The purpose of this editorial is to increase psychiatric nurses’ awareness of the multiple adversities that many women Veterans face to increase safety and promote protective factors. Prevention of suicide among Veterans is a top clinical priority of the Veterans Health Administration (VHA) (Brignone et al., 2018). A major concern is the suicide rate for women Veterans, which has increased approximately 50% since 2005, while the number of women Veterans has only increased 6.5% (U.S. Department of Veterans Affairs [VA], 2019). According to the Veteran Suicide Prevention Annual Report of 2019, women Veterans were 2.2 times more likely to die by suicide than their civilian counterparts (VA, 2019). Multiple traumas contribute to suicidal ideation, suicide attempts, or death by suicide in women Veterans:

- Women Veterans experience significantly higher rates of adverse childhood experiences (ACEs) compared to civilians (Katon et al., 2015).
- Thirty-eight percent of women Veterans report military sexual trauma (MST) (Monteith et al., 2019).
- Thirty-three percent of women Veterans experience intimate partner violence (IPV) compared to 24% of non-Veteran women (Brignone et al., 2018).

The above risk factors increase the cumulative risk for posttraumatic stress disorder (PTSD), traumatic brain injury, depressive symptoms, and substance use disorders (Iovine-Wong et al., 2019). Conversely, a protective factor for women Veterans is engagement in care at VA clinics, where they are significantly less likely to die by suicide, likely related to the VA’s trauma-informed approach (Disabled American Veterans, 2018).

TRAUMA-INFORMED CARE
Trauma pervasively affects physical, mental, and spiritual health. Trauma-informed care (TIC) is necessary to address multiple traumas in women Veterans. TIC provides a “greater sense of safety and a platform for preventing more serious consequences of traumatic stress” (Substance Abuse and Mental Health Services Administration, 2014, p. 8). Often, Veterans do not identify the importance of understanding their traumatic histories. TIC facilitates the understanding of trauma’s impact and identifies the individual’s strengths for coping and resilience.

TIC starts with screening for military status, exposure to combat, and war-related experiences (Koblinsky et al., 2017). Often Veterans do not volunteer this information to providers. It is the responsibility of the provider to inquire about military service and issues that may have occurred as a result of service. The simple act of establishing Veteran status can go a long way to informing the plan of care.

Building the therapeutic relationship between the provider and Veteran is a crucial step in providing TIC. Women Veterans’ treatment plans should be individualized to promote therapeutic relationships (Koblinsky et al., 2017). To establish the therapeutic relationship, psychiatric nurses must:

- assure women Veterans they are worthy to receive care;
- treat women Veterans with empathy, dignity, and respect;
- assess anger as a potential treatment issue; and
- recognize the diversity of women Veterans.

Clinicians must be sensitive to military culture and war-related mental health conditions that are commonly identified in the Veteran population regardless of era served or military occupational specialty. Recalling that women Veterans are at increased risk for higher ACEs scores, MST, and past and/or present IPV, is crucial in providing a comprehensive plan of care. Below we give an overview of the three most common risks for suicide for women Veterans.

COMMON RISK FACTORS AND TRAUMAS IN WOMEN VETERANS
Adverse Childhood Experiences
ACEs have been extensively studied by the Centers for Disease Control and Prevention (CDC; 2020). ACEs are associated with poor outcomes in adult health that are lifelong (McGuinness & Waldrop, 2015). The CDC’s Adverse Childhood Experiences questionnaire screens for the three types of ACEs that include: (a) abuse: physical, emotional, and sexual; (b) neglect: physical or emotional; and (c) household dysfunction: mental illness, incarcerated relative, substance use, mother treated violently, and divorce.
Military Sexual Trauma

MST includes any type of sexual harassment, assault, or unwanted sexual activity that occurs at any point in a woman’s military career. MST is associated with an increased rate of mental illness, a seven-fold elevated odd of developing PTSD, and a three-fold elevated odd of suicide attempts (Rosellini et al., 2017). Universal screening of women Veterans will help ensure identification of injuries, illnesses, and psychological conditions related to MST. Identification of MST survivors provides documentation to ensure appropriate mental and physical care are provided. Screening for MST begins with asking about MST. The VHA currently uses the following questions to screen for MST:

1. “When you were in the military, did you ever receive unwanted threatening or repeated sexual attention such as touching, cornering, pressure for sexual favors, or inappropriate verbal remarks?” (Kimerling, 2007, p. 2161).

2. “When you were in the military, did you have sexual contact against your will or unable to say no after being forced or threatened or to avoid consequences?” (Kimerling, 2007, p. 2161).

An affirmative response to either question would be coded by the VHA as positive for MST (Kimerling, 2007).

Intimate Partner Violence

IPV includes violence that is psychological, physical, and sexual. The consequences of IPV for women Veterans often result in isolation and low social support, both of which are correlated to increased risk of suicide (Brignone et al., 2018). Recognizing that IPV is an experience, not a diagnosis, is important for treatment (Brignone et al., 2018). Assessment should begin by validating patients’ experiences. Furthermore, by educating patients about the significant impact of IPV to their health, and providing referral options, clinicians can mitigate suicide risk and other adverse mental health outcomes in women Veterans (Brignone et al., 2018). The E-HITS (Extended–Hurt, Insult, Threaten, Scream) screening tool assesses the following (Portnoy et al., 2018):

1. How often does your partner physically hurt you?
2. How often does your partner insult or talk down to you?
3. How often does your partner threaten you with physical harm?
4. How often does your partner scream at you?
5. How often are you forced to have sex or do sexual things?

PSYCHIATRIC NURSING IMPLICATIONS

Multiple types of trauma increase the risk of poor physical, mental, and spiritual health outcomes in women Veterans. Psychiatric nurses’ knowledge and use of a trauma-informed approach are vital for effectively treating the needs of women Veterans. The cornerstone of TIC is the therapeutic relationship. The building and maintenance of this relationship is essential and incorporates elements such as training in TIC; addressing immediate needs; attentive listening; and expressions of compassion, kindness, and trust.

Psychiatric nurses are urged to adopt a trauma-informed approach and ask about Veteran status, ACEs, MST, and IPV. This approach will identify, protect, and treat our women Veterans who are at an increased risk for trauma-related disorders and suicide. Evidence-based trauma-informed interventions must be implemented to address treatable physical, mental, and spiritual needs. If left unassessed and untreated, women Veterans are more likely to die by suicide.

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