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Angela Sue Casper
Predictors and Prevention
Strategies for Homelessness
among Women Veterans: A
Theoretical Study

ABSTRACT

This theoretical study was undertaken to explore the experience of women in the military and to gain an understanding of military women's vulnerability to homelessness and their service needs. A study conducted by Gamache, et al. (2003) established that women veterans did show a higher instance of homelessness than non-veteran women. This study includes an exploration of trauma theory and approaches for treatment of homelessness to develop a better understanding of an effective model to treat homelessness within women veterans. Knowledge about effective treatment of combat trauma and homelessness in male veterans and trauma and homelessness among women is used as a way to gain insight into the multi-faceted issues faced by women veterans at risk for homelessness.

The specific needs of the female veterans, especially homeless female veterans, has not been extensively explored or researched. This study uses a combination of the known patterns of experiences and characteristics of homeless women and homeless male veterans from earlier studies to gain a greater understanding of how homeless female veterans may be best served. This study explores the issues presented by homeless female veterans through the established literature of homeless women and women veterans to present suggestions for more effective services. This study offers a direction and suggestions for further research in this field to explore the needs of homeless female veterans and to eventually lower the instance of homelessness among female veterans.

PREDICTORS AND PREVENTION STRATEGIES FOR
HOMELESSNESS AMONG WOMEN VETERANS:
A THEORETICAL STUDY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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Northampton, MA

2007

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CHAPTER I

INTRODUCTION

As the proportion of women in the military grows, a need exists for a clear understanding of the vulnerabilities of this population. Women within the military are now deployed to more combat situations and experience a higher degree of danger than in the past. Reports have also shown that women veterans are disproportionately represented in the homeless population (Gamache, Rosenheck & Tessler, 2003). As this homeless population continues to grow, a re-evaluation needs to take place for the services available to veterans. The emerging population of homeless veteran women promises to pose unique issues and needs that previously have not been the focus of services for the male dominated veteran population.

A study conducted by Gamache, et al. (2003) established that women veterans did show a higher instance of homelessness than non-veteran women. One limitation was that specific risks for homelessness could not be ascertained from the measures used. Gamache, et al. speculated that some of the predictors for female veterans to experience homelessness were life instability before military service and trauma experienced during military service. Whatever the reasons might be for these women to experience more homelessness than non-military women, services and interventions need to reflect the particular needs of this population. Before services can be matched to needs and experience, an understanding of the risk factors must be determined.

This theoretical study explores how trauma theory and an understanding of the military and veteran treatment approaches can explain added vulnerability to homelessness among veteran women and inform improved services provided to veteran women. The experiences of women in the military and the similarities of experience with other homeless women will be discussed as a way to understand increased vulnerability to homelessness. Further, this study will consider how the literature focused on services for homeless women and women veterans can better inform current programs in the development and implementation of more relevant and effective service delivery.

As of the year 2000, women veterans made up five percent of the total veteran population and that number is expected to double within ten years (Gamache, et al., 2003). Veteran women were shown to have higher levels of education, more intact marriages than non-veteran homeless women, and are assured to have access to benefits through the Department of Veteran Affairs (VA) (Gamache, et al., 2003). These factors would suggest that female veterans would have more protective factors against homelessness than non-veteran women (Rosenheck, Leda, Frisman, Lam & Chung, 1996; Tessler, Rosenheck & Gamache, 2002). However, the incidence of homelessness in female veterans is nearly 4 times higher than it is for non-veteran women (Gamache, et al., 2003). Women are increasingly more involved in combat which suggests that they are most likely exposed to the same type of trauma and violence as men in the military. Male veterans make up between 25% and 40% of the male homeless population and women veterans were found to account for approximately 5% of the female homeless population (Gamache, et al., 2003) before increased exposure to combat, again suggesting that women veterans will continue to grow in the homeless population. The

vulnerabilities shown in preliminary studies are the amount of trauma and general instability reported by the veteran female participants.

Research has shown that mental illness, substance abuse, lack of affordable housing or livable wage, experience of trauma both in childhood and adulthood, instability in relationships and criminal history are the common predictors of homelessness for all populations (Caton, Dominguez, Schanzer, Hasin, Shrout, Felix, et al., 2005; Herrman, Evert, Harvey, Gureje, Pinzone & Gordon, 2004; Roll, Toro & Ortola, 1999; Tessler, Rosenheck & Gamache, 2001). The level of involvement or severity of those characteristics listed above can help to predict the length of time that anyone will experience homelessness. Caton, et al. (2005) found that age and arrest history are the strongest correlates to chronic or long-term homelessness. In contrast, those people that have stable families and either currently or recently had a job were able to be re-housed more quickly.

Homeless women, both veteran and non-veteran, reported a greater amount of sexual and physical assault than homeless men (Roll, et al. 1999). When asked about their reasons for homelessness, homeless women cited more interpersonal conflict or lack of support, where men reported economic difficulties (Tessler, et al. 2001). Tessler, et al. (2001) found that each person surveyed had a different experience and specific reasons as to why they felt they were homeless, as is the case with many studies conducted with the homeless population. The call then is to look for patterns among groups and to match services to each person's or a group's specific needs with careful consideration (Roll, et al., 1999). The specific needs of the female veterans, especially homeless female veterans, has not been extensively explored or researched. This study will use a

combination of the known patterns of experiences and characteristics of homeless women and homeless male veterans from earlier studies to gain a greater understanding of how homeless female veterans may be best served.

The experience of trauma is common among all homeless women and women veterans. Within the female veteran population, 35% are diagnosed with posttraumatic stress disorder (PTSD) (Suris, Lind, Kashner, Borman & Petty, 2004). Many more of these female veterans experienced some form of trauma but do not show symptoms of PTSD. Yet these female veterans will be affected by the trauma in ways that encompass much of their lives. In a study comparing social support of male and female veterans in a substance abuse program, 41% of the female participants reported experiencing sexual abuse during military service (Benda, 2006). In the same study 76.8% of the women veterans reported experiencing trauma within the past six months. In general, homeless women consistently reported higher rates of childhood physical and sexual abuse than homeless men (Barrow, 2004). As women veterans are more likely to have experience with violence as an adult within the military, they have an added level of vulnerability to becoming homeless. This study will explore the literature on trauma from both the military and general population to compare difference and similarities in approaches and effectiveness of treatment.

This study will approach an exploration of the service availability and service approaches for female veterans in a similar way, with a comparison of the approaches favored by the VA and other community based agencies who serve chronically homeless women. A small number of studies have begun to examine whether the services available to veterans are able to deal with female specific issues (Gamache, et al., 2003;

Kressin, Skinner, Sullivan, Miller, Frayne & Kazis, 1999). These studies have focused on the satisfaction of women with the services that they have received from the Department of Veteran Administration (VA). One such study found that women differed from men only in the amount of satisfaction in the location of available clinics (Kressin, et al., 1999). A limitation of this study was the fact that questions about a welcoming atmosphere and a sense of understanding of the women's specific issues were not asked. The assumption in the past was that the VA has been too centered on services for men and issues presented by women have not been a focus of services, and that many women veterans prefer to receive services outside of the VA because of the high instance of trauma associated with the military for the women.

This study will explore and synthesize what is currently known about homelessness, trauma and service policy to develop a program description centered on effective services for homeless female veterans. As the population of women veterans continues to grow, social workers will need to be ready to address the unique issues presented by this new client. The core of any effective service provided is an understanding and examination of the issues and problems that are faced by a specific client. Without a concrete understanding of the issues faced by the client, service providers may be rendered ineffective. This study will explore the issues presented by homeless female veterans through the established literature of homeless women and women veterans to present suggestions for more effective services. The hope is to offer a direction and suggestions for further research in this field to explore the needs of homeless female veterans and to eventually lower the instance of homelessness among female veterans.

CHAPTER II

CONCEPTUALIZATION AND METHODOLOGY

Conceptualization

Pervasiveness of Trauma in the Military

Trauma has long been an experience of soldiers at war. Women are not exception to this phenomenon and often experience trauma at a greater level than men in the military as they are often subject to not only combat trauma but also interpersonal and sexual trauma. In both cases, women do not report these experiences as they are often not in a place where they will see an improvement, or they will be seen as weak which could affect their deployment opportunities (Suris, et al., 2004). This situation can often lead to a continued and prolonged experience of trauma, especially in the case of sexual assault. These women are usually required to work and interact with their perpetrator. In these cases, women within the military are not able to use active coping skills shown to assist victims of trauma in recovery (Rayburn, Wenzel, Elliott, Hambarsoomians, Marshall & Tucker, 2005), even if that is the woman's normal coping style. Although the current military in the United States is an all volunteer force, those who are serving are not in control of their status or job responsibilities. This means that it is not easy for women who may have experienced sexual assault to transfer jobs, or simply quit; forcing the victim to remain in a rather passive role. Without adequate support, these women also do not have much chance of developing and maintaining the coping skills that could

prove to be protective against the negative outcomes that are often seen with the experience of trauma. This lack of ability to effectively cope with the experiences of trauma would account for the high rate (35%) of PTSD among female veterans (Suris, et al., 2004).

Women who do experience trauma not only have the difficulty of being unable to move to a new and potentially safer area, but often times cannot receive proper services to address the traumatic event. While deployed, transferring units is sometimes close to impossible. To acknowledge a difficulty in being able to manage a situation can appear to others as a sign of weakness in character and in loyalty; leading to a tendency to underreport any type of difficulty.

