Psychotherapeutic Considerations in Facilitating Treatment Efficacy in Female Veterans and Active Duty Service Members

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The number of women serving in the U.S. military is rapidly growing and their available occupational roles are ever expanding. Following the end of the draft in 1973, it is reported that women comprised only 8% of the officer corps and 2% of enlisted forces. In 2018, the officer corps was comprised of 19% women and the enlisted component was comprised of 16% women. In 2013, Secretary of Defense Leon Panetta ordered all branches of the military to open combat roles to women no later than 2016. As roles have evolved, women are exposed to a greater variety of experiences in the military, including traumatic events. Coupled with the increasing number of women serving, the psychotherapy community should anticipate greater mental health care needs and utilization by women service members and veterans over time.

In the active duty and veteran sectors, women's needs are varied across the life span and include unique roles in both personal and professional spheres. This paper was written to address some of these unique needs and experiences and includes information related to 1) demographic characteristics and health care needs, 2) accessing mental health care, 3) treatment considerations, 4) the utility of single-gender therapy options, 5) building resilience, 6) offering holistic care, 7) intersectionality, and 8) training providers.

Demographics of Women Service Members/ Veterans and Their Health Care Needs

Female service members/veterans differ from their male counterparts in meaningful ways. Some studies of mental health help-seeking and assessment of mental health needs have observed that, when compared to men, women are more likely to be single, younger, report lower combat exposure, have completed more education, and have a history of greater use of mental health services, but are higher risk for PTSD, suicide, and depression (e.g., Adams et al., 2021). Studies circumscribed to Department of Veterans Affairs (VA) healthcare users suggest that women are likely to be older than their male counterparts (Maguen et al., 2010). Such findings suggest that the healthcare setting in which women are seen may be related to key demographic characteristics that should be considered when providing care.

Even within sex, female service members/veterans are diverse in their identities. As of 2015, 42% of female veterans using VA identified as a racial/ethnic minority, with the most common minority identity being Black (30%; Frayne et al., 2018). Sixteen percent of women service members identified as a gender or sexual minority (Meadows et al., 2018), and 43% are 18-44 years old, 46% are 45-64 years old, and 12% are 65 years old and older (VA, 2018). Older women veterans are more likely to access VA care relative to women veterans who served in military operations in Iraq and Afghanistan (Bielawski et al., 2014; Washington, 2011). As we strive to improve the care we offer female service members/veterans, it is vital that we understand our patients' intersecting identities. It is further imperative that we take responsibility for learning about minority stress (Meyer, 1995) and come to understand and engage with the process of cultural humility (Tervalon & Murray-Garcia, 1998).

Females are at increased risk for mental health concerns relative to their male military and civilian counterparts. Recent surveillance data show that women are twice as likely to die by suicide relative to their civilian counterparts. They are also nearly twice as likely as their male military counterparts to be diagnosed with a mental health concern, such as posttraumatic stress disorder (PTSD; e.g., Adams et al., 2021; Lehavot et al., 2018), adjustment disorder related to their military experience, and depression (Maguen et al., 2010). There are many factors that could account for these gender differences. For example, women are more likely to report exposure to military sexual trauma (Blais et al., 2022; Kimerling et al., 2007; Morral et al., 2015) and are more likely to seek treatment (Gaffey et al., 2021), resulting in a higher likelihood of being diagnosed with a mental health disorder.

Indeed, these demographic factors could impact the manner in which women initiate and progress in mental health care. For example, it is possible that identifying as single may be a component of more limited social support or social connectedness, and indeed, female veterans are

known to have smaller social networks than men veterans or civilians of either gender (Campbell et al., 2021). Alternatively, being single could mean the absence of relationships that create distress or tension secondary to the low satisfaction or quality, and distress and tension are associated with higher suicide risk (Blais & Geiser, 2019; Blais, 2020a, b). Similarly, being single may suggest a lack of dependents (e.g., children, aging parents), but could also mean greater responsibilities associated with single parenting. Notably, women who are actively serving whilst being single parents may have very few childcare options or supports available to them, particularly as they navigate permanent changes of duty station. In a recent focus group of pregnant service members who already had at least one child while in the military, several women reported that as they attended to the regular care needs of their children (e.g., staying home to provide care when the child was too ill to go to school), they often felt as though they had to choose their career or their child, a feeling that was reinforced by their immediate command who would council them out of the military when they could not easily fulfill both roles (Blais, personal communication, September 22, 2022).

