet to be defined.

Adopted by DoD 1 Oct 07

Concussion

- **Concussion, also known as Mild TBI**
  - **A clinical diagnosis with no singular objective test to confirm diagnosis**
  - **Diagnosis based upon a definition**
    - Requires an injury event AND an alteration of mental status
    - Definition in HA policy 1 OCT 07
    - IAW major medical academic definitions
  - **Requires clinical judgment**
  - **May require self-report**
  - **Symptoms are not definitional - symptoms such as headache, dizziness, irritability, fatigue or poor concentration, when identified soon after injury, can be used to support the diagnosis of mild TBI, but CANNOT be used to make the diagnosis**
  - **Most important thing to do is allow enough time to heal**
  - **Recovery is usually quick, but the time greatly depends on the individual and the nature of the injury**
  - **Important to let a provider decide when it's time to return to duty**

Sexual Assault: Background

- **Persistent problem**
- **Varying definitions**
  - Sexual trauma, sexual assault, harassment, rape

- **Different data depending on source**

[Sexual Assault Prevention and Response Office Website http://sapr.mil/index.php/news](http://sapr.mil/index.php/news)

Photo courtesy of COL (Ret.) Elspeth Ritchie

Many perspectives

- Medical
- Leader
- Subject matter expert
- Victim advocate
- Legal
  - Defense
  - Prosecution

Used by permission from Curator of Collections from Women's Memorial Foundation

Ways to View the Problem

- Individual vulnerability
- Unintended consequence
  - Often related to alcohol
- Sexual predator
- Leadership failure
- Occupational hazard
- Environmental contribution

Used by permission from Curator of Collections from Women's Memorial Foundation

Individual Vulnerability

- Victim often had prior risk factors
  - Impulsiveness
  - Prior history of abuse
  - Alcohol or drug use
  - Marginal Soldier
  - No one to confide in

- Afterwards
  - Too embarrassed to tell

Photo courtesy of COL (Ret.) Elspeth Ritchie

Unfortunate event

- Begins as date or party
- Alcohol often involved
- Something happens
- "He said-she said"
  - Usually he says it was voluntary and she says it was not or that she was too drunk to remember
    - Caveat: men can also be victims and women perpetrators
- Both end up as victims
  - Usually she leaves the Army
  - If convicted he goes to jail

Photo Courtesy of COL (Ret) Elspeth Ritchie

Sexual predator

- Often power imbalance
  - Recruiter, drill sergeant
  - Older, higher rank
- May select and groom vulnerable victim
- May use force, but seldom uses weapons
- Threatens her if she tells
  - She will get into trouble
    - Caveat: men can also be victims and women perpetuators

Leadership Failure

- May occur in chaotic units
  - poor discipline
  - porous boundaries
  - "Lord of the Flies"
- Rapid turnover in basic training
  - Trainees just want to graduate
- Leader may ignore warning signs
- Leader may collude in behavior

Environmental Problem

- Remote locations
  - Coast Guard station
  - Aberdeen
  - Recruiter's office
- Secluded area
  - Park bench
  - Latrines
  - Jail cell
- No one there to tell

Photo courtesy of COL (Ret.) Elspeth Ritchie

Overall Recommendations

- Several gaps in policy
  - Training for all service members on women's issues
- Many gaps in research that merit further study
  - Urinary tract infections impact on readiness
  - TBI and PTSD gender specific issues

Used by permission from Curator of Collections from Women's Memorial Foundation

Conclusions

- More attention needs to be paid to issues of female reproductive and urogenital health
- Lack of clean facilities degrade ability of women in deployment and combat
  - Health planners need to anticipate deployed women
- BLUF: let us develop an organized approach to solving these problems

Questions/Discussion

Lt. Holly Harrison, Commanding Officer of the U.S. Coast Guard Cutter Aquidneck (WPB 1309) sights in on a target with an M-4 rifle during small arms refresher training onboard the cutter which is one of four 110-foot patrol boats continuing to perform missions in support of Operation Iraqi Freedom, Arabian Gulf, June 23, 2003.
US Coast Guard photo by PA1 John Gaffney

References

Ritchie, E (1998). Reactions to Rape: A Military Forensic Psychiatrists Perspective. Military Medicine, 163 (8) 505-9.