Service Availability and Effectiveness for Female Veterans

As described earlier, a number of studies have looked at whether services currently available to male veterans are able to address the issues presented by women. One study that focused on the satisfaction of women with the services that they have received from the Department of Veteran Administration (VA) found that women only differed from men in the amount of satisfaction in the location of available clinics (Kressin, et al., 1999). The survey used for this study asked three basic questions: 1) location; 2) access (ease of making an appointment, length of time waiting, length of time between call and visit, and availability of medical information over the phone), and 3) prescription services. Kressin et al did not investigate the perception of female veterans having to do with the atmosphere of the clinic (general feelings of understanding or welcome) and availability of female specific care. Another study focused on the level of

comfort of women who received treatment for PTSD (Fontana & Rosenheck, 2006). The results showed that women did not differ from men in the level of comfort they experienced when receiving treatment at that specific center. Both studies only surveyed those female veterans who chose to receive care at the VA and did not collect data from women who chose a non-military facility. Despite these findings, Kressin, et al. (1999) and prior researchers continue to be concerned that the VA is still too centered on care for men and that changes will need to be made as the number of women veterans grows.

Lack of Literature

The importance of specific and comprehensive service availability was an ongoing theme in previous studies (Kressin, et al., 1999; Fontana & Rosenheck, 2006; Suris, et al., 2004) as an effective way to assist vulnerable populations. As the number of women veterans and, in turn, the number of homeless women veterans increases, a greater understanding is required to ensure that services are available that will assist them in gaining permanent housing and stability in their life. An understanding of the specific risk factors and predictors are for homelessness in this population is needed. These factors have not been comprehensively investigated thus far. This lack of exploration is most likely due to the fact that this is a fairly new population within this society and the first time that these issues have become prevalent.

Methodology

In the proceeding sections, a multi-dimensional conceptualization of a complex and budding social phenomenon was presented. First, Chapter II conceptualized the

theoretical understanding and course of the proposed research. In Chapter III, the contemporary phenomenon with specific regard to female role and experience within the military, both historically and currently, will be presented. The focus will be on the psycho-social impact of task assignments and experiences within in the military, as a way to understand added vulnerability to homelessness among female veterans. In Chapter IV, trauma theory will be explored and applied to the specific experiences of female veterans, both interpersonal violence and combat trauma. Chapter V is an exploration of the service approach of mental health, substance abuse and homelessness within the Department of Veteran Affairs (VA) and the Department of Defense (DOD). This information will then be compared to the service approaches most often used with the general population of chronically homeless people. Finally, in Chapter VI, a program description will be offered to address homelessness among female veterans using the established literature on veterans and chronic homelessness as a foundation of understanding. The intention of this approach will be to offer female veterans a way to transition from a vulnerable and unstable position in society to a more resilient level of functioning within the civilian community. In conclusion, a new model for social work practice will be developed. This new model will integrate the main concepts of trauma theory and theory of practice for chronic homelessness to offer mental health, substance abuse, and employment services, along with a clean and safe place to live. Both the systemic and individual interventions will be identified to alter the trend of over-representation of female veterans among the homeless population.

This discussion and theoretical synthesis of vulnerability for homelessness among female veterans will be based on a deductive conceptualization of the phenomenon. I do,

however, acknowledge the potential for multiple biases and limitations of theoretical exploration of this population. Biases include my own personal frame of reference, psychosocial history and approach to researching the phenomenon. Finally, it is important that I be aware of my own biased understanding of the military and veteran services.

As someone who has not served in the military or worked in a government agency, potential biases from generalizations based on secondary sources of information must be acknowledged, and in turn, grounding theoretical findings in multiple and diverse empirical data and first hand accounts is crucial. Further assumptions of this study are that added and improved services are called for military women that will address their specific needs in a male dominated environment. Finally, the discussion section will consider the limitations of the chosen theoretical frames, including the assumption that all homeless female veterans have experienced some type of trauma in the past and will need services to address it.

Currently, gaps in the literature of experience and vulnerability of women in the military need to be addressed. Women are more and more involved in every part of the military, specifically in combat. Although women are not eligible for all available careers within the military, they are often in areas of extreme danger due to changes in warfare over the past few decades (Solaro, 2006; Williams, 2005). This study will also explore the importance of gender specific care for female soldiers both during and after military service which have been shown to be lacking in many areas (Corbett, 2007).

The next chapter will describe the phenomenon in greater detail through a review of the literature of women in the military, and how their experiences, stressors and mental health can add together for increased vulnerability to homelessness.

CHAPTER III

WOMEN IN THE MILITARY: A BRIEF COMTEMPORARY OVERVIEW

This chapter will focus on the experiences and roles of women in the military and with the military currently and throughout U.S. history. Women have been a part of the military since before the formation of our country, often working in some supportive way in the functioning of the camp life (Willenz, 1983). Women's role in and connection to the military has changed with time and they have become ever increasing integrated into the culture of the military. This chapter will explore women's roles throughout history and provide a brief overview of their current experience in the branches of the military, including their reasons for enlistment. Finally, this chapter will examine the effects of military service and increased vulnerability for homelessness among military women.

Historical Context

Women have been a part of the United States' military culture since the Revolutionary War, much to the chagrin of General Washington (Willenz, 1983). Even before women were allowed to enlist formally in the military they were wives, widows, and common-law wives of soldiers who refused to be separated from their men during times of war and would follow the units as they moved. These women often would work for the company of soldiers in supportive roles; cooking, cleaning, caring for the wounded and carrying water (DeGroot, 2001). Women in these supportive roles were

seen as essential to the running of the camps and barracks, allowing the soldiers to focus on the work of combat. The female camp followers, found to be so important to the logistical running of a camp, were subject to the same rules and regulations of the military culture just as the male soldiers.

They also received the same rations and expected the same treatment as any other member of the camp. This is demonstrated by Martha May, a camp follower of the British Army during the French and Indian Wars (1755-65), who wrote to the commander of her husband's unit "I have been a Wife 22 years and have Traveld with my Husband every Place or Country the Company Marcht too and have workt very hard ever since I was in the Army." (DeGroot, 2001, pg. 24). What is striking about this statement is her sense of membership to this unit and felt she was in fact a part of the Army. She expected that her long record of good service would warrant her leniency after her unknown act of insubordination.

With this lengthy history, which really stems much further back in time in most cultures, one would expect that women would have been granted some of the privileges of military services earlier than they were. Women were not considered veterans of the U.S. military until 1901 when the Army Nurse Corps was created, and in 1908 with the Navy Nurse Corps (Perlin, Mather & Turner, 2005; Willenz, 1983). With the creation of the nursing corps women were finally considered to be *in* the military rather than simply *with* the military performing supportive services. Even then women's status was ambiguous and quasi-military as they were appointed to the military rather than enlisted or commissioned (Willenz, 1983). This shaky status within the military was only offered to nurses within the Corps. Women continued to work with the military in day to day

supportive services for bases, manufacturing requirements for the world wars, and even as gunnery instructors and mechanics (Manning, 2004). During the World Wars women were hired and used for a variety of positions within the military, but were always released from those positions when the war ended.

World War I

World War I saw a large increase in the number and a shift in the status and position of women in the military. During this war female nurses worked under combat conditions on a daily basis for the first time. Approximately 22,000 Army nurses and 1,400 Navy nurses served in the United States and abroad. A large number of these nurses were sent to Europe. In Europe, the nurses were subjected to the same experiences of shelling, gassing, disease, filthy living conditions and all of the horrors of war that the troops suffered, outside of direct combat. Nearly 300 nurses died of disease, and some were taken prisoner and incarcerated by the Germans. Because women continued to have a quasi-military status, they were not paid for the time they were imprisoned. Women were actively recruited to the Marines and Navy during this time. The Marine Corps was the only branch of the military to grant full veteran status to the women who served during World War I for their clerical and administrative service. The Army did not follow the suit of the other two branches and refused to recruit women for any type of services. Civilian women were hired when the need arose for translators and telephone operators, but they were afforded very little status within the Army. The end of World War I brought with it the end of the need and the desire to incorporate women into the military. All women were released from service in all branches (Willenz, 1983).

World War II

World War II had its own struggles and needs for women. Following WWI, a campaign was initiated to gain commissioned officer status for women in the military. Officer status was not granted, but a bill was passed by congress establishing the Women's Army Auxiliary Corps (WAAC) in 1942. This bill established the WAAC as a division of women who were led by women. Unfortunately the status of the WAAC was again as an auxiliary *with* the Army not *in* the Army, and from the beginning was plagued by poor public opinion and low morale. To rectify the situation, the War Department decided to give the WAAC a stronger footing within the Army and created the Women's Auxiliary Corps (WAC). The women of the WAAC were encouraged to enlist in the WAC and were then afforded full veterans benefits following the war. After the creation of the WAC, other branches of the military followed suit with the WAVES (Women Accepted for Voluntary Emergency Service [Navy]), SPARs (Semper Paratus – Always Ready [Coast Guard]) and WASPs (Women's Air Force Service Pilots) (Willenz, 1983). Women were also recruited to work on the "homefront" in factories building ships and planes much more than in previous wars, mostly due to the shortage caused by the attack on Pearl Harbor (Denman & Innis, 1999). Once again, following the war the women who had served in the military were demobilized, sent home and replaced by the returning men.

Post World War II

Finally in 1948, with the beginning of the Cold War, Congress passed the Women's Armed Services Integration Act, which gave women a permanent place in the military (Manning, 2004; Willenz, 1983). This legislation offered women the

opportunity to become commissioned officers earning the same salary as men. But, many limitations were placed on the rank, benefits, positions, and numbers of women in the military (Manning, 2004). In subsequent decades, these restrictions and limitations were lifted through individual bills passed in Congress. In 1973, with the end of the draft, the all-volunteer force required an increase in women recruits to fill the gap of needed volunteers. The number of women enlisted in the military rose from 12,000 in 1972 to 53,000 in 1978 (Willenz, 1983). The final limitations were not lifted until 1994 when women were both allowed to serve on combat ships and in aircraft on combat missions. The one remaining limitation was exclusion from ground combat units. As noted by Solaro (2006) any change in military policy require authorization from congress and a notice of at least 30 days.

