ADDRESSING CUMULATIVE TRAUMA IN WOMEN VETERANS

RECONNECTION THROUGH DIALECTICAL BEHAVIOR THERAPY

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This VA facility developed a cost-effective program that provides long-term counseling services to women veterans with a history of military sexual trauma.

Trauma can affect every aspect of human functioning. Traumatic experience disrupts biology, behavior, affect, sensation, knowledge, and social connectedness. Cumulative trauma—that is, the experience of more than one traumatic event—increases the complexity of all health care treatment issues.

At the VA Roseburg Healthcare System in Roseburg, OR, 93% of the female veterans enrolled in the women's trauma clinic for military sexual trauma (MST) reported having experienced cumulative trauma.

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The complex needs of these patients required us to evaluate our approach to treatment critically, rely on the most current information, and use the most appropriate applications for this population.

In 1992, with Public Law 102-585, Congress authorized VHA facilities to provide sexual trauma counseling services to women veterans who had been assaulted during military service. Providing MST services in an era in which resources are on the decline has been a challenge. Despite barriers, our facility initiated a unique treatment program that met this need.

The purpose of this article is twofold: first, to present data collected on cumulative trauma among women veterans treated at our clinic over a period of two years; second, to describe the treatment approach developed based on that data. This approach incorporates Linehan's dialectical behavior therapy (DBT)[1] and Herman's trauma recovery stages.[2] The innovative application presented involves a new use of DBT—in a different stage of treatment (the final stage of a trauma treatment program), with a new population (women veterans), and in a new clinical setting (the VHA).

CHARACTERISTICS OF WOMEN VETERANS

Women veterans often share demographic and sociocultural commonalities. The Veterans Administration Women's Health Project reported that, when quality-of-life indicators are measured, this group of women

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has characteristics that set them apart from their civilian counterparts.[3] Women veterans who use VHA services scored lower on every quality-of-life scale compared to civilian women.[3] According to Skinner and colleagues, the most notable differences were in the areas of physical role limitations, emotional role limitations, and social functioning.[3] In addition, women veterans had attained higher education without corresponding employment status.[3]

There are also important differences between women who report having been sexually assaulted or harassed while in the military and those who do not.[4] The former are significantly more likely to identify problems encountered in readjusting to life after discharge, including having trouble getting a job; having a drinking or drug problem; experiencing anxiety; feeling lost, depressed, or angry; or having trouble settling down.[4] These women report increased isolation both in the military and after their return to civilian life.[4]

Few women veterans ever discuss their military careers—even with family members or significant others in their lives.[5] The isolation reported by women veterans after leaving the military combined with the problems associated with cumulative trauma call for a treatment approach that facilitates connections with others and promotes safety and skill building.

STAGES OF TRAUMA TREATMENT

Treatment models that address the final stage of trauma recovery (that is, reconnection) for women veterans who have reported cumulative trauma are nonexistent in scientific literature. The model presented here is a new application of interventions that have shown efficacy in various clinical settings with men and women at other stages of recovery.[6,7] Published works describing stages of trauma recovery as well as treatment approaches for posttraumatic stress disorder (PTSD) are substantial.

For over 100 years, clinicians and researchers have identified stages of trauma recovery in an effort to apply order and a human construct to a process that is inherently turbulent and complex.[2] Stages of recovery identified throughout a wide range of scientific literature, while not identical, are congruent.[8] As a framework with which to approach trauma treatment, clinicians at the VA Roseburg Healthcare System used the three stages of recovery identified by Herman: safety; remembrance and mourning; and reconnection.[2] These stages and Herman's focus on safety and empowerment are uniquely suited to the fundamental issues facing women trauma survivors. In addition, this framework, which identifies reconnection as a fundamental goal, emphasized that establishing and maintaining interpersonal relationships was developmentally important for women.[9]

DBT: OVERVIEW AND APPLICATION

Historically, DBT has been used as an early intervention for stabilization. Julian Ford of the National Center for PTSD has described the potential value of DBT within the VA, calling it an "intervention that is conceptually sophisticated yet down-to-earth operationally."[10] The use of DBT in treating women veterans has received little coverage, though Koons and colleagues reported on the efficacy of DBT in treating women veterans diagnosed with borderline personality disorders.[11] In the early intervention program they described, DBT was used to treat suicidal and impulsive behavior in such individuals and to help provide stability.[11]