Ritchie, E., Best, C., Pierce, M., & Everest, T. Sexual Abuse and Female Recruits (2006).Textbook of Military Medicine, Chapter 21.

Naclerio, C. A., Stola, C. J., Trego, L. L., & Flaherty, M. E. (2011). The Concerns of Women Currently Serving in the Afghanistan Theater of Operations.

PSYCHOLOGICAL HEALTH ISSUES AFFECTING WOMEN SERVICE MEMBERS AND VETERANS

DEFENSE CENTERS OF EXCELLENCE FOR PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY
OCTOBER 23, 2014

JENNIFER STRAUSS, PHD, WOMEN VETERANS MENTAL HEALTH PROGRAM MANAGER
MENTAL HEALTH SERVICES, DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Overview

This presentation will:

- Describe health service utilization patterns and clinical profiles of women Veterans
- Review the scope of women Veterans' mental health needs
- Define gender-sensitive mental health care

Disclosures

No conflicts of interest:

- I have no commercial or personal relationships that could bias or otherwise influence our involvement in this CME activity.
- The views expressed are mine, and do not necessarily reflect those of the Department of Veterans Affairs or the United States Government.

Trends in Women Veterans' Use of VA Mental Health Services and Clinical Presentations

Today's Woman Veterans

Women are one of the fastest growing segments of the military and Veteran populations

- Within the military, women comprise:
  - 15% active duty
  - 20% of new military recruits
  - 12% of OEF/OIF/OND Veterans
- Women comprise ~10% of the overall Veteran population
- Projected to comprise 16% of the Veteran population by 2043