Moreover, women may experience discrimination that exacerbates psychological and social stressors both during and after military service. Research shows that nearly one-third of women experience gender bias during their service and have difficulty connecting with their female counterparts (Thomas et al., 2018). For example, female service members frequently report that they are held to different fitness and readiness standards by their peers and immediate command, and failure to meet those requirements can lead to being ostracized. Females who are post-partum are expected to meet fitness standards six months after delivery, regardless of complications during pregnancy or delivery (US Army Public Health Center, 2019). Excelling in those standards can also lead to feeling ostracized as members of their unit perceive them to be threats (Blais, personal communication, September 22, 2022). Women further report verbal interpersonal violence perpetrated by fellow female service members. Such violence is hypothesized to be the result of masculine socialization over time or women leaders holding women subordinates to different standards than male subordinates (Blais, personal communication, September 22, 2022). For those actively serving, both these explicit biases as well as more subtle microaggressions should be discussed to understand their impact. And for those that have separated, such factors should be explored as possible barriers to connecting with others after military service.

Accessing Mental Health Care

Notable barriers to accessing mental health care have been identified and include logistics, access, and stigma (Lehavot et al., 2013; Vogt et al., 2006). Optimistically, more recent data suggests that wait times may be decreasing as many women reported timely appointments and overall high satisfaction with care received (Brunner et al., 2019). That said, the COVID-19 pandemic introduced access challenges for both men and women, which may have impacted these gains. However, there was a rapid increase in the use of tele-mental health (Connolly et al., 2021), which might have mitigated these challenges. For those not able to access care quickly, delays may create opportunities for decreased motivation for change and increased utilization of unhealthy coping, such as binge drinking, social isolation, and maintaining unhealthy relationships. These factors can result in greater psychological distress and dysfunction over time, potentially resulting in more complex needs once care is initiated.

Treatment Considerations

Military culture largely discourages expression of emotions and encourages aggression, independence, and decisiveness, traits that are typically associated with masculinity (Ashley et al., 2017). In contrast, traits associated with femininity (e.g., kindness, emotionally expressiveness), are often deemed undesirable or unhelpful. Derogatory language is often used to sexualize and harass women service members and veterans. Hearing this language has been associated with women leaving the military earlier than anticipated (Dichter & True, 2015). Further, women have reported that if they socially engage with male service members, they may be called “easy,” whereas if they decline sexual advances, they are seen as “playing hard to get” or “a challenge” (Blais, personal communication, September 22, 2022). Internalized misogyny can develop when females spend time in an environment that devalues women and, therefore, they may choose to avoid VA care due to feeling unworthy of receiving care (Mattocks et al., 2012) or not wishing to revisit this culture. Despite intervention, females reported stable perceptions of gender and sexual harassment when utilizing VA services, with the most frequent perpetrator identified as male veterans (Fenwick et al., 2021). Moreover, the authors of this paper have heard female veterans express that it is difficult for them to see themselves as a “veteran” and worthy of services because of their gender. A sense of inclusion, cohesion and social support are borne out in the literature as important contributors to emotional well-being (Costa & Kahn, 2010), but females may miss out on these experiences, due, in part, to the hypermasculine expectations of behavior and de-valuing of women in the military.

While a number of efficacious treatments are available to treat women service members and veterans, it is important to note that the clinical trials for the primary treatments offered to address individual psychological concerns, such as PTSD or depression (Eftekhari, 2013; Kaysen et al., 2014) or interpersonal issues, such as low relationship satisfaction in the context of a PTSD diagnosis (see review, Kugler et al., 2019), have largely been tested with a male service member/veteran as the identified military patient. Importantly, studies show that women reported greater reductions in PTSD in prolonged exposure and cognitive processing therapy (Khan et al., 2020), highlighting the importance of additional studies in women. Notwithstanding, the preponderance of testing in male samples makes it unclear whether these interventions are

