

Psychosocial Effects of Trauma on Military Women Serving in the National Guard and Reserves

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Abstract: *Women involved in all aspects of the United States Armed Forces face mental health needs that are unique from women in the general population. Because the most recent wars in Iraq and Afghanistan are involving more women in combat situations, social workers encounter female clients who are increasingly experiencing post-traumatic stress disorder, substance misuse, and sexual violence. Special attention must be paid particularly to women who serve in the National Guard or Reserves, as they have different concerns than enlisted active duty women. These concerns include less social support and fewer resources upon return from deployment. Thus, it is imperative for social workers in the community to be aware of these military women's experiences and unique mental health challenges in order to effectively treat their needs.*

Keywords: *Military women, military sexual assault, female service members, women in the military, National Guard, United States Reserve Component*

INTRODUCTION

Who are “Military Women”?

The term “military women” has numerous meanings. Until recently, most descriptions of women involved in military life referred to wives of enlisted men, women in civilian posts within the military, or women in other non-combat related military service. This changed with Operation Desert Shield and Desert Storm in the early 1990s, when women began serving closer to the combat theatre. For example, women flew operational combat missions for the first time in 1998 (Martin, 2010). Regardless of what “military women” has meant throughout the years, one thing has remained the same: these women have been affected in some way by military involvement.

“Military women” have an extensive history of service in the Armed Forces. Women have been involved in U.S. military service since the Revolutionary War, but they did not enter all branches of the Armed Forces until World War II. In 1948, Congress allowed women to be permanent members of the military in non-war times (Alliance for National Defense, 2005). However, they stipulated that women could make up no more than 2% of the force and this was not repealed until 1967 (Alliance for National Defense, 2005). While there were women serving in the Vietnam War, most were registered nurses (Taft, Monson, Hebenstreit, King, & King, 2009). Women were not deployed to the combat theatre until the conflicts of the 1990s (Operation Desert Shield and Operation Desert

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Storm) and more recently, Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) (Cave, 2009).

Women currently represent approximately 10% of all U.S. armed forces in Iraq and Afghanistan (Martin, 2010). Recent surveys report women comprise approximately 15% of the U.S. military (Military Family Resource Center, 2009) and about 55% of women serving in the military are minorities (Haskell, Gordon, Mattocks, Duggal, Erdos, Justice, & Brandt, 2010). Women represent 17% of National Guard and Reserve Component members (Military Family Resource Center, 2009), 20% of new military recruits to active duty (Goldzweig, Balekian, Rolón, Yano, & Shekelle, 2006), and about 7% of the veteran population. Approximately 40% of women returning from service in Iraq and Afghanistan utilize VA health services (Haskell et al., 2010).

Enlisted women are now witnessing injuries and deaths whereas previous exposure was limited to their roles as medics or nurses, helping to heal the wounded men. Thus, in the past ten to fifteen years, researchers have been able to examine the toll of military life, especially combat, on the lives of women. However, there remains a gap in the research on military women, particularly active duty enlisted women and officers, including women in the National Guard and Reserve components. Because there has been limited research investigating the impact of military service among servicewomen, particularly deployment during wartime, and because social workers in the community will more often work with women in the National Guard and Reserve Component rather than active duty members, this paper focuses on women serving in the National Guard and Reserves of the United States Armed Forces.

Branches of the U.S. Military

Women's service in the branches of the U.S. military varies. There are differences between branches in the military with regard to types of service and mental health issues women may be likely to encounter. Women experience unique challenges depending upon the branch; some branches are known more for having a higher percentage of occupations and positions available to women (e.g., Coast Guard) and others the lowest (e.g., Marine Corps) (Alliance for National Defense, 2005). Though the size of both active and Reserve components of the military have significantly decreased since 1990, the number of women has increased for both components (Military Family Resource Center, 2009). Women comprise 17.8% of Reserve component members (Reservists), 10% of National Guard, and 14.3% of active duty members (Military Family Resource Center, 2009; Haskell et al., 2010).

Reservists, women who serve in the Reserves component of all branches of the Armed Forces, experience perhaps the greatest amount of challenges. Men and women serving in the National Guard and Reserve units are typically older than full-time enlisted soldiers and more likely to have civilian jobs or careers (Kehle & Polusny, 2010). They do not usually live around their military installation after they return home and thus typically have little postdeployment support (Kehle & Polusny, 2010), yet they comprise about half of the forces in OIF (Stetz, Castro, & Bliese, 2007). Studies have shown National Guard women and men tend to have a greater risk for post-traumatic stress

disorder (PTSD) and mental health issues than active duty personnel; in fact, approximately 42% of OIF National Guard troops and Reservists have mental health problems (Milliken, Auchterlonie, & Hoge, 2007). There has been little, if any, research on gender differences, other than sexual harassment and assault rates among Reservist women (e.g., Street, Stafford, Mahan, & Hendricks, 2008).

Service-related Trauma

Post-traumatic stress disorder (PTSD) is a common outcome of war-zone exposure. According to Shea et al. (2010) the current war efforts in Iraq and Afghanistan have led to the interest in studying post-deployment mental health issues. Shea et al. (2010) examined members of the National Guard and Reserve deploying in support of OEF and OIF, and found a strong association between PTSD and poorer psychosocial functioning. Further, they note that study participants who were unable to interact functionally in social situations had more symptoms of avoidance, distress, and hyperarousal.