Source: National Center for Veterans and Statistics, 2014

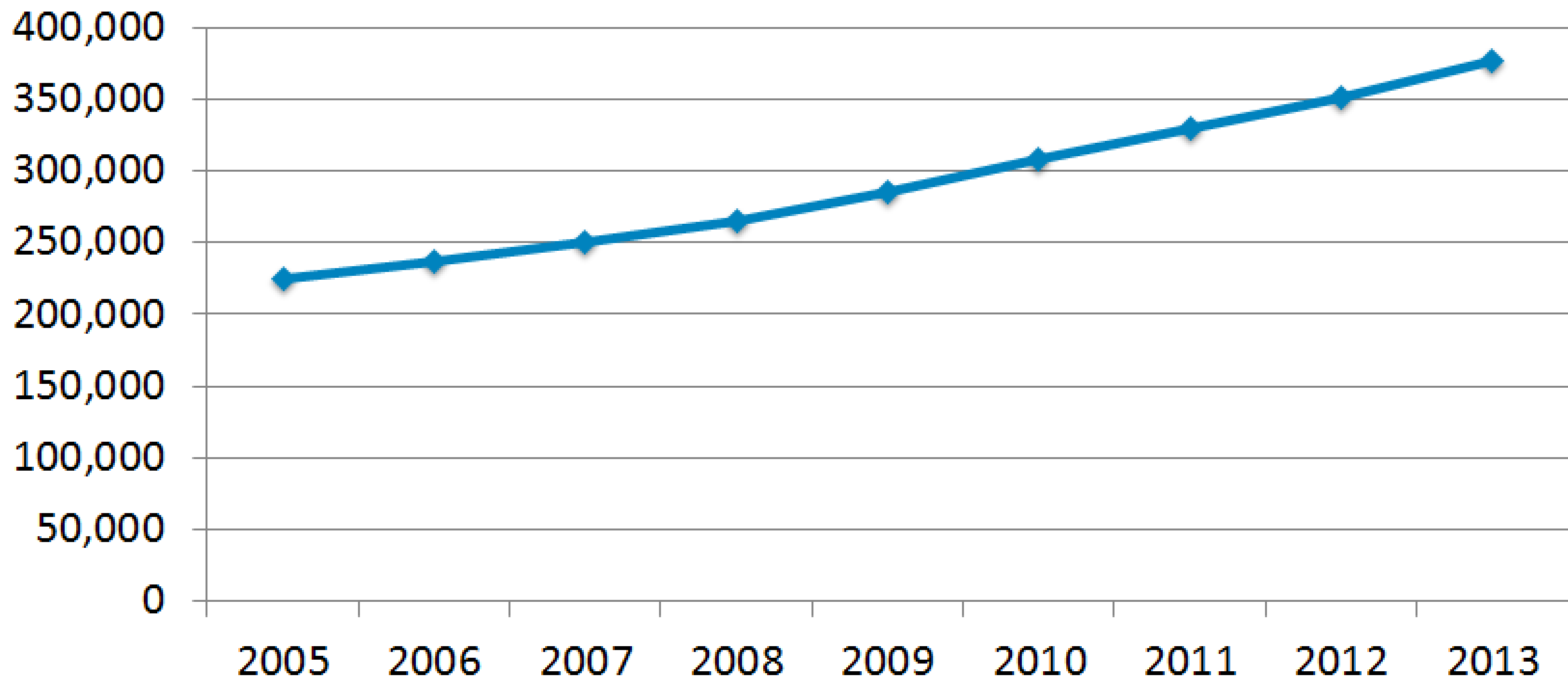
Today's Woman Veterans

Women Veterans are increasingly accessing Veterans Health Administration (VHA) services

- Use of VHA:
  - Between FY 2005 and FY 2013, there was a 68% increase in the *number* of women Veterans accessing VA health care (16% increase among men)
- FY 2013:
  - 377,530 female Veteran VHA users (~7%)
  - 5,188,746 Veteran male VHA users

Source: Northeast Program Evaluation Center (NEPEC), 2014

Total Number of Female Veterans Who Utilized VHA Services, FY 2005 - 2013



The total number of women Veterans who utilized VHA services **increased by 68%** between FY 2005 and 2013.

Source: NEPEC, 2014

Women Veterans' Mental Health: Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND)

Between 2002-3rd Quarter 2014:

- 62% of women Veterans accessed VA care (versus 60% of men)
- 55% of women Veterans seen at VA received a mental health diagnosis (versus 57% of men)
- Adjustment reactions (including PTSD) and depressive disorders among most frequent diagnoses for women and men Veteran VHA-users
  - Adjustment reactions: 35% of women versus 39% of men
  - PTSD: 26% of women versus 32% of men
  - Depressive disorders: 31% of women versus 24% of men

Source: Veterans Health Affairs, 2014

Potential Determinants of Gender Differences in Veterans' Mental Health and Well-Being

Mental Health Issues among Women Veterans

As compared to male Veterans, women Veterans are:

- More likely to have a mental health diagnosis
- Higher rates of depression and anxiety
- Higher rates of mental health and medical comorbidities
- These patterns mirror gender differences observed in the general population
- Interesting caveat: similar rates of PTSD among male and female OEF/OIF/OND Veterans

Runnals, J.J, Garovoy, N., McCutcheon, S.J., Robbins, A.T., Mann-Wrobel, M., Ventimiglia, A., … Strauss J.L. et al., 2014

Potential Differences Between Women Veterans and Civilian Women

Examples of social/occupational factors may uniquely characterize women Veterans:

- Qualities and life experiences that influence decision to serve
- Professional and social experiences; physical and emotional stressors during military service
- Experiences post-deployment/after military service

Sourced from: Ross, Garovoy, McCutcheon, & Strauss, in press

Women Veterans' Mental Health Care Needs

- Women Veterans may differ from Veteran men in the prevalence and expression of certain mental health disorders, as well as their response to treatment
- Differences may be due to:
  - Biological sex differences
    - Female reproductive cycle stages
    - Effects on pharmacokinetics
  - Social and cultural differences
    - Gender roles
    - Gender-linked traumas