Current Experience and Status of Women in the Military

Today, women constitute 14% of active duty forces, and are 20% of new military recruits (Perlin, et al., 2005). Women are now exposed to all experiences and areas of the military. Even with the exclusion from ground combat units, the current war in Iraq has increased the amount of exposure to combat that women experience (Corbett, 2007; Perlin, et al., 2005; Williams, 2005). This increase in exposure to combat like situations suggests that women are more likely to experience the same type of trauma and violence as infantry men in the military. Outside of this added exposure, women in the military report experiencing a tremendous amount of stress related to interpersonal problems and the changes that have come with this new war, such as long tours of duty and lack of a clear front.

One female soldier spoke of her experience in the military and women's role in the military clearly and frankly:

...91 percent of all Army career fields are now open to women, and 67 percent of Army positions can be filled by women. Women are currently authorized to sign up for 87 percent of all enlisted military occupational specialties (MOS). But isn't Congress keeping women out of combat? There are no women in artillery, no women in the infantry. We are not permitted to drive tanks. We can't be Ranger or Special forces. There are also some teams we rarely go out with because the gear is considered too heavy for the average female to hump on her back.

So people conclude that girls don't do combat zones. That we're somewhere else from where the action is. But that's bullshit. We are Marines. We are Military Police. We are there as support to the infantry in almost every way you might imagine. We carry weapons—and we use them. We may kick down doors when an Iraqi village gets cleared. We do crowd control. We are also often the soldiers who negotiate with the locals—nearly one third of Military Intelligence (MI), where I work, is female.

Insurgents' mortar attacks reach us, too. In fact, because insurgents strike supply routes so often, it's frequently the non-infantry soldiers like us—with fewer up-armored vehicles—who end up getting hit and engaging in combat. (Williams, 2005, pg. 15-16)

This female veteran's explanation of her experience and what she saw while in service lends well to our understanding of what women are actually doing in war and combat

zones. She describes the work that women were expected to do and that often this placed them in as much, if not more peril, as the men in the infantry. This situation calls for a recognition that women are already doing the job of war alongside men and that they are just as competent and, at times, can be just as incompetent as the men. Females in the military do their jobs well and work hard to ensure safety for their unit as much as they can.

Throughout history, women have consistently shown to be competent workers with and for the military, often invisibly. But occasionally military women have been recognized for quality that exceeds expectations (Solaro, 2006; Willenz, 1983). They have been seen as an integral and important part of the running of the military and war. As women became more integrated into more of the military, they have had to not only prove themselves as worthy soldiers, but they also have to stand as a symbol for the abilities of all women. Where men are often seen as good soldiers until otherwise shown, women are expected to fall short until they can prove themselves capable (Solaro, 2006). This means that when a female soldier falls short, they are seen as a good example of why women do not belong in the military and what the risks are of having the “weaker” sex involved in the stress of war. According to the reports of the returning veterans of the current war in Iraq and on terrorism, it appears as though both men and women veterans are struggling to consolidate their experiences and re-integrate back into their civilian families and lives. The constant and prolonged stress of war takes its toll and leaves its mark on all who are involved (Alvarez, 2007; Corbett, 2007; Simon, 2007; Vogt, Pless, King & King, 2005; Williams, 2005).

A number of recent books and articles have described the experience of women in the military and how gender shapes the views and experiences of enlisted women. In her book titled, *Love My Rifle More Than You*, Kayla Williams (2005) wanted to show what it *feels* like to be a woman soldier in peace and in war. Williams works to integrate and showcase many of the aspects of military life for women; the terror, the boredom, the joy and the honor. This first hand account was one of the first to inform the public of military life for female veterans. Another collection of poetry from female Vietnam veterans also allowed those women to have their voices heard. Norma Griffiths wrote of her dreams in her poem 'The Statue' which concludes with:

I dream of a woman
with only her heart, hands and mind
her 'weapons'
to deal with the world of carnage. (Reilly, 2000, pg. 209)

Another veteran, Sara McVicker, asked a simple question at the end of her poem 'Saigon' that seems to hold much of her frustration of the invisibility of women during war:

I've read so much about them.
Couldn't they learn something
About me? (Reilly, 2000, pg. 210)

These women offer insight into the world of a woman soldier, which can seem rather ambiguous. This ambiguity stems from the lack of understanding of the role women play, the lack of recognition awarded to women in the military, and the policies written in a way that allows for a portrayal of a situation not as it is, but as the public may like it to be.

The All-Volunteer Force and Women's Choice to Serve

Women often choose to serve in the military for many of the same reasons men currently choose to enlist—for the education benefits, the job training, the chance to travel, and because military service is a family tradition (Manning, 2004). What sets women apart from men is that women have always been a part of the military on a voluntary basis and have been excluded from all drafts in this country (Holm, 1982; Solaro, 2006; Willenz, 1983). World War II was the first time that women were recruited for service in any branch of the military and then it was only when the temporary need for added personnel became too great to be filled solely by men (Willenz, 1983). It was not until 1973 when conscription to the military was abolished that women were actively recruited to all branches of the military. Again the recruitment of women was intended to supplement a need for personnel that was not filled by male volunteers (Solaro, 2006, Willenz, 1983). During the early years of the all-volunteer force, salaries within the military were low and prestige for serving was scarred by the Vietnam War. This situation forced military recruiters to be less selective than they might have wished to be (Tessler, Rosenheck & Gamache, 2003).

Even during the early years of the all-volunteer force, questions were raised as to the changes that would emerge in the military and the impact on demographic representation resulting from these changes. No longer could the selective service be used to ensure that representation from ethnic groups and socioeconomic levels would be somewhat equal to the general population (Janowitz, 1975). In those years, the military did see an increase in minority groups, such as Blacks, Hispanics and women (Janowitz, 1975; Tessler, et al., 2003). Tessler, et al. (2003) also found that those with weaker

family ties and less education began to enlist in the military; possibly as a way to ensure stability in their lives. The impact of the change to an all-volunteer force on women's choice to enlist would have been minimal because women had always served on a voluntary basis, although the change did offer new opportunities for career choices within the military.

A study conducted by Segal, Segal & Bachman (1998) explored gender differences in the tendency of high school seniors to be inclined to and to actually enlist in the military. They found that race and ethnicity had effects on women's inclination to enlist with Black women having the highest and White women the lowest rates. The findings of this study also showed that women who have intact families, higher high school grades, plans to go to college and children are less likely to plan to enlist in the military after graduation. Women, who actually enlisted in the military following graduation tended to be Black or Hispanic, not have two parents living in their homes, not have college educated parents, and not come from farms or metropolitan areas. Finally, the factor that had the most powerful effect on the likelihood that a woman would enlist in the military was her desire, or propensity, to do so.

Women Veterans and Homelessness

Veteran women were shown to have higher levels of education, more intact marriages than non-veteran homeless women, and were assured guaranteed access to benefits through the Department of Veteran Affairs (VA) (Gamache, et al., 2003). This guaranteed access would suggest that female veterans would have more protective factors against homelessness than non-veteran women (Rosenheck, et al., 1996; Tessler, et al,

2002). However, the incidence of homelessness in female veterans is 3.6 times higher than it is for non-veteran women (Gamache, et al., 2003). Women are increasingly more involved in combat, which suggests that they are most likely exposed to the same type of trauma and violence as men in the military. Male veterans make up between 25% and 40% of the male homeless population and women veterans comprise approximately 5% of the female homeless population (Gamache, et al., 2003) before increased exposure to combat, suggesting that the number of women veterans will continue to grow in the homeless population. The vulnerabilities shown in preliminary studies are the amount of trauma and general instability reported by the veteran female participants.

Research has shown that mental illness, substance abuse, lack of affordable housing or livable wage, experience of trauma both in childhood and adulthood, instability in relationships and criminal history are the common predictors of homelessness for all populations (Caton, et al., 2005; Herrman, et al., 2004; Roll, et al., 1999; Tessler, et al., 2001). The level of involvement or severity of those characteristics listed above can help to predict the length of time that anyone will experience homelessness. Caton, et al. (2005) found that age and arrest history are the strongest correlates to chronic or long-term homelessness. In contrast, those people that have stable families and either currently or recently had a job where able to be re-housed more quickly.

Homeless women, both veteran and non-veteran, reported a greater amount of sexual and physical assault than homeless men (Roll, et al. 1999). When asked about their reason for homelessness, homeless women cited more interpersonal conflict or lack of support, where men reported economic difficulties (Tessler, et al. 2001). Tessler, et al.

(2001) found that each person surveyed had a different experience and specific reasons as to why they felt they were homeless, as is the case with many studies conducted with the homeless population. The call then is to look for patterns among groups and to match services to each person's or a group's specific needs with careful consideration (Roll, et al., 1999). The patterns of experiences and characteristics that have been found to be present in homeless women in earlier studies, also the focus of this study, are social support, mental illness, trauma and violence and lack of service availability.

Social Support

Social support, more importantly the perception of social support, has been shown to be a protective factor against homelessness (Anderson & Rayens, 2004). Separation from a person's support system can also lead to longer periods of homelessness. This isolation is something that is often seen in the veteran population, both male and female. Veteran homeless men reported feeling more isolated than non-veteran homeless men (Tessler, et al. 2002), which may place them at higher risk for other factors predictive of homelessness, such as mental disorders and substance abuse. This isolation is likely to be felt by veteran women, adding to their vulnerability for homeless experienced by female veterans. Since becoming an all-volunteer army, the military has become increasingly more disconnected from civilian life (Janowitz, 1975). This disconnection may be attributed to the fact that those who may have fragile or non-existent relationships with friends and family outside of the military are now seeking to serve.