optimally designed for women who may be navigating unique roles, index traumas, and symptoms. While cognitive processing therapy was initially developed to treat women survivors of sexual assault, the majority of studies in military samples include men (e.g., Kaysen 2014). Clinicians should consider that alterations in treatment could be needed to address unique cultural concerns, exposures, or expressions of distress. For example, Blais (2020a) observed that women's reports of low romantic relationship satisfaction were associated with higher self-reported anhedonia (e.g., loss of interest, social detachment) and dysphoric arousal (e.g., anger, irritability, sleep disruption), but men's reports of low romantic relationship was associated with higher anhedonia only (see also, Renshaw et al., 2014). Such results suggest that when addressing low relationship satisfaction in women, therapies may be most effective if they addressed *both* anhedonia and dysphoric arousal clusters whereas these treatments in men may achieve the same or similar gains by addressing anhedonia only. Moreover, among survivors of military sexual assault, a mechanism of women's relationship dissatisfaction was difficulties with the sexual response cycle (e.g., low arousal, lubrication) and their subjective happiness with sexual activity, but in men, it was engagement in compulsive sexual behavior that was associated with lower relationship satisfaction (Blais, 2021b). Relatedly, women were more likely to report more exposures to sexual violence across the life cycle relative to men, including before they joined the military and after (Blais et al., 2022), and reported different posttraumatic responses to these exposures, particularly as the number of exposures increased (Tannahill et al., 2021). These studies suggest unique, gender-informed points of intervention.

When offering treatment to address posttraumatic stress and dysfunction, it will be critical to understand the sources of trauma that create the greatest distress. A recent review suggested that up to 40% of women report exposure to military sexual harassment and assault (Wilson, 2018). However, there is evidence of barriers to reporting (Andresen & Blais, 2018; Blais et al., 2018), suggesting the review's estimate is likely low. Emerging evidence suggests that exposure to sexual violence during military service creates unique and perhaps heightened challenges for women. For example, when exposure to sexual violence was compared to other military trauma exposures among women, such as combat, military sexual violence exposure was associated with higher sexual dysfunction and lower sexual satisfaction (Blais et al., 2020; Pulverman et al, 2021) as well as increased risk for suicide (Blais and Monteith, 2019). Indeed, while some studies show that VA-enrolled men have a higher risk for PTSD more generally, exposure to sexual violence during military service confers a greater risk for PTSD in women than men, such that overall rates of PTSD look similar to that of men when women report such exposures (Tannahill et al., 2020).

Unfortunately, some providers do not feel equipped to adequately assess and address concerns related to military sexual violence using patient-centered approaches. Providers report that they feel uncomfortable asking about exposure to sexual violence and therefore avoid asking in-depth questions (Bergman et al, 2019). Indeed, a qualitative analysis exploring barriers to disclosing exposure to military sexual violence during screening revealed that some women opted not to disclose because they felt the topic was not important to their provider or that their provider did not care (Blais et al., 2018). Collectively, these findings suggest that additional training would be helpful in reducing discomfort when asking questions about sexual assault histories. Clinicians should do all they can to take a proactive approach that creates a safe space for discussing such experiences.

Supporting Women's Engagement in VA and Community Settings: The Importance of Single-Gender Offerings

As female's roles have changed in the military, their integration has been met with concerns from their male peers. Specifically, findings from the *Gender Integration Study* (TRADOC Analysis Center, 2015) observed that integration of women in the military has increased concerns that physical fitness standards would be lowered to accommodate women, and lowering these standards would result in greater risk of death in combat. Other concerns included the ability of women to become pregnant during service, thus making them temporarily unavailable to serve and perhaps distracted by non-military matters. Such concerns or stereotypes may discourage women from taking on multiple roles concurrently (e.g., serving, motherhood) or feel as though they are a liability to their unit if they do. Not surprisingly, many women service members and veterans continue to lack a sense of belonging and support (e.g., Thomas et al., 2017a; Burkhart et al., 2015) and avoid using VA provided health and social services once discharged, with only 37.2% of women Veterans enrolling in VA in 2019 (Congressional Research Service, 2021).

Anecdotally, some female service members and veterans describe using a "buddy system" with other women when using the restroom, laundry facilities, or to access their car in a parking lot (Blais, personal communication, September 22, 2022), in order to increase their sense of safety against assault. Some females feel betrayed when they are promised an experience of comradery and instead are mistreated by those meant to keep them safe (Andresen et al., 2019; Dichter & True, 2015; Holliday & Monteith, 2019). This experience is called institutional betrayal (Smith & Freyd, 2014). Clinicians treating women service members and veterans should have some understanding that their patients may have experienced disillusionment in the military as a consequence of their gender. Furthermore, concerns that institutional betrayal may continue as females transition out of the military is a reasonable concern that may impact care. This knowledge may help inform case conceptualization and aid in building a therapeutic relationship.