Biological Considerations

- Sex-specific hormonal differences and reproductive lifecycle stages have known effects on mental health
  - 20% of pregnant women in the general population experience mood or anxiety disorders
  - 10%-15% experience postpartum depression
- Physiological hormonal transitions during woman's lifecycle may influence mental health/risk for experiencing mental health problems
  - 42% of women Veterans seeking VHA care are within their reproductive years (ages 18-44)
  - 29% are aged consistent with perimenopause (ages 45-55)

Source: Frayne et al., 2014; Marcus, Flynn, Blow, & Barry, 2003

Biological Considerations

Reproductive mental health issues can affect treatment conditions

- There are known risks to psychiatric medication use during pregnancy, yet untreated mental health disorders may also have adverse effects on the Veteran, her baby, and her family
- Before prescribing medication that is potentially teratogenic, providers must consider:
  - contraception counseling
  - pregnancy testing
  - risk/benefit counseling

Social and Cultural Considerations

- Gender-differences in social resources and socioeconomic status (SES) are well known, and research indicates that SES is associated with women's psychological health
- Known differences between women and men Veterans:
  - Women Veterans are more likely than Veteran men to be unmarried
  - Women Veterans are more likely to divorce and remain divorced as compared to Veteran men and age-matched civilian women
  - Among VHA-users receiving PTSD treatment, women Veterans report fewer interpersonal and economic resources than Veteran men
- Specific impact of these factors on mental health of women Veterans unknown

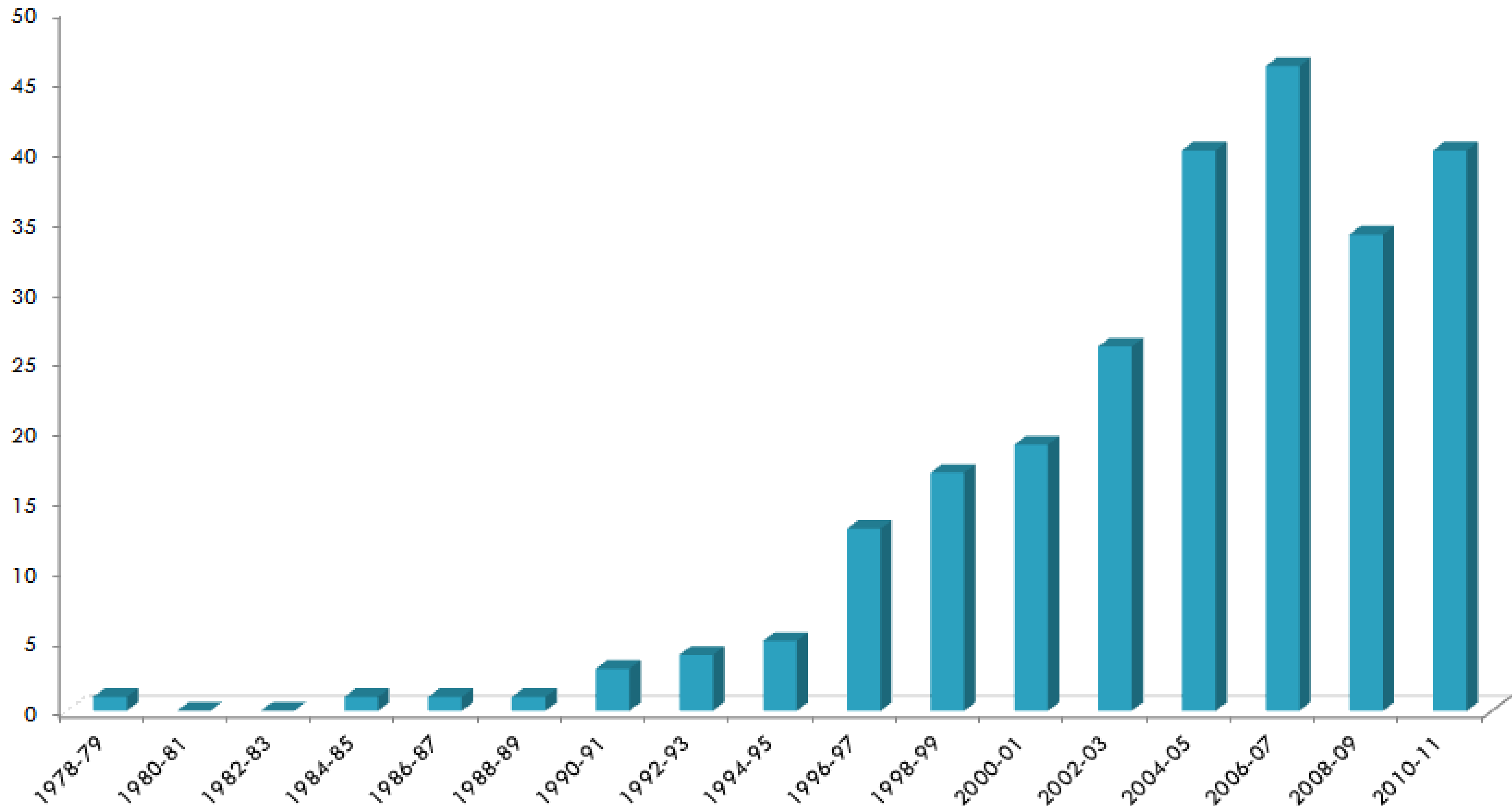
Sourced from: Ross, Garovoy, McCutcheon, & Strauss, in press