A general feeling of connectedness and perceived support are quite important as protective factors against homelessness. The nature and quality of these relationships are also important to examine as part of either a risk or protective factor for the experience of

homelessness. The ability to form and maintain relationships is a crucial factor in a person's experience and serves as a protection against homelessness (Anderson & Rayens, 2004). Forming and maintaining relationships includes a person's ability to be autonomous and intimate at the same time. *Autonomy* is a person's ability to be interdependent on others: to depend on others, and to be depended on by others. *Intimacy* is the ability to feel close and connected to others in sharing experiences, feelings and point-of-view. In contrast, an added feeling of separation from those around a person, especially in childhood, may lead to an increased risk of homelessness later in life. Experiences that can lead to this separation are neglect and abuse by a parent, and being permanently removed from home and foster care placement.

As social support is so important to a feeling of connectedness and stability, a clear understanding of a veteran's experience is needed to ensure that time spent as a homeless person is as short as possible. Social support can also be cultivated later in life and used to recapture that stability once achieved by the homeless individual.

Mental Illness

As mental illness has been cited as a predictor of homelessness, an examination of the relationship that mental illness has with homelessness is pertinent. A comparison study conducted by Leda, Rosenheck and Gallup (1992) found that female veterans were more likely to experience major mental illness than male veterans. This finding is contrary to what is seen in the general population where men are more likely to experience major mental illness. The question is then raised as to whether homeless veteran women also differ from homeless non-veteran women. Leda, et al (1992) also

found that male veterans are more likely than female veterans to be diagnosed with a substance abuse disorder, following the general population norm.

The symptom picture or diagnosis of a client can give the clinician information about a critical piece of that person's experience. There appear to be two relationships between mental illness and homelessness. One relationship is that some diagnoses may lead to a deterioration of functioning and ultimately homelessness. The most common example is schizophrenia or other psychotic disorders (Herrman, et al. 2004). Another relationship between homelessness and mental illness is that these symptoms that appear to be caused by the experience of homelessness, such as depression and anxiety. Many homeless people report a higher level of depression and anxiety since becoming homeless (Roll, et al. 1999). Higher levels of depression and anxiety is quite understandable if someone had been able to support themselves and then find that, because of something unforeseen, they are now thrown into a very vulnerable and stressful situation. Whatever the circumstance might be for the homeless person struggling with mental illness, added support is needed to ensure that stability can be accomplished.

Trauma and Violence

Within the female veteran population, 35% are diagnosed with posttraumatic stress disorder (PTSD) (Suris, et al., 2004). Many more of the female veterans experience some form of trauma but do not show symptoms of PTSD. Yet these female veterans will be affected by the trauma in ways that encompass much of their lives. In a study comparing social support of male and female veterans in a substance abuse program, 41% of the female participants reported experiencing sexual abuse during military service (Benda, 2006). In the same study 76.8% of the women veterans reported

experiencing trauma within the past six months. In general, homeless women consistently reported higher rates of childhood physical and sexual abuse than homeless men (Barrow, 2004). As women veterans are more likely to have experience with violence as an adult within the military, they have an added level of vulnerability to becoming homeless.

Violence and trauma have been connected to the experience of homelessness. Violence has been correlated with an increase in the severity of symptoms among homeless mentally ill women (Goodman, Dutton & Harris, 1997). The experience of both mental illness and violence places many women at greater risk for not being able to maintain a stable life, which in turn places them at higher risk for homelessness. Women in the military are often exposed to violence and trauma beyond their coping ability which adds another level of vulnerability to this population that is not often seen in many other groups. Women within the military not only witness the violence of combat, but are frequently victims of sexual assault. In both cases, women do not report these experiences as they are often not in a place where they can access clinical services, or they will be seen as weak which could affect their deployment opportunities (Suris, et al., 2004). This situation can often lead to a continued and prolonged experience of trauma, especially in the case of sexual assault. These military women are usually required to work and interact with their perpetrator. In these cases, women within the military are not able to use active coping skills shown to assist victims of trauma in recovery (Rayburn, et al., 2005), even if that is the woman's normal coping style. Although the current military in the United States is an all volunteer force, those who are serving are not in control of their status or job responsibilities. This means that it is not easy for

women who may have experienced sexual assault to transfer jobs, or simply quit; forcing the victim to remain in a rather passive role. Without adequate support, these women also do not have much chance of developing and maintaining the coping skills that could prove to be protective against the negative outcomes that are often seen.

Service Availability

A small number of studies have begun to examine whether the services available to veterans are able to deal with female specific issues. These studies have focused on the satisfaction of women with the services that they have received from the Department of Veteran Administration (VA). One such study found that women only differed from men in the amount of satisfaction in the location of available clinics (Kressin, et al., 1999). The survey used for this study asked three basic questions: 1) location; 2) access (ease of making an appointment, length of time waiting, length of time between call and visit, and availability of medical information over the phone), and 3) prescription services. Kressin et al did not investigate the perception of female veterans having to do with the atmosphere of the clinic (general feelings of understanding or welcome) and availability of female specific care. Another study focused on the level of comfort of women who received care treatment of PTSD (Fontana & Rosenheck, 2006). The results showed that women did not differ from men in the level of comfort they experienced when receiving treatment at that specific center. Both studies only surveyed those who had chosen to receive care at the VA and did not collect data from women who chose a non-military facility or did not access any services or supports. Despite these findings, Kressin, et al. (1999) and prior researchers continue to be concerned that the VA is still

too centered on care for men and that changes will need to be made as the number of women veterans grows.

The importance of specific and comprehensive service availability was an ongoing theme in previous studies (Anderson, et al., 2004; Markos, Baron & Allen, 2005; Morgan, 2002; Roll et al. 1999) as an effective way to assist vulnerable populations. As the number of women veterans and, in turn, the number of homeless women veterans increases, a greater understanding is required to ensure that services are available to them that will assist them in gaining permanent housing and stability in their life. An understanding of the specific risk factors and predictors are for homelessness in this population is needed. These factors have not been comprehensively investigated thus far. This lack of exploration is most likely due to the fact that this is a fairly new population within this society and the first time that these issues have become prevalent.

Implications for Further Research and Summary

A gap in the understanding of the effects of military service on women and why women veterans are overrepresented in the homeless population continues to exist. The influx of veterans from the current war in Iraq offers both challenges to be faced and opportunities to gain greater understanding of the impact of combat trauma on women. A large challenge will be that the women returning from the war in Iraq will require adequate and timely services for experiences that have not been extensively researched. The DOD and VA, along with community mental health centers, will need to be proactive in their research of treatment approaches for trauma and stressors related to the experiences of women in the military. The following chapter provides an overview of the

current trends in the treatment of trauma, both within military service providers and in community mental health, and the efficacy of the separate approaches. Chapter IV examines the ways that mental health services can be more accurately tailored to the experiences of women veterans.

CHAPTER IV

TRAUMA THEORY AND TREATMENT

Trauma and loss are as much a part of life as joy and birth. Each person has or will experience trauma and loss at some point in their life and it is the human's ability to adapt to misfortune and hardship that has assisted us in evolution. Humans have been able to adapt to difficult situations and become stronger and smarter in our actions. Throughout history humans have had a fascination with tragedy and how people cope with those inevitable experiences of life. This ability to adapt is shown in the historical records kept of war, famine and epidemics and in the interest art and literature often has with tragedy (van der Kolk, Wwisaeth & van der Hart, 1996).

Most people who are exposed to traumatic events are able to adapt and cope by using creativity and flexibility without developing psychiatric disorders. Others become fixated on memories of the event and the stress incurred as a result of that event can overwhelm their capacity to cope. This subset of individuals can go on to lead traumatized and traumatizing lives. Trauma experiences can overshadow and encompass people's entire existence, radically altering their psychological, biological and social well-being (van der Kolk, 2002). This preoccupation with past experiences can hinder any appreciation of the present and can interfere with the ability to pay attention to new and familiar situations (van der Kolk, et al., 1996). This chapter presents: 1) the history and overview trauma theory, 2) the effects of trauma on women who serve in the

military, 3) the treatment approaches to disorders related to traumatic stress and 4) the ways in which traumatic experiences can enhance vulnerability for homelessness.

Overview and History

Trauma became an important area of study when neurologists and psychiatrists in France and Germany noticed that many of their patients suffering from “hysteria” had common experiences of trauma during childhood. Two French doctors, Pierre Janet and Jean-Martin Charcot, were the first to systematically explore the relationship between traumatic experiences and psychological problems while working at Salpetiere in the 1880s (van der Kolk, et al., 1996). Freud also began to study the etiology of hysteria in his patients using the ideas learned while visiting Salpetiere in 1885 (van der Kolk, et al., 1996). During that era the effects of trauma, psychologically and biologically, were not clearly understood and were often dismissed due to the fact that it could not be shown whether the issues were biological, psychological, due to “false memories” or a characterological deficit..

The idea that problems caused by traumatic experience were due to cowardice and a “disease of the will” (van der Kolk, et al., 1996, pg. 50) became the primary method of conceptualizing ensuing difficulties exhibited in many soldiers returning from War I and in the following decades. This early understanding of the response of war trauma continued to be the primary explanation of experienced problems by soldiers through World War II, even though researchers, such as Janet, Charcot, Freud and Kardiner, continued to gain understanding of the profound and long-lasting effects of traumatic events.