It is well established that trauma significantly disrupts the ability to make connections with others. This is particularly true for individuals who have had multiple traumas. Trauma that occurs during formative developmental stages puts individuals at elevated risk for attention and attachment problems.[8] Traumatic experiences are known to alter adversely the skills required to manage and to interact effectively with the environment. DBT is uniquely tailored to address difficulties individuals have with attention and attachment. It provides women veterans with the tools and support they need to participate actively in their lives. Restorative experiences, in turn, can provide the most powerful counteraction to trauma.

The biopsychosocial theory of DBT examines personality development within the context of an invalidating emotional environment. DBT includes four interrelated modules that address the skill development potentially disrupted by such an environment: core mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance.

Linehan developed DBT for the treatment of personality disorders.[1] While not all veterans enrolled in DBT group are diagnosed with personality disorders, it is reasonable to infer that subjugation to multiple traumatic experiences constitutes repeated invalidation and disturbance of developmental processes. The impact of such experiences and emotional turmoil can result in

behavioral disruptions that interfere with health, safety, quality of life, and daily functioning.

In recent years considerable controversy has emerged regarding diagnostic labeling of trauma survivors. The core controversy involves identifying the etiology underlying the difficulties as trauma (extrapsychic) versus a character pathology (intrapsychic). While it is beyond the scope of this article to address this controversy, in our clinic, we approach trauma—both philosophically and pragmatically—as the predominant causative factor behind the difficulties experienced by the women enrolled in the DBT group.

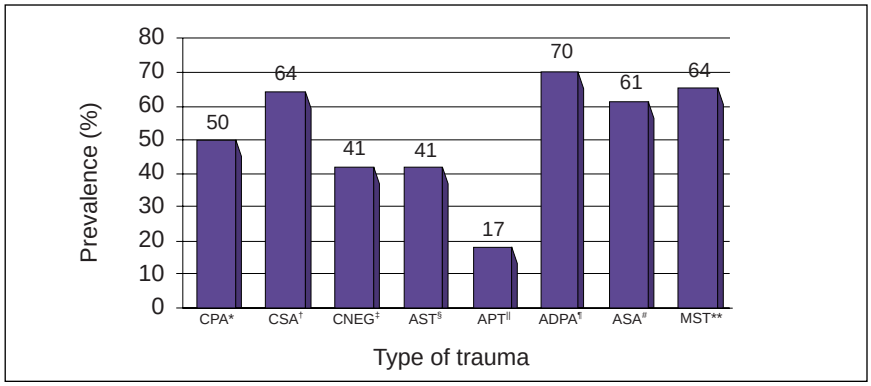

Figure 1. Prevalence of trauma by type. *CPA = child physical assault. †CSA = child sexual assault. ‡CNEG = child neglect. §AST = adolescent sexual trauma. ‖APT = adolescent physical trauma. ¶ADPA = adult physical assault. #ASA = adult sexual assault. **MST = military sexual trauma.

COLLECTING THE DATA

Through retrospective chart review, data were collected on cumulative trauma experienced by 42 women veterans, aged 21 to 72 years, who were seen at least three times in the Women's Trauma Clinic at the VA Roseburg Healthcare System over a period of two years. All women accessing these services are screened through clinical interview for lifetime histories of trauma.

We identified the following types of trauma as having been experienced by this group: child physical assault, zero to 11 years old; child sexual assault, zero to 11 years old; child neglect, zero to 11 years old; adolescent sexual trauma, 12 to 18 years old; adolescent physical trauma, 12 to 18 years old; adult physical assault, over 18 years old; adult sexual assault, over 18 years old; and MST, over 18 years old while serving in the military (Figure 1). Adult physical assault was the type of trauma most commonly reported by this group (with a 70% prevalence) and adolescent physical trauma was the type least commonly reported by this group (with a 17% prevalence).