Social and Cultural Considerations

- Women may experience less unit support during deployment/service
- After separation/post-deployment, as the gender minority among Veterans, women may have greater difficulty connecting with other Veterans in their community
- Impact of traditional gender roles (e.g., family caregiver) on post-deployment reintegration?
- Public does not always recognize or remember that women can be Veterans, and may be less likely to acknowledge their service/provide support

Gender Differences in Veterans' Mental Health and Well-Being: Recent Research Findings

Number of Publications That Include Women Veterans And Mental Health Content



Adapted from Bean-Mayberry et al., 2010; excludes non-mental health-related citations

Systematic Review of Women Veterans' Mental Health

- Database search for peer-reviewed articles related to women Veterans/gender differences and mental health (2008-2011)
  - Built upon prior reviews (Batuman et al., 2011; Bean-Mayberry et al., 2011; Goldzweig et al., 2006)
  - **Full citation**:
    - Runnals, J.J., Garovoy, N., McCutcheon, S.J., Robbins, A.T., Mann-Wrobel, M., Ventimiglia, A., Mid-Atlantic Mid-Atlantic Mental Illness Research Education and Clinical Center MIRECC) Women Veterans Workgroup, Strauss, J.L. (2014). Systematic review of gender differences in mental health and unique needs of women Veterans. Women's Health Issues, 24, 485-502.

Gender Findings: Functional Impairment, Utilization and Barriers

Functional Impairment:

- For both genders, post-deployment trauma symptoms associated with relationship disruption
  - Limitation: largely male sample
- Among Veterans with PTSD, women report more health and interpersonal impairment than men

Utilization and Barriers:

- Women OEF/OIF Veteran VHA-users are younger and show greater increase in primary care and mental health service use
- Barriers include service eligibility awareness and perceptions about providers

Sourced from Fontana, Rosenheck, & Desai; 2010; Frayne et al., 2011; Friedman, Phibbs, Schmitt, Hayes, Herrera, & Frayne, 2011; Haskell 2011; Sayers, Farrow, Ross, & Oslin, 2009; Washington, Bean-Mayberry, Mitchell, Riopelle, & Yano, 2011.