Abram Kardiner described his observations of the effects of trauma on U.S. war veterans he was working with and was able to begin to organize the symptoms of hyperarousal and sensitivity to threat within those who had experienced war trauma (van der Kolk, et al. 1996). In Kardiner's (1941) book *The Traumatic Neurosis of War* he described the symptoms of traumatic stress as “*acute, transitional, and stabilized*” (pg. 7) forms. He also recognized a number of common features of traumatic neuroses among soldiers. Those were a fixation on the trauma, “dream life” (flashbacks), contraction of general level of functioning, irritability and proclivity to explosive aggressive reactions (Kardiner, 1941). His understanding of the symptomology of trauma related disorders and that the prognosis of recovery when treated earlier (in the acute stage) was very astute and lead to a greater understanding of the experiences of soldiers in war zones.

Institutional change did not come about for the treatment of trauma until after the Vietnam War when the veterans themselves organized for their own benefit, as trauma survivors have needed to do throughout history (van der Kolk, et al., 1996). Prior to the Vietnam War, veterans lived with the assumption that they would return from combat and have a short period of readjustment during which problems would be mild and short-lived. Connected to this assumption was the societal myth that “*heroes do not or should not have any problems*” (Scurfield, 1994, p. 179). This myth became especially problematic following the Vietnam War as public opinion of the war and support for the returning veterans was very low. The Vietnam veterans who then did break the silence around their experience were faced with extreme difficulty in having their struggles recognized and properly treated.

It was not until 1980 that the experience of trauma was recognized by the American Psychiatric Association. Posttraumatic Stress Disorder (PTSD) was included in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III) (van der Kolk, et al., 1996). It was not until approximately ten years after this inclusion that the VA recognized that war-related PTSD required specialized treatment and began to develop and open specialized treatment centers for veterans with symptoms of PTSD (Scurfield, 1994). The VA currently integrates trauma treatment in its medical centers and operates treatment centers focused on trauma related disorders.

Since its inclusion in the DSM-III in 1980, the diagnostic criterion for PTSD has continued to be clarified and expanded. Currently the diagnosis of PTSD in the DSM-IV-TR requires the presence of all categories of symptomatic responses to a traumatic experience: (1) re-experiencing the trauma; (2) avoidance of stimuli associated with the trauma (including an emotional numbing) and (3) symptoms of increased arousal. Additionally, the diagnosis of PTSD requires that the disturbance last longer than one month and that symptoms cause significant distress or impairment in functioning (American Psychiatric Association, 2000). Other disorders where trauma is recognized as hallmarks of etiology are Acute Stress Disorder and Adjustment Disorder; both are also included under the diagnostic category of Anxiety Related Disorders, and Borderline Personality Disorder. Often the experience of extreme and overwhelming stress can contribute to the presence of co-morbid Mood Disorders and Psychotic Disorders, adding to the complications that are be associated with responses to traumatic stress.

Characteristics of Trauma in Military Women

This section focuses on the experiences of trauma of military women and how these experiences contribute to symptoms of PTSD. With reports of the rate of PTSD at 35% of military and veteran women (Suris, et al., 2004), a very real need for an understanding of the experience of both combat and sexual trauma among military women exists. This section will explore the experience and effects of war-zone exposure on women in the military and the effects and rates of military sexual trauma. The combination of the environmental and interpersonal stress complicates the manifestation and treatment of trauma and warrants a greater understanding of the experiences.

War-zone Exposure

Although female veterans from World War II were exposed to the highest rate of combat and war-zone trauma, the effects of this trauma was not studied in women until the Vietnam War era (Wolfe, 1993). This delay is most likely due to the increase in the amount of research conducted on trauma following the Vietnam War in all areas. Fontana, Schwartz and Rosenheck (1997) focused on the causes of PTSD in women veterans from the Vietnam era and found that war trauma significantly increased the likelihood that women veterans would develop symptoms of PTSD. Women have consistently been exposed to and affected by war trauma throughout their involvement in the military and will continue to be as all military occupations (aside from ground combat) is open to them.

A conceptual model of war-zone stress was presented by Fontana and Rosenheck (1999) in a paper studying the effects of war-zone stress on the etiology of PTSD in Vietnam War veterans. They separated combat stress into five different categories:

fighting, threat of death or injury to oneself, death or injury to others, killing others, and committing atrocities. Additionally, the experience of a “malevolent environment” was split into two components: the physical conditions of the environment and the conditions of insufficiency (in supplies) and constraint (in movement). With this model Fontana and Rosenheck demonstrated the effect that each experience had on the development of PTSD Vietnam veterans. Their survey showed that the combination of the harsh physical conditions, fighting, death of others, and killing and injuring others had the strongest connection to the development of PTSD.

Fontana and Rosenheck’s (1999) model can assist in our understanding of the different areas where women in the military would be vulnerable due to their exposure to war-zone stressors in the current Iraqi War. Women are deployed as “combat support”, which often means they are working with the infantry and driving trucks to deliver supplies. Most often attacks on American soldiers has come to the supply lines and the convoys of trucks (Corbett, 2007; Solaro, 2006; Williams, 2005), increasing women’s likelihood to be exposed to the death of others. During attacks women have also described being a part of the fighting that takes place during and after the attack (Williams, 2005). Women are also involved in many of the intelligence operations that often entail living conditions that are rather harsh and lacking freedom of movement (Manning, 2004; Williams, 2005).

From the beginning of the Iraqi War the combat experience of women in the military has taken a center role in the literature on the war. This central role was made especially true when three women were taken prisoner in 2003 (Adeboyejo, 2003). A study conducted by Lindstrom, Smith, Wells, Wang, Smith, Reed, et al. (2006) found that

women who participated in combat support occupations were less likely to develop PTSD than those who were involved in non-combat support occupations. This debate as to what women's role should and should not be in the military has continued throughout the duration of the war and has sparked continued research and publications. The role of combat trauma in PTSD symptoms in women veterans continues to be an area where greater understanding is needed.

Military Sexual Trauma

Military women are significantly more likely to experience sexual assault than civilian women, with one in four military women experiencing sexual assault during their lifetime (Suris, Lind, Kashner, Borman, 2007). Sexual harassment and often assault is reported by many women soldiers when they speak and write about their experiences within the military (Borch, 2000; Corbett, 2007; Solaro, 2006; Williams, 2005). The pervasiveness of the experience of sexual assault in the military has gotten more attention with the nearly full integration of women in the military. Corbett (2007) wrote of a young woman who decided to go AWOL from her unit rather than return to an environment where she would be exposed to someone who she alleged had assaulted her. The fact that she had reported any type of harassment is actually quite unusual as women often do not report these incidences because of the adverse social and career consequences (Pershing, 2003; Williams, 2005). The experience of sexual trauma within the military has been linked to increased rates of PTSD among female veterans (Fontana, et al., 1997; Suris, et al., 2004)

In fact, Suris, et al. (2004) found that women veterans who reported a history of military sexual assault are nine times more likely to have PTSD than women veterans

who do not report a history of sexual trauma. A number of possible reasons for this increase in PTSD are offered by the authors. These reasons include the fact that women who are sexually assaulted cannot easily transfer or quit their jobs, increasing their exposure to the perpetrator. Soldiers, both male and female, frequently suppress mental health needs as it may affect their career and deployment opportunities. This suppression of needs and issues delays reports of difficulties and ultimately delays availability of assistance (Suris, et al., 2004). It appears that women are not only experiencing more sexual trauma while in the military, but then they are not able or choose not to use the supports and mental health care available to soldiers and this combination increases the rates of PTSD in military women.

Treatment Approaches for PTSD in the VA Institutions

No standardized treatment protocols exist for the treatment of PTSD within the military treatment centers, so there is no way to know how someone will be treated. The DOD and VA have published clinical guidelines for treating PTSD. The guidelines recommend four evidence-based therapies: Eye Movement Desensitization Reprocessing (EMDR), cognitive therapy, exposure therapy and Stress Inoculation Therapy. Cognitive Processing Therapy has also recently been added to training programs within the VA (Simon, 2007). The therapies have a number of qualities in common, including exposure and processing of the traumatic event and a cognitive re-structuring of the meaning of the traumatic event. The therapies do differ in protocol, focus of change and amount of exposure to the traumatic event.

Eye Movement Desensitization Reprocessing (EMDR)

In 1987 Francine Shapiro noticed that when she moved her eyes back and forth while thinking about a distressing event in her life, she felt better. Through further investigation and research, Shapiro developed this process into what is known as EMDR (Russell, 2006). Shapiro and Maxfield (2003) attributed the positive effects of EMDR to an adaptive information processing model where all memory is associated and new learning occurs through new associations. This means that perceptions of objects in the present are affected by the associations placed on them from experience in the past. Problems that arise in this model are due to a dysfunction in the system of processing memories and experiences adaptively. EMDR therapy works to address those experiences which are dysfunctionally rather than adaptively stored through cognitive restructuring of the associations linked to the traumatic event.

EMDR consists of eight stages of treatment designed to address changes in the information processing system (Shapiro & Maxfield, 2003). The first phase of treatment is history-taking, assessment, and treatment planning. The assessment and history include the collection of events that could be potential targets for EMDR processing, along with the common elements in most psychotherapies. The second phase of treatment is preparation. During this phase the therapeutic alliance is established, education about symptoms and EMDR is provided, and the therapist assesses to ensure that the patient has sufficient self-control and adequate stabilization. Phases three through six involve processing a distressing memory and present triggers, including installation of adaptive responses to stress (Russell, 2006). In the seventh phase, the therapist determines whether the psychological material has been adequately processed,

and future projections are made about how to manage distressing events and triggers (Russell, 2006; Shapiro & Maxfield, 2003). The eighth, and final, phase of treatment is a reevaluation of the changes accomplished through the clinical work, and how well the skills and changes have been maintained (Shapiro & Maxfield, 2003).