In this group of patients, 39 (93%) reported having experienced more than one type of trauma; 32 (76%), three or more types of trauma; 25 (60%), four or more types of trauma; 21 (50%), five or more types of trauma; 11 (26%), six or more types of trauma; and 3 (7%), seven or more types of trauma (Figure 2). This information was vital in formulating a treatment approach that would meet the needs of these women veterans.

It should be noted that the relatively high levels of cumulative trauma reflected in our data may be attributable in part to the fact that these data were collected during the clinic's initial years. With the introduction of a new MST service, veterans with the most severe symptoms may be more likely either to self-present or to be referred by other providers in the system.

STAGE 1: SAFETY

During the first stage of trauma recovery, the safety stage, treatment is focused on supporting the individual's return to physiologic and psychological equilibrium within her current environment. Attention to physical problems and stabilization of the basic body functions of eating, sleeping, and moving are fundamental, as is education concerning the treatment of common posttraumatic stress symptoms and effective coping strategies.

Patient safety status is always a priority. Following any trauma, the individual is at substantial risk for both self-harm and revictimization by others. Research indicates that 19% of all rape victims attempt suicide.[12]

Every woman veteran who has accessed the VA Roseburg MST clinic has reported having been harmed by others, often multiple times. As a result of such experiences, the individual's self-protective capability is disrupted. For these reasons, a safety plan is generated at this first stage of treatment.

Initial treatment incorporates a therapist trained in posttraumatic stress and a primary care clinician to provide medical management. From the beginning, patient and therapist carefully review the patient's current relationships and