Women's Mental Health Care: Challenges and Best Practices

Avoid Conflation of Terms

- **Trauma-Sensitive**: addresses the effects of trauma history on current care; may be gender-related (e.g., women-only groups may be clinically appropriate for those who have experienced sexual trauma)
- **Gender-Specific**: Care that is "specific" to gender (e.g., treatment of postpartum depression)
- **Gender-Sensitive**: Informed by understanding that there are gender differences with regard to mental health treatment needs and response; includes impact of social, cultural and family realities on mental health, treatment access, delivery and environment

Gender-Sensitive Mental Health Care

- In 2011, Women's Section of Mental Health Services surveyed mental health leadership within each VA health care system (N = 141) to determine availability of gender-sensitive mental health care for women Veterans.
- The term "gender-sensitive" often defined in terms that emphasize differences in the expression and experience of mental illness, treatment needs, and responses.
- Initial challenge: how to operationalize "gender-sensitive" care in terms of measureable organizational features and processes within VHA?

Gender-Sensitive Mental Health Care

Key components of gender-sensitive mental health care:

- **Comprehensiveness**: includes full continuum of service availability for women (general mental health, specialty mental health, residential/inpatient)
- **Choice**: of treatment modality (e.g., mixed-gender, women-only service options)
- **Competency**: to address women's unique treatment needs
- **Innovation**: creative options and settings for subgroups of women, especially when caseloads of women are small

Summary and Key Points

- Rapidly growing population of women Veterans
- Gender differences among Veterans in risks, prevalence and expression of some mental health conditions
  - Biological sex differences
  - Social, cultural differences
- Women Veterans' mental health: growing area of research
- Gender-sensitive care:
  - Comprehensiveness
  - Choice
  - Competency
  - Innovation

Please stay in touch!

To be included in future communications and educational opportunities related to women Veterans' mental health, please join:

Women's Mental Health Distribution List

Mental Health Services, Department of Veterans Affairs

Requests can be sent to Jennifer.Strauss@va.gov

Save the Date! The next VA women's mental health teleconference call is scheduled for Thursday, November 13, 3pm ET

Speaker: Alison Hamilton, PhD MPH; Topic: Clinically Complex Women Veterans

Please visit our recently launched VA SharePoint site:

https://vaww.portal.va.gov/sites/OMHS/WMH

References

Batuman, F., Bean-Mayberry, B., Goldzweig, C., Huang, C., Lye-Miake, I.M., Washington, D. L., … Shekelle, P.G. (2011). Health effects of military service on women veterans. (No. VA-ESP Project # 05–226). Washington, DC: Department of Veterans Affairs Health Services Research & Development Service.

Bean-Mayberry, B., Yano, E. M., Washington, D. L., Goldzweig, C., Batuman, F., Huang, C., … Shekelle, P.G. (2011). Systematic review of women veterans' health: Update on successes and gaps. Women's Health Issues, 21(4S), S84–S97.

Epidemiology Program, Post-Deployment Health Group, Office of Public Health, Veterans Heath Administration, accessed from http://www.va.gov/vetdata/Veteran_Population.asp

Frayne, S. M., Chiu, V. Y., Iqbal, S., Berg, E. A., Laungani, K., Cronkite, R. C., ... Kimerling, R. (2011). Medical care needs of returning veterans with PTSD: Their other burden. Journal of General Internal Medicine, 26(1), 33–39.

Frayne, S. M., Phibbs C. S., Friedman, S. A., Saechao, F., Berg, E.,Balasubramania, V., et al. (October 2012). Sourcebook: Women Veterans in the Veterans Health Administration. Volume 2. Sociodemographicand Use of VHA and Non-VA Care (Fee). Women's Health Evaluation Initiative, Women's Health Services, Veterans Health Administration, Department of Veterans Affairs, Washington DC.

References

Frayne, S.M., Phibbs, C.S., Saechao, F., Maisel, N.C., Friedman, S.A., Finlay, … Haskell S. (February 2014). Sourcebook: Women Veterans in the Veterans Health Administration. Volume 3. Sociodemographics, Utilization, Costs of Care, and Health Profile. Women's Health Evaluation Initiative, Women's Health Services, Veterans Health Administration, Department of Veterans Affairs, Washington DC.

Friedman, S. A., Phibbs, C. S., Schmitt, S. K., Hayes, P. M., Herrera, L., & Frayne, S. M. (2011). New women veterans in the VA: A longitudinal profile. Women's Health Issues, 21(4S), S103–S111.