EMDR has been surrounded by controversy since its development and has been intensely investigated due to its popularity. From early on to the present, case studies have consistently showed remarkable changes within patients treated with EMDR (Errebo, 2007; Russell, 2007; Shapiro & Maxfield, 2003). In comparison to no treatment, EMDR has been shown to be effective in lessening symptoms of PTSD (Shapiro & Maxfield, 2003). The question remains as to whether EMDR is more or less effective than other treatment modalities available. A study conducted by Taylor, Thordarson, Maxfield, Fedoroff & Lovell (2003) compared EMDR to two other common treatments for PTSD, exposure therapy and relaxation therapy. The study showed EMDR to be similar to relaxation therapy in effectiveness, but significantly less effective than exposure therapy. This finding is consistent with other meta-analyses conducted with EMDR with exposure and cognitive therapies (Taylor, et al. 2003). No clear explanation of the importance of the eye movement has been offered thus far, although the hypothesis that the eye movement works as a distraction or as a way to activate the brain to process events differently have been posed (Shapiro & Maxfield, 2003).

Cognitive Behavioral Therapies

Cognitive Behavioral Therapy (CBT), when focused on the treatment of trauma, involves prolonged imaginal exposure, in vivo exposure, and cognitive restructuring (McDonagh, Friedman, McHugo, Ford, Sengupta, Mueser, et al., 2005; Rothbaum & Fao,

1996). CBT helps the traumatized client to identify the responses to and beliefs about the trauma experienced in the past and restructure the maladaptive thoughts and learn coping skills to manage present stress and anxiety. Two therapy techniques have been developed and are used by VA services to treat trauma, they are prolonged exposure therapy (PE) and stress inoculation therapy (SIT).

Prolonged Exposure Therapy (PE): Exposure therapy was first demonstrated to be effective for treatment of PTSD as shown in several case reports on war veterans (Rothbaum & Foa, 1996). PE uses exposure to the traumatic memory through images called to mind during the sessions and exposure to distressing stimuli in the environment (Foa, Dancu, Hembree, Jaycox, Meadows & Street, 1999; Rothbaum & Foa, 1996). During PE sessions the patient is asked to recount their traumatic event in present tense, as if it is currently happening, including all sensations from all five senses. This recounting is repeated a number of times during one session and the recounting is tape recorded. The patient is then asked to listen to the tape once a day as homework (Foa, et al., 1999). Following the imaginal recounting of the event, an in vivo flooding will also occur. This will include exposure to specific harmless but distressing trauma-related environments and objects (Taylor, et al., 2003). The systematic desensitization to the fear and anxiety producing stimuli while in a safe and relaxed state is thought to reduce the amount of fear and anxiety produced by the trauma-related stimuli (Rothbaum & Foa, 1996).

Stress Inoculation Therapy (SIT): SIT is a form of anxiety management therapy developed by Kilpatrick and Veronen for trauma victims with chronic disturbances (Rothbaum & Foa, 1996). Where PE focuses most of the therapy time on the recollection

of the event and the systematic desensitization of the memories and stimuli SIT focuses more on learning coping skills to manage the present day stress experienced by the patient (Foa, et al. 1999). The first phase of treatment in SIT is assessment, information gathering, and an explanation of the rationale of the therapy. The second phase then is focused on the acquisition and application of coping skills (Foa, et al., 1999; Rothbaum & Foa, 1996). Training includes deep muscle relaxation, breathing control, cue-controlled and differential relaxation, role playing, covert modeling, thought stopping, cognitive restructuring, and guided self-dialogue. Patients are asked to practice the techniques learned during sessions as homework during treatment (Foa, et al., 1999).

Combined PE and SIT: In studies conducted by Foa, et al. (1999) PE alone was found to be more effective than SIT alone and PE combined with SIT. The researchers had hypothesized that the combination of the two therapies would be superior to the therapies alone. All therapies performed very well in reducing symptoms of PTSD, with a large number of participants losing their diagnosis of PTSD. PE alone was the only therapy to significantly reduce the level of anxiety experienced by participants in the study. This finding was supported by a previous study where similar results were reported by Marks, et al. (as cited in Foa, et al., 1999). Foa, et al. (1999) offer a number of possible explanations for this unexpected outcome, such as an information overload during sessions with the combination of procedures, or an overload in homework where the patients could not practice as much as they were asked to.

Cognitive Processing Therapy (CPT)

A second program combining exposure and coping skill acquisition was developed by Resick called Cognitive Processing Therapy (CPT) to treat sexual assault

victims (Rothbaum & Foa, 1996). CPT focuses on cognitive interventions for the treatment of PTSD and uses exposure through writing and reading over 12 sessions (Monson, Schnurr, Resick, Friedman, Young-Xu & Stevens, 2006). During the first session the patients learn about PTSD and CPT, and are given an assignment to write an impact statement about the personal meaning of the traumatic event. In the second session the relationship between thoughts, events and responses is introduced and for the third session the patients are asked to write a detailed account of the traumatic event. This account is read and processed in the third session with the therapist. During the fourth session the cognitive therapy is begun by questioning the person's elements of self-blame and other cognitive distortions. For the fifth session the account of the event is written and processed again. Following the fifth session the therapy shifts to teaching patients to challenge and change their beliefs about the meaning of the event and the impact it has on their lives (Resick, Nishith, Weaver, Astin, Feuer, 2002).

CPT has been shown to be effective in reducing the number of symptoms experienced by the patients who have completed the program (Monson, et al., 2006; Resick, et al., 2002). In the study conducted by Monson, et al. (2006) CPT was found to be effective for the reduction of symptoms due to military-related trauma. Their trial offered some of the most promising outcomes for chronic PTSD in veterans that has been shown thus far and offers strong support for continued cognitive therapy in that population. Resick, et al. (2002) found that CPT was just as effective as exposure therapy in all areas, which was not seen in the combined PE/SIT therapy protocol. The benefits of CPT were that patients only spent two sessions recounting their experience and were asked to complete half the amount of homework (Resick, et al., 2002). The findings of recent

studies such as these have led to increased interest and use of CPT. It is expected to be added to the clinical recommendations offered by the DOD and VA in 2007 (Simon, 2007).

Psychopharmacology

Studies have also shown that medications help ease associated symptoms of depression and anxiety and help with sleep. The most widely used drug treatments for PTSD are the selective serotonin reuptake inhibitors (SSRIs), such as Prozac and Zoloft, which are approved by the Food and Drug Administration as treatments for PTSD. At present, cognitive-behavioral therapy appears to be somewhat more effective than drug therapy. Drug trials for PTSD are at a very early stage and it would be premature to conclude that drug therapy is less effective overall. Drug therapy appears to be highly effective for some individuals and is helpful for many more. In addition, the recent findings on the biological changes associated with PTSD have spurred new research into drugs that target these biological changes (Department of Veterans Affairs, 2007a).

Conclusion

As discussed in Chapter 3 of this paper, the experience of trauma and violence is strongly connected to the experience of homelessness. The extreme stress placed on women within the military who are both exposed to combat related trauma and sexual trauma can easily overwhelm the defenses of even the highest functioning coping skills (Rayburn, et al, 2005). The combinations of traumatic events can leave returning women unsure of themselves and their capabilities to function at all. Treatment centers serving

women veterans will need to use and incorporate the most effective therapies to ensure easily re-integration into civilian communities.

CHAPTER V
COMPARISON OF GOVERNMENT AND COMMUNITY SERVICE APPROACHES
TO HOMELESSNESS

Introduction and Overview

The previous chapters have explored the personal vulnerabilities and risk for homelessness among female veterans, and how their experience may have shaped that vulnerability. This chapter will look at the ways in which government agencies, the Department of Defense (DOD) and the Department of Veterans Affairs (VA), and community based agencies view and approach homelessness and at risk populations. The aspects of programs that have shown to be helpful and efficacious in getting people they served housed and stable are described as well as those aspects of agencies that have limited availability of services.

Homelessness in America is a cyclical problem. Each day people exit homelessness and do so quickly, but many more individuals become homeless as others are re-housed. Homelessness did not end in the economic boom of the 1990s, and appears to have increased in many areas (Burt, 2001). Veterans have been consistently overrepresented in the homeless population and are often more susceptible to being chronically homeless (episodes lasting longer than six months) than the general population (Gamache, et al., 2003; Rosenheck & Fontana, 1994; Winkleby & Fleshin, 1993). The constantly changing homeless population and unique needs of homeless

veterans poses a challenge to providers to focus and offer services that will address the issues of the population they serve.

Current Status of DOD and VA Programs

Before programs based in the VA to serve homeless veterans and women veterans can be discussed, an understanding of how returning soldiers and veterans apply for and become eligible for benefits and services is needed. Recent reports of the services available to recently returned veterans and the red-tape that has been associated with receiving services have been bleak. The DOD is responsible for offering disability benefits that include full military retirement pay, life insurance, health insurance, and access to military commissions to soldiers who have been wounded during their tour of duty (Robinson, 2007). The VA, in turn, processes claims for disability benefits from retired veterans and provides medical care to servicemen and women after they are released from the military (Ephron & Childress, 2007).

The DOD does not often focus on the needs of homeless veterans as they intercept in a soldier's life while still within the military where basic needs, such as housing, are met. An examination of how soldiers are deemed eligible for disability benefits from the military and current trends within the screening process is helpful in gaining an understanding of how veterans can fall through the cracks of services. Each branch of the military has its own Physical Evaluation Boards (PEB) that determines whether a wounded or ill soldier is fit to return to duty. If the soldier is deemed fit, they return to their assignment. If not, the soldier is assigned a disability rating for the condition that makes them unable to do their job. This disability rating is the key factor. Those soldiers

who receive a rating below 30 percent disabled are simply sent home with a severance check. Those who receive a rating of 30 percent or higher qualify for the list of lifelong DOD benefits listed in the previous paragraph (Robinson, 2007). This rating system seems rather straight forward and easily understood. Unfortunately, in practice the rating system is much more complicated and problematic. For example, the military doctors who present cases to the PEB select only one condition for the service member's rating. In reality, most current injuries are much more complex than a single diagnosis or condition.