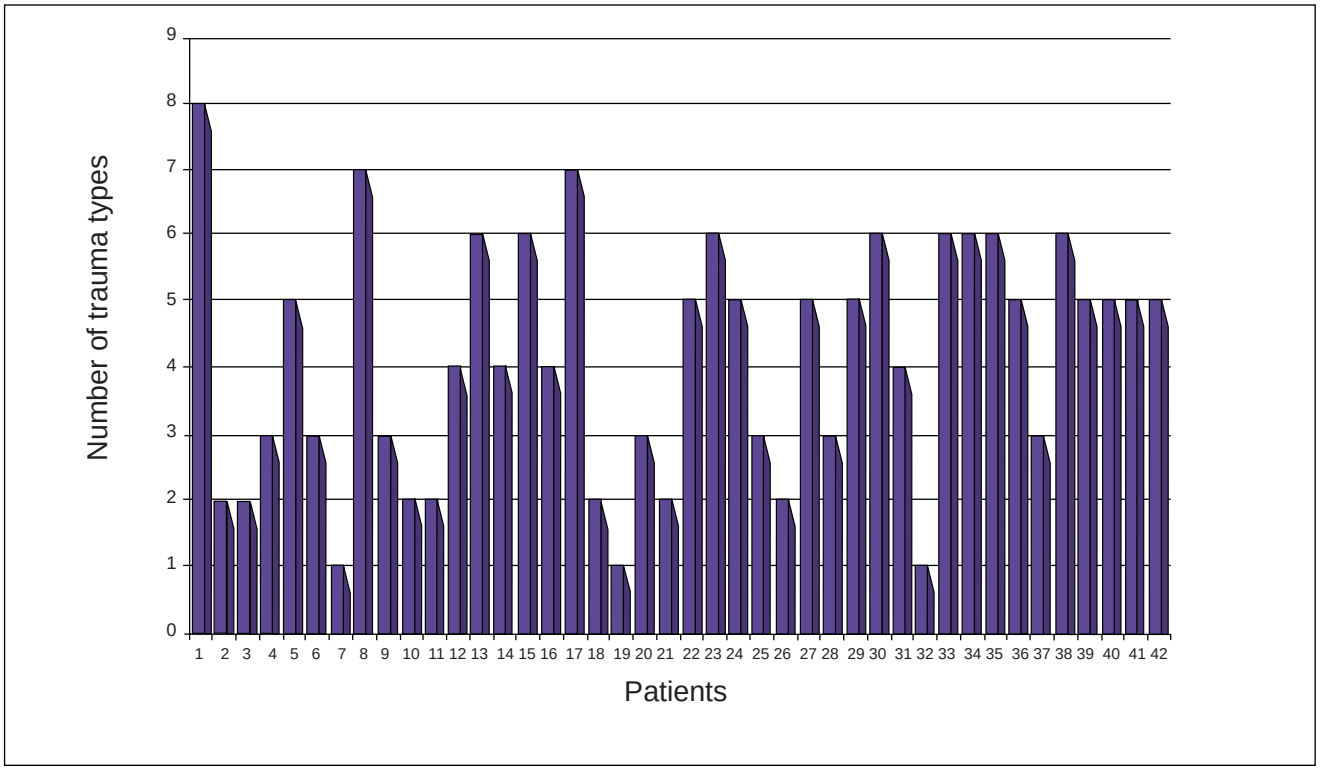

Figure 2. Number of trauma types experienced by each patient.

discuss contact with past perpetrators as a primary source of potential risk. In accordance with the patient's ability to follow through, the patient and therapist develop a safety plan that includes a general strategy for engaging social support systems and provides referral to appropriate community resources. If DBT skill building is introduced to the patient as part of the stabilization process, individual therapy is the setting, because group therapy is contraindicated in the early stages of outpatient trauma treatment.[2]

On a macro level, community involvement and perceived community support have been identified as critical factors influencing long-term outcomes of traumatized individuals.[13] Involving such various community sectors as advocacy agencies, courts, the police, probation officers, and social services contributes to both perceived and real personal safety.

STAGE 2: REMEMBRANCE AND MOURNING

The second stage of recovery focuses on processing traumatic material and grieving losses related to the trauma. At our facility, we employ an eclectic combination of various trauma processing modalities to address each individual's specific needs. Flexibility, pragmatism, and diversity are key to providing the greatest possibility of successful treatment and favorable outcomes. During this stage of treatment, we use eye movement desensitization and reprocessing (EMDR)[14] as well as cognitive processing therapy (CPT) for rape victims.[15] We do not use trauma processing groups as part of this model. Since the majority of our patients have a history of cumulative trauma, they are at elevated risk for adverse events if exposed to additional traumatic material from group members. Patients consistently have reported having an aversion to listening to specific details of other people's trauma when they struggle daily to manage their own. Thus, the second stage of treatment also occurs in individual therapy where symptoms can be monitored closely and paced, and the development of coping strategies can be supported.

STAGE 3: RECONNECTION

Once the individual comes to terms with a traumatic past, says Herman, she faces "the task of creating

a future."[2] At our facility, DBT skill building provides the essential format and content for the third and final stage of recovery. Our rationale for using it within this stage is as follows:

- Reconnection that occurs in a group setting promotes the development of competencies that are both positive and oriented toward future goals.
- A focus on skill building encourages the individual to be present in the moment and adaptive to her unique environment.
- Learning to stay present and attend to self and environment counter fear-induced dissociation and, thereby, can improve an individual's self-protective abilities.
- Through the acquisition of new skills, the individual experiences a sense of self-mastery and competency, which enhances personal safety. All DBT skills counter socially induced and trauma-enforced passivity.
- Reconnection facilitates the establishment and maintenance of relationships with others, a necessary component for developmental maturation.
- Group skill building provides a common language that encourages connection and reconnection and provides a medium through which patients learn to communicate with and support one another.
- The acquisition of skills, rather than the shared histories of trauma, becomes the basis for reconnection.

HOW DBT IS USED

The use of DBT for reconnection in the final stage of recovery is central to our treatment model. During reconnection, women veterans participate in individual therapy and in a DBT skill building group that focuses, in large part, on establishing the basic competencies disrupted by trauma during normal developmental processes. Use and daily practice of such skills in the veteran's personal environment are emphasized. Practice, progress, and application of learned skills occur outside of the therapeutic setting. Both trauma processing and the management of personal crises occur in individual therapy.

Group DBT content is divided into four modules, each of which continues for eight to 12 weeks. Participants are encouraged to complete all four modules. A unique facet of our program encourages veterans who complete all four modules to return to help facilitate groups and mentor new members the following year. In this manner, connections and relationships are maintained and skill building is reinforced through teaching others.