In order to increase usage of VA services, researchers have explored factors that draw women to the VA and help maintain engagement. Factors include the VA's focus on Whole Health (Krejci et al., 2014), peer social sup-

port, proactive clinicians (Evans et al., 2019), and specialized mental health services for women (women-only groups, receiving care in women-only settings, seeing a female provider; Kimerling et al., 2015) as well as addressing unhelpful behaviors of men (Moreau et al., 2020). Of those who do engage in mental health care at the VA, only half report that the institution met their mental health care needs completely or very well, and women are more than twice as likely to report their needs were met if they were able to engage in gender-related services as often as desired (Kimerling et al., 2015). To improve engagement and satisfaction with VA services, recommendations from the literature include targeted programming for women veterans and service members, single gender offerings, improvement of services at points of separation and transition, available childcare, peer outreach, and telehealth services (Thomas et al., 2017a; Thomas, 2017b; Brooks et al., 2014; Durham et al., 2017). Finally, given that the majority of female veterans are not seeking care at VA, and much of what is known about health care use comes from VA studies, non-VA clinics may need to be sensitive to unique needs that were not captured in VA studies.

Research on both female civilians and veterans suggests that single-gender treatment groups can uniquely benefit women. Females may be more likely to initially engage and to stay in treatment when single-gender groups are offered (e.g., Weller, 2005; Oliva et al., 2012). Furthermore, research suggests that single-gender groups can facilitate better mental health outcomes, including reduced alcohol use and better social adjustment for women compared to mixed gender groups (see Grella, 2008 for a review focused on substance abuse treatment). Perhaps lending to improved treatment outcomes, women in single -gender groups report a sense of connection, safety, and group cohesion (e.g., Greenfield et al., 2013), and are more likely to stay in treatment (Brady & Ashley, 2005). A sense of safety is critical among female service members and veterans, as the majority of women who experience military sexual violence are assaulted by fellow service men (e.g., Blais et al., 2018; Morral et al., 2015). Thus, co-ed groups may trigger traumatic memories in a counter-therapeutic manner. Groups could address any treatment topic or function as a process group, providing a space for women veterans to discuss their experiences as women in the military, as women veterans, and how other intersecting identities can impact health and wellbeing. VAs can also set up women's only waiting areas, which may promote a sense of safety, particularly in clinics that see predominantly male clientele.

Building Resilience in a Group that is Likely to be Revictimized

Building resilience among women service members/ veterans is critical to ensuring positive well-being and value before, during, and after military service. In addition to stressors experienced related to wartime that can decrease resilience, women are also at greater risk for sexual revictimization, which contributes to even greater dysfunction relative to other stressors (e.g., Blais & Monteith, 2019). Indeed, rates of sexual revictimization are high among women veterans (Tirone et al., 2020a; Tirone et al., 2020b), and notably higher than the rates of revictimization in men (Blais et al., 2022).Strengthening a sense of community and shared identity among women service members and veterans is a viable and promising pathway to resilience employed by women veterans (e.g., Leslie & Koblinsky, 2017) and can be furthered by creation of gender-specific groups devoted to discussing the intersection of military experience and gender, as described below. Increasing participation in these communities would be a wise treatment goal and focus. Mental health providers in the community can also assist with social prescribing of resources such as WoVeN, or Women Veterans Network, a program for women veterans to build connections with one another (Brownley & Dunn, 2021).

Additional strategies for building resilience include meaning-making of military service (Leslie & Koblisnky, 2017), and increasing self-efficacy and internal locus of control, or the sense that one has agency over outcomes (Agaibi & Wilson, 2005). Cognitive behavioral strategies are helpful in enhancing a sense of self-efficacy (Gallagher et al., 2013), suggesting that this treatment approach might be especially fruitful for increasing resilience in this population. Recommended strategies for enhancing resilience following trauma exposure for people more generally include therapeutic trauma disclosure to close others and engaging in altruistic or prosocial behavior (Agaibi & Wilson, 2005). Indeed, these strategies seem particularly relevant for women service members and veterans. Although disclosure of trauma to military personnel or supervisors has been linked to dissatisfaction and disillusionment with the military, disclosure to close others is not (Dardis, Reinhardt, Foynes, Medoff, & Street, 2018). Clinicians could thus work with women service members and veterans to identify appropriate personal sources in their lives to whom they can have therapeutic disclosure and enhance their resilience.