The current trend of the number of wounded soldiers who are rated at or above the 30 percent threshold is decreasing. Since 2000, 92.7 percent of the disability ratings issued by PEBs has been 20 percent or lower. Moreover, fewer veterans have received a disability rating of 30 percent or more since the war in Iraq and Afghanistan has begun. As of 2006, 87,000 disabled, retired veterans were on the list for lifetime benefits; decreased from 102,000 recipients in 2000. The question, raised by some, (Robinson, 2007) is whether this decrease is indicative of a budgetary ceiling imposed to contain war costs. A case may be made regarding the fact that veterans from WWII are dying which would lower the number of veterans receiving benefits. However, it is odd that the number of veterans rated as disabled would decrease during a war. This is especially true if you consider the fact that ratios of soldier who are injured to those killed is much different from that of previous wars. During WWII, two men were injured for each one killed; during the Korean and Vietnam wars the ratio was 3:1. The ratio for the current war is close to 16 soldiers who are injured or become ill for every one who dies (Ephron & Childress, 2007). This ratio would suggest that *more* soldiers are surviving wounds

that would have killed in the past, possibly due to improved armor and medicine, and would require disability benefits, not *less*.

One recommendation to remedy the situation is to change the DOD standards of disability to match that of the VA that has traditionally rated soldiers' percent of disability higher. The DOD has asserted that they are assessing for fitness of duty and compensating for loss of military career, as opposed to assessing civilian employability. Another recommendation has been to simply unify the entire process within the VA and remove the responsibility from the DOD's domain. The VA is currently faced with its own struggles of back-logged applications for benefits and an over-extended health system (Ephron & Childress, 2007). If the VA were to take on this responsibility, it would need to be matched by an enormous infusion of staff and money (Robinson, 2007).

The VA is responsible for providing ongoing health care and benefits to veterans. The VA constitutes outpatient and inpatient medical centers around the country and leads the research on veteran issues. As women veterans are a fairly new population and the VA is viewed as male-dominated, the thought was that women did not pursue services from the VA due to a feeling of discomfort. This discomfort may have been a factor for some time. Now, the VA has formed the *Center for Women Veterans* whose mission is to ensure that:

- Women veterans have access to VA benefits and services on par with male veterans.
- VA programs are responsive to gender-specific needs of women veterans.
- Outreach is performed to improve women veterans' awareness of services, benefits, and eligibility criteria.

- Women veterans are treated with dignity and respect. (Department of Veteran Affairs, 2006, ¶1)

With the Center in place, women veterans can hopefully benefit from gender-sensitive health and mental health care from VA facilities.

The VA also offers a variety of special programs and initiatives specifically designed to help homeless veterans live as self-sufficiently and independently as possible (Department of Veteran Affairs, 2006a). The programs within the VA provide outreach to homeless veterans, clinical assessments and referrals for needed medical and psychiatric treatment, long-term sheltered transitional assistance, employment assistance, and supportive permanent housing. In 1987 large number of grants, loans, and programs were put in place around the country when they were first authorized by the VA, and “constitute the largest integrated network of homeless treatment and assistance services in the country” (Department of Veteran Affairs, 2006a, ¶1). The programs of the VA often contract with community agencies to supplement the supportive and mental health services often needed by homeless veterans. The National Coalition for Homeless Veterans reports that approximately 400,000 veterans are homeless each year. The VA serves just over 100,000 homeless veterans and community based programs serve 150,000, leaving an unmet need of nearly 45% (National Coalition for Homeless Veterans, 2007).

Currently, three separate programs exist in the country that specifically target homeless women veterans. All three programs offer safe and supportive services to homeless women under the umbrella of the VA. They are located in Washington, Massachusetts, and New York/New Jersey. Each program targets the psychological,

economic and social causes of homelessness and offers supportive services to assist homeless women find and maintain appropriate permanent housing (Department of Veteran Affairs, 2007a). These programs are good examples of the growing recognition that women veterans are struggling in many the same ways that male veterans have in the past. Although these programs are much needed, the problem of female veteran homelessness is one that will require many resources and strong support as the number of females are discharged from combat-related duty.

Evaluations conducted by the U.S. Government Accountability Office (GAO) that focused on health care for women and homeless veterans program noted improvement in services over the last few years, but also showed continued room for growth. The report prepared on health care for women veterans cited progress in removing barriers to treatment and providing gender-specific services—pap smears, mammograms, and reproductive health care. At the time of the GAO report, the VA was also working to increase its capacity to provide inpatient psychiatric services to women (U.S Government Accountability Office, 1999). As veterans continue to return from the current war and women continue to constitute a larger portion of the veteran population, services will need to be evaluated to ensure a sense of comfort, recognition and safety in the service provided to women veterans. A report prepared by the GAO on the status of the programs for homeless veterans cited improved communications and follow-up as areas of needed growth (U.S. Government Accountability Office, 2006). The GAO report also described plans to increase transitional housing beds to meet demands, and recommended continued collaboration with other agencies to assist veterans in obtaining health care, jobs and other resources to enable them to live independently. Transitional housing is

often a strong way for the temporarily homeless to regain footing. Chronically homeless persons in community agencies require more permanent supportive housing that also offer adjunct services (Morgan, 2002). As veterans are more likely to experience chronic homelessness, they would benefit from the ongoing supportive services of permanent housing options.

Supportive Housing Programs

The growth in understanding homelessness produced a shift from emergency shelters to transitional housing given the recognized need for long-term intensive services to make the transition from streets and shelters to permanent housing. What has become more apparent is that many chronically homeless people, even those who complete transitional programs, still require supportive housing to avoid falling back into the cycle of homelessness (Morgan, 2002).

The homeless service system in the United States has grown tremendously since the McKinney/Vento Homeless Assistance Act was passed in 1987 by congress and signed by a reluctant President Reagan (National Homeless Coalition, 2006). Available beds more than doubled, from 275,000 in 1988 to approximately 607,000 in 1996. Emergency shelter capacity also grew by about 20 percent during the same time period. An increase in available transitional housing and supportive permanent housing for disabled formerly homeless people followed. Prior to the McKinney/Vento Act, supportive programs were non-existent. A decade after the act was passed, 1996, an estimated 274,000 beds (160,000 transitional and 114,000 permanent) were available, comparable to the capacity of emergency shelters in 1987 (Burt, 2001).

Women who are homeless and mentally ill require comprehensive, continuous and integrated services as described in Minkoff and Cline's (2004) model of care for a general population of dually-diagnosed clients. This system of care includes assessment of needs, dual diagnosis evaluation, program planning based on assessment results, individualized evidence based best practice treatment, case management that meet the need of each person, considering both substance abuse and psychiatric disorders to be primary when they coexist. Through its integration of services to address the multifaceted issue presented by mentally ill and chronically homeless women, this model has the potential to significantly improve their lives. Minkoff and Cline's (2004) model can also be used as a basis for a long-term supportive housing program that will continue to address issues faced by newly housed individuals.

The Department of Housing and Urban Development (HUD) has increased its focus on developing permanent supportive housing within its Continuum of Care funds and other programs. Localities and states seeking funds for homeless assistance programs are now required to describe how other HUD program dollars—such as Section 8, public housing, Community Development Block Grant and HOME—are being used to assist homeless people. HUD now requires states and localities to clearly describe their strategy for overall improvement of access to mainstream programs. Providers must submit specific plans to ensure that clients receive all of the services they are eligible for. This requirement has been put in place as a reaction to the argument that too much of HUD's homeless assistance funds were being used for services that could be accessed in other areas (Morgan, 2002).

Through the Continuum of Care, HUD programs have worked to end chronic homelessness. Although, not everyone agrees with the emphasis on ending chronic homelessness and not many can agree on who is chronically homeless, the programs funded by HUD have begun to decrease the number of homeless people and length of time that some experience homelessness. These integrated and comprehensive programs that offer long-term services are the programs that would have the greatest impact on the homeless veterans who also often present with complex problem sets. These programs view homelessness as more than simply a housing issue and offer a plan to address the core issues and causes of homelessness.

Conclusion

It is often difficult to organize and provide effective services for homeless people, as the problems faced by this population are usually very complicated and all-encompassing of the individual's life. When programs focus on treating the global condition of homelessness, not simply the symptoms of a lack of housing but also the causes of a person's experience of homelessness, the client can begin to stabilize their life and regain control. When these services are offered in an ongoing program, the client is better able to use the services and the time provided to truly become independent again. The final chapter will offer a program description to serve homeless female veterans in a way that will enable them to regain a resilient and stable level of functioning in the greater community.

CHAPTER VI

AN INTEGRATED MODEL TO SERVE HOMELESS FEMALE VETERANS

This theoretical study was undertaken to explore the experience of women in the military and to gain an understanding of military women's vulnerability to homelessness and their service needs. This study included an exploration of trauma theory and approaches for treatment of homelessness to develop a better understanding of an effective model to treat homelessness within women veterans. Knowledge about effective treatment of combat trauma and homelessness in male veterans and trauma and homelessness among women is used as a way to gain insight into the multi-faceted issues faced by women veterans at risk for homelessness.