CORE MINDFULNESS

Linehan describes three states of mind: reasonable mind, emotional mind, and wise mind.[1] Core mindfulness helps the individual balance emotional and reasonable mind to achieve wise mind. Mindfulness skills encourage a focus on the present and, thereby, counter the dialectic of trauma, which drives the individual to relive the past or to worry about the future. Mindfulness enables individuals to strengthen their sense of self and become effective in responding to the needs and demands of their environment.

A specific benefit observed in our group experience has been that the mastery of mindfulness skills provides strong protection against numbing dissociation, which can occur under stress. Being present and attending to the environment enhances personal safety and enables the individual to access innate and learned self-protective skills. Safety is, thereby, revisited and strengthened as a core component of trauma therapy.

INTERPERSONAL EFFECTIVENESS

In this module, group members build a sense of self-mastery and competence in their relationships. They learn to attend to personal objectives, relationships, and self-respect effectively. Relational competencies are central to developmental processes that occur throughout life. They are viewed as the essential components of self-competency.[9] The emphasis is on developing patterns of behavior that help the individual balance interpersonal relationships and empower her to become a self-advocate.

EMOTIONAL REGULATION

As survivors of cumulative trauma, group members learn to address and understand emotional chaos as an aftermath of violence. Understanding emotions, reducing vulnerability to harmful emotional states, and decreasing emotional suffering are components of this module.

DISTRESS TOLERANCE

In the final module, participants learn to manage and respond to emotional distress effectively. Distress tolerance does not propose that individuals should endure or accept violence or abuse. Rather, it teaches individuals to remain effective during distressful life events instead of compounding problems. Group members come to understand that, in the past, they faced the distress resulting

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from their multiple traumas without assistance, guidance, or support. Through DBT, however, participants acquire coping skills to face future life challenges and make connections with others who can provide support. Discussion and group exploration expand these skills and promote participants' sense of strength.

The combination and integration of all four modules facilitate reconnection among the women veterans. Cumulative trauma can create emotional dysregulation. DBT facilitates the shift from an emotive to a problem solving focus. In so doing, DBT provides a unique forum in which women veterans can dismantle isolation and collectively explore the following questions:

- What is typical, average, normal?
- What makes a healthy relationship?
- How can I solve problems and make effective decisions?
- How can I maintain self-awareness in my relationships with others?
- How can I recognize emotional cues?
- How can I develop communication skills?
- How can I be assertive?
- How can I strengthen my self-protective skills to enhance my safety?

FILLING A GAP

Trauma and its untreated aftermath foster isolation and disconnection from others. While individual therapy for trauma processing is recognized universally as being necessary, it is also recognized as being labor intensive and time consuming.

Before the VA Roseburg Healthcare System developed a DBT group for women veterans with MST, these patients faced a gap in services. The DBT group offers these women support while fostering reconnection in a way that is both creative and efficient. It provides a setting in which participants can sustain gains made during individual therapy. Thus, even in an era of cost containment, the VA Roseburg Healthcare System has been able to address the need delineated in Public Law 102-585 and provide sexual trauma counseling services to women veterans with MST.

Recognizing that the vast majority of women veterans accessing the MST clinic report histories of cumulative trauma was a requisite step in developing appropriate treatment options. With its focus on skill building, our DBT group offers these patients an alternative therapeutic experience in an emotionally safe, validating environment. Ultimately, it fosters an experience that honors their service and reinforces their connection to one another as women veterans.

Previously published studies have not limited study populations exclusively to women veterans with trauma histories. The unique needs of these veterans provided the impetus to establish a new application of DBT in clinical practice. It is our hope that describing and publishing the results of our efforts will create an opportunity for clinicians to identify best practices and establish clinical guidelines for treating these patients.

While it is always prudent to be cautious when introducing new applications for established therapies, it is reasonable to endorse DBT for use in diverse settings. Further research on applications of DBT across a variety of settings will be valuable. The use of DBT within the VA, and especially with women veterans who have trauma histories, may contribute further to the development of theory and effective interventions. ●

The opinions expressed herein are those of the authors and do not necessarily reflect those of Federal Practitioner, *Quadrant HealthCom Inc., the U.S. government, or any of its agencies.*

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