Fontana, A., Rosenheck, R., & Desai, R. (2010). Female veterans of Iraq and Afghanistan seeking care from VA specialized PTSD programs: Comparison with male veterans and female war zone veterans of previous eras. Journal of Women's Health, 19(4), 751–757.

Goldzweig, C. L., Balekian, T. M., Rolon, C., Yano, E. M., & Shekelle, P. G. (2006). The state of women veterans' health research: Results of a systematic literature review. Journal of General Internal Medicine, 21, S82–S92.

Haskell, S. G., Mattocks, K., Goulet, J. L., Krebs, E. E., Skanderson, M., Leslie, D., ... Brandt, C. (2011). The burden of illness in the first year home: Do male and female users differ in health conditions and healthcare utilization. Women's Health Issues, 21(1), 92–97.

References

Marcus SM, Flynn HA, Blow FC, Barry KL. (2003) Depressive symptoms among pregnant women screened in obstetrics settings. Journal of Women's Health, 12(4):373-80.

National Center for Veterans Analysis and Statistics (2014). The Veteran Population Model 2014 (VetPop2014); National Center for Veteran Analysis and Statistics, Department of Veterans Affairs, Washington, DC.

Northeast Program Evaluation Center, Office of Mental Health Operations, Department of Veterans Affairs (2014). *2013 National mental health fact sheet (NEPEC-MHFS13-1).*

Ross, I., Garovoy, N.D., McCutcheon. S.J., Strauss, J.L. (in press). Women Veterans. In E.C. Ritchie & A. Naclerio (Eds.), Women at War, Oxford University Press, New York, NY.

Runnals, J.J., Garovoy, N., McCutcheon, S.J., Robbins, A.T., Mann-Wrobel, M., Ventimiglia, A., … Strauss J.L. (2014) Systematic review of gender differences in mental health and unique needs of women Veterans, Women's Health Issues, 24(5), 485-502.

Sayers, S. L., Farrow, V. A., Ross, J., & Oslin, D. W. (2009). Family problems among recently returned military veterans referred for a mental health evaluation. Journal of Clinical Psychology, 70(2), 163–170.

Washington, D. L., Bean-Mayberry, B., Riopelle, D., & Yano, E. M. (2011). Access to care for women veterans: Delayed healthcare and unmet needs. Journal of General Internal Medicine, 26(2S), 655–661.

Questions?

- Submit questions via the Q&A box located on the screen.
- The Q&A box is monitored and questions will be forwarded to our presenters for response.
- We will respond to as many questions as time permits.

Continuing Education Details

- If you pre-registered for this webinar and want to obtain a CE certificate or a certificate of attendance, you must complete the online CE evaluation and post-test.

- After the webinar, please visit http://continuingeducation.dcri.duke.edu to complete the online CE evaluation and post-test and download your CE certificate/certificate of attendance.

- The Duke Medicine website online CE evaluation and post-test will be open through **Thursday, Oct. 30, 2014,** until 11:59 p.m. (EDT).

Webinar Evaluation/Feedback

We want your feedback!

- Please complete the Interactive Customer Evaluation which will open in a new browser window after the webinar, or visit: https://ice.disa.mil/index.cfm?fa=card&sp=131517&s=1019&dep=*DoD&sc=11
- Or send comments to usarmy.ncr.medcom-usamrmc-dcoe.mbx.dcoe-monthly@mail.mil

Chat and Networking

Chat function will remain open 10 minutes after the conclusion of the webinar to permit webinar attendees to continue to network with each other.

Save the Date

Next DCoE TBI Webinar:

Technology Interventions for TBI

Nov. 13, 2014

1-2:30 p.m. (EST)

Next DCoE Psychological Health Webinar:

Technology Interventions for Psychological Health

Nov. 20, 2014

1-2:30 p.m. (EST)

DCoE Contact Info

DCoE Outreach Center

866-966-1020 (toll-free)

dcoe.mil

resources@dcoeoutreach.org