The purpose of this research was to support the assumption that women veterans will present unique and new problems than have previously been seen in both the VA and community based agencies, and that interventions will need to reflect the specific needs of this population. More and more, women veterans are experiencing traumatic events within the military and combat situations during deployment. There are limited options for comprehensive and gender sensitive care upon return to civilian life and female veterans are finding that reintegration to civilian life can be extremely difficult. This study explored those experiences during and after military service that explain an increased vulnerability to homelessness.

This chapter presents a synthesis of the information on effective treatment strategies of trauma and homelessness that includes suggestions for approaches as they would apply to the treatment of homeless female veterans.

Findings

The primary findings of this research are that women in the military are at greater risk of exposure to events that have been shown to be precursors to homelessness; that they often have trouble accessing effective services to aid in re-integration after the military; and that they often lack proper social and policy support to acknowledge and treat their specific issues. Although programs designed to serve homeless female veterans do exist, they are few in number and often approach the experience of homelessness in a way that may not ensure successful long-term integration in civilian society.

The experience of trauma and loss is a part of life that often cannot be avoided. With regard to military women, trauma is not only pervasive but also complicated by the multiple sources of traumatic stress as well as the culture and hierarchical system of the military (Fontana, et al., 1997). The complicated nature of the experience of trauma in the military warrants increased acknowledgement of the effects of the trauma and increased availability of effective and comprehensive treatment for trauma related disorders (Suris, et al., 2004, Vogt, et al., 2005). Government and community based programs approach the needs of homeless veterans in different ways and (National Coalition for Homeless Veterans, 2007), even with the combined effort of both service sectors, the unmet need comprises approximately 150,000 homeless veterans not

receiving services annually. Although homelessness is a cyclical problem, the cycle can be altered and broken through effective and comprehensive treatment of not only the symptoms of homelessness, but also the causes behind the experience of homelessness. With comprehensive treatment and understanding of the issues specific to homeless women veterans the cycle of overrepresentation can be decreased and hopefully prevented.

Implications for Social Work Practice

Comprehensive treatment of women veterans who are at risk for becoming homeless or who are already homeless requires an understanding of effective treatment for trauma and of effective treatment strategies for homelessness. A program must approach all areas of vulnerability in a sensitive manner in order to alter the cycle of homelessness for clients.

A few programs have begun to look at the specific needs of homeless veterans and how best to serve this population. One program is the United Veterans of America based in Massachusetts (National Coalition for Homeless Veterans, n.d.) that offers a wide variety of services including safe, clean and quiet shelter, mental health and substance abuse treatment, employment assistance, essential medical care, and transitional programs for re-integration. This program along with the initiatives of the National Coalition for Homeless Veterans (National Coalition for Homeless Veterans, 2007) can offer examples of comprehensive and integrated services for the treatment of homeless veterans.

Recovery and Treatment

Recovery and treatment includes a variety of services and needs. Treatment includes access to medical care, substance abuse programs (including AA and NA) and mental health care. Medical care within the VA centered on the needs of women veterans is increasingly available as women continue to serve in the Armed Forces (Department of Veterans Affairs, 2006). However, many veterans continue to find that accessing quality care rather difficult, especially when looking for specialized care. This was discussed in the increased difficulties that veterans are experiencing to qualify for treatment and disability treatment within the DOD and VA (Robinson, 2007). When medical issues go untreated they can affect many areas of a person's life in negative ways. Maintaining employment and mental health can be very difficult when physical problems are untreated and ignored.

Comprehensive treatment for homelessness among women veterans requires effective and sensitive mental health treatment. Mental health providers for veteran women need to be aware of the multiple stressors they experience and the most effective ways to address those stressors. Successful re-integration into civilian life for veteran women requires a decompression of the effects of the stressors they experience and an approach in treatment to address other mental health and illness issues also experienced by many who are vulnerable to homelessness.

The reports of the pervasiveness of trauma among women veterans, as discussed earlier in this study (Suris, et al., 2004), requires that effective treatment for trauma related problems is offered as part of the mental health services provided. Women in the military are faced with a tremendous amount of stress both during service and when they

leave and are working to rebuild their civilian life. The study of trauma and trauma related disorders has been a constantly changing process with many changes in the endorsement of different treatment modalities. Most recently, research has shown that cognitive processing therapy is most helpful in treating trauma related stress, with a combination of exposure and cognitive re-structuring (Resick, et al., 2002). This protocol allows for the client to process the experience of the trauma. Cognitive processing therapy also addresses the cognitive distortions around the traumatic experiences and works on problem solving around present stressors (Resick, et al., 2002). This approach has helped veterans to integrate the aspects and benefits of exposure therapy and stress inoculation therapy, and maintain the efficacy of prolonged exposure therapy.

Many homeless veterans struggle with drugs and alcohol, so along with a need for mental health services they will require substance abuse treatment. Promoting a clean and sober lifestyle and environment is a crucial part of promoting a productive and stable lifestyle. Continued abuse of drugs and alcohol sets clients up to repeat the cycle of homelessness, making this type of treatment an important part of re-integration. A focus on sobriety and sober supports through AA or NA will foster a community where women can become clean and have access to appropriate supports, such as sponsors who have many similar experiences. A sober community is where the most effective recovery can take place.

Housing

Central to the issue of homelessness is clean, safe and affordable shelter. A program that is centered on offering supportive permanent housing has recently been shown to best break the cycle of homelessness for many populations, especially veterans

and the chronically homeless (Morgan, 2002). Often supportive permanent housing is required to assist chronically homeless people regain enough stability in their life to maintain a household. Supportive housing programs can offer the ongoing support and treatment that is needed by many homeless women veterans who find they have a multitude of obstacles in their lives. Without that ongoing support and stability it is possible that many women would be likely to continue to experience the cycle of homelessness. Facilities where women can feel safe and comfortable are very important to recovery from the trauma of homelessness and maybe other past experiences. Comfort in the face of intensive mental health treatment and the social stressors of re-integration would best be cultivated through the social supports of other clients who have experienced many of the same experiences in the facilities and treatment centers.

Through the Continuum of Care initiative, programs have begun to work at bringing an end to chronic homelessness (Morgan, 2002). These programs have use integrated and comprehensive models, including supportive housing, to not only treat the symptoms of homelessness (i.e. lack of housing), but the more root causes of homelessness (i.e. mental illness and substance abuse). In the case of homelessness, to simply treat the symptom of a lack of housing would be to miss the pieces of a person's experience and situation which contributes so much to the cyclical nature of homelessness. Treatment strategies must address both the symptoms and etiology of homelessness in order to have any effect on phenomenon.

Strengths of Theoretical Thesis

The strengths of conducting a theoretical study are multifold. A theoretical study on this new and invisible population allows for the synthesis and review of known research on the population and on similar populations. This type of study is able to use the knowledge of studied populations and apply it to the experiences of another population, albeit in a speculative way. This speculation can direct future research in a direction to more fully understand and integrate the knowledge of similar populations. If the general public were made aware of the individual life circumstances of just a few of these women and were then asked to multiply those individual experiences over six thousand times, the impact of this awareness could create a demand for more understanding of this population. This has been shown to a degree in the amount of attention offered women veterans returning from the Iraqi War in the popular press already.

Limitations of Theoretical Thesis

This study only presented two theories that were considered the most pertinent to the difficulties homeless women veterans face in sustaining housing. Further research may indicate that other issues are more relevant to the experiences to homeless women veterans. Those issues may center more on other psychiatric disorders, such as mood or thought disorders, rather than trauma related disorders. A theoretical study can only speculate at the needs and experiences of the population also. In order to be sure that the needs of homeless female veterans a comprehensive survey of experience would need to be conducted.

Just as my personal, professional experiences with homeless women and veterans are an asset to this study; my experiential perspectives can be viewed as a limitation of this study. Our experiences shape the view of the world we have. My experiences with homeless women and my limited experience with women veterans lead me to adopt the stance that *most, if not all*, homeless women or women veterans have experienced some kind of trauma in their lives; and that their coping abilities are overwhelmed by those experiences. Many women are able to work through the experience of trauma and still experience homelessness. For those women another issue entirely may have led to homelessness, which will need to be assessed and addressed.

Implications for Future Research

As discussed earlier continued research needs to take place on this emerging population. Women are growing in numbers in the military (Perlin, et al., 2005), thus will continue to grow in the veteran and homeless veteran population. An in-depth survey of predictors for homelessness in female veterans will offer the best information to direct development and implementation of programs to serve this population. Also, a longitudinal study of the experiences of female veterans will offer insight into the effect of military service on women and their needs for added support.

Conclusions

In conclusion, this study calls for a more sensitive and comprehensive approach and understanding of the issues involved in care and treatment to homeless women veterans. It is important to hold both the similarities and differences to male veterans

and other homeless women. An understanding of the experience of women in the military can help us understand how so many women find re-integration into civilian life so difficult. Ms. Williams gives us a very clear picture to the difficult task of adjusting to life and expectations with:

While I was in Iraq, everything was clear. I wanted to become a journalist. I wanted to go to graduate school and get a master's degree. I wanted to become a Middle East correspondent for National Public Radio. That was what I wanted to do with my life. So I'd apply for Georgetown University—the worst thing they could do was turn me down. There were no fucking explosives if it didn't work out.

Back home, all that clarity of purpose faded almost before I knew it. I wanted it back. I wanted to that feeling of solidity and strength again. (Williams, 2005, pg. 280)

Even for those women who leave the structure of the military and sustain housing, there is a very disconcerting time when major shifts in perceptions and expectations take place.

It continues to feel far-fetched that we can bring an end to homelessness, especially when we see the new population of homeless female veterans growing in numbers. The hope is that as we effectively treat the symptoms and causes of homelessness, more energy can be focused on the prevention of homelessness in vulnerable populations. Ideally, the hope to be able to continue to lower the number of those who “fall through the cracks” of treatment and services and can maintain a stable home.

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