Lastly, engagement in prosocial and altruistic activities is strongly linked to a sense of military identity (Castanheira, Chambel, Lopes, & Oliviera-Cruz, 2016), which may be both a reason for joining the military to begin with and a pathway to resilience further in a service member's career or following separation. Although military members may experience disruptions in this aspect of their identities following separation or military-related traumas (McCormack & Ell, 2017), re-engagement in civic activity, connection to community, and volunteer work can foster a sense of resilience and recovery among women veterans and military personnel (Angel et al., 2019), and for those that maintain a strong sense of military identity following separation, engagement in prosocial and altruistic activities may be a way to honor and preserve this identity in a values-driven approach. Given the aforementioned deficits in women veterans' social support networks (Campbell et al., 2021), such re-engagement in prosocial or altruistic activity may have the added benefit of enhancing social support and social connection.

In summary, many strategies exist for enhancing resilience in a vulnerable population such as women service

members/veterans, and these are both easily integrated into standard mental health practice (e.g., fostering self-efficacy, meaning-making) and require creativity on the part of practitioners (e.g., connecting to community organizations, enhancing structural and functional social support).

Offering More Holistic Care

Research shows that exposure to sexual violence in the military is associated with higher eating disordered behavior, depression, PTSD, and risk for suicide, as well as poor relationship satisfaction, all of which are associated with poorer sexual function and satisfaction (Blais, 2020c; Blais et al., 2017; Kimerling et al., 2007). Unfortunately, sexual health is largely ignored in most assessments and interventions (Dickenson & Blais, 2021). Moreover, similar to the concerns of asking about sexual victimization reported by providers, many providers feel uncomfortable asking about sexual well-being (Zhang et al., 2020). These findings highlight the need for graduate and professional schools to more adequately train students on how ask sensitive questions about sex, sexuality, and sexual assault. Anecdotally, clinicians report that clients have expressed gratitude about being asked about their sexual well-being, with some clients reporting discomfort initiating the topic, signaling the need for clinicians to be proactive on these topics (Sadovsky, 2003). Asking about sexual well-being or ensuring your clinic assesses for sexual satisfaction and function is a key way to provide more holistic care. Indeed, the VHA has had a requirement to conduct annual sexual health reviews with veterans since 2017 (VA, 2017).

Intersectionality, Minority Stress, and Clinicians' Cultural Humility

Intersectionality is defined as how various identities (e.g., race, gender, class) and experiences interact and overlap to influence social relations among individuals and groups (Collins & Bilge, 2020). Women veterans do not uniformly have the same experience while accessing mental health resources. For example, women who identify as a sexual minority (e.g., lesbian) and/or gender minority (e.g., transgender) are more likely to endorse harassment from male veterans and feel unwelcome at VA compared to women who do not identify as a gender and/or sexual minority (Shipherd et al., 2018). Negative impacts of these experiences extend to care engagement as these women report missing or delaying care due to fears about interacting with other veterans (Shipherd et al., 2018). This is an example of intersectionality whereby (put simply) the experience of being both a woman and identifying as a gender and/or sexual minority confers unique risk for harassment, shaped by the historical discrimination and exclusion of women and individuals who identify as lesbian, gay, bisexual, and transgender. That said, intersecting minority identities do not always equate to more difficulties. Although women veterans of a minority race/ethnicity or sexual orientation may experience higher severity of mental health symptoms compared to White and heterosexual women, women who are both racial/ethnic and sexual minorities may develop resilience from their experiences, resulting in less severe mental health symptoms (Lehavot et al., 2019).

As we work with women service members and veterans, it is important to be continually curious as to how each woman's intersecting identities affect how she is treated by others, how she is differentially impacted by systems, and how her identities shape the way she experiences the world around her, including her interactions with those of us serving as providers of care. We must not assume that being a woman is the most important or salient identity for women service members and veterans, and we must acknowledge that this may change throughout the course of treatment. In fact, helping women identify and even celebrate this aspect of their identity may be a critical part of intervention given their time and service in a masculine culture. It is vital that we validate the adverse impact of chronic "othering"/feeling out of place and microaggressions (Sue et al., 2007) and we can explore with our patients the synergistic connections between their multiple identities.

Training Providers

As we train new clinical providers, women's experiences in the military and as veterans must be uniquely highlighted if we are to build a culturally sensitive workforce. Seminars orienting trainees to military culture should include information on the history of women in the military and ways in which men and women's experiences might differ. It is imperative that we strive for cultural humility, a concept that incorporates a lifelong commitment to self-evaluation and self-critique, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities (Tervalon & Murray-Garcia, 1998). It is critical that providers see the process of understanding the experience of women service members and veterans as a life-long learning process where expertise is not a goal.

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