PTSD can negatively impact the overall health status of female veterans. Ouimette and colleagues (2004), state that members who have PTSD typically possess poorer overall health functioning and an increased likelihood of a greater number of medical conditions, including mental health disorders like anxiety, depression, and substance abuse. PTSD can be devastating for any military service member, but women returning from deployment with the National Guard or Reserves may have an even more difficult time recovering from their condition for a variety of reasons including lack of resources and social support. The following sections highlight two main traumas associated with service-related PTSD and how women in the National Guard and Reserves can have more difficulty in recovery: combat trauma and military sexual trauma.

Combat Trauma

There is a very small body of research measuring female veterans' exposure to combat, however, as more women continue to deploy, interest in this topic has steadily increased (Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, & Frueh, 2007). Many military women will have direct exposure to combat operations, and as a result some will become injured, or even lose their life. The cost of war is insurmountable, and in addition to injury and death, members are at risk for developing serious mental health conditions such as posttraumatic stress disorder (Shea, Vujanovic, Mansfield, Sevin, & Fengjuan, 2010).

One of the strengths with the female veteran population is that they are more inclined than men to report combat exposure, and as a result, they are likely going to receive treatment they need; whereas male veterans may not report these issues, thus remain untreated (Zinzow et al., 2007). Even though women are more inclined to report exposure to trauma, there are still barriers to receiving this treatment, especially in a VA setting. For example, women are often reluctant to disclose military-related trauma experiences with clinicians from the VA because of the shame and stigma associated with these feelings (Zinzow et al., 2007). Additionally, service women have expressed a lack of continuity of care for military-related trauma (e.g. consistency).

Military Sexual Trauma

Sexual trauma is a traumatic experience for all women, however, women in the military experience more challenges with reporting the incident and obtaining legal and medical attention than their civilian counterparts. Oftentimes, they have to report back to their duty station and face the perpetrator every day; this situation is not as common in the general population (Suris, Lind, Kashner, Borman, & Petty, 2004). For military women, experiences of military sexual trauma (MST) often result in several co-morbid disorders such as substance abuse, depression, anxiety, and PTSD. Natelson (2009) reported that MST is a stronger predictor of PTSD among female service members than exposure to combat operations (Natelson, 2009). In fact, studies have shown that exposure to sexual trauma and harassment causes equal amounts of PTSD in women as combat exposure does to men (Natelson, 2009).

In the military, women are more often victims of sexual harassment and assault than are men (Murdoch, Pryor, Polusny, & Gackstetter, 2007). Recent reports show ranges of sexual assault from 4.2% to 7.3% for active duty women and 11% to 48% for female veterans; sexual harassment rates ranged from 55% to 79%, based on reported events (Goldzweig et al., 2006). More recent research on women veterans from OIF/OEF show 14% screened positive for MST (Haskell et al., 2010). Perpetrators can be residents of the overseas country where women are stationed, or more commonly colleagues or superiors of the enlisted women. Actual rates of assault and harassment are unclear, as many women are afraid to charge their fellow soldiers—or worse, their superiors—with crimes. Although the Armed Forces have recently put a great deal of effort into sexual assault reporting practices, women are still hesitant to bring charges.

Women are encouraged to report assault through the Sexual Assault Prevention and Response (SAPR) Program, established by the Department of Defense in 2004; however, many military regulations serve as barriers to reporting the incident. For example, the Department of Defense's two-tiered system of reporting may discourage a woman from reporting an incident. Under this two-tiered system, the report is either filed as restricted or unrestricted; both differ drastically when it comes to confidentiality and anonymity. Restricted reporting occurs when the victim's primary goal is to seek medical assistance and counseling (Williams & Kunsook, 2010). This type of reporting is said to be confidential and the victim's report remains anonymous. However, if the victim wishes to prosecute their assailant, they are required to file an unrestricted report, which is not anonymous. Unrestricted reporting impacts the victim's decision to proceed with prosecution, making it difficult for the perpetrator to be punished (Williams & Kunsook, 2010).

Female service members serving in the National Guard and Reserve components of the military have unique challenges to reporting and seeking help for MST. They often lack many of the resources that their active duty counterparts receive. Survivors of MST in the National Guard and Reserve are asked to report incidents to the chaplain's office, however limitations include issues with confidentiality and quality of care. Chaplains are often not licensed clinicians, therefore many are not qualified rape counselors. Moreover, unlike civilian women, victims of MST can rarely change their careers (Service Women's

Action Network [SWAN], 2010). If the unit's chain of command fails to enforce an equal opportunity policy, victims are forced to live in hostile environments and fear future incidences of harassment or assault. Reports show that approximately three-fourths of servicewomen who were raped did not report the assault (SWAN, 2010). Several factors influence the victim's ability to report the incident, including pressure from the victim's chain of command, the victim's efficacy in their ability to report the information, fear of the consequence from disclosing the information, and the unit's operation tempo (op tempo).

In military environments many times the perpetrators outrank their victims, as they may be supervisors or superiors. This allows higher-ranking perpetrators considerable control over the victims in the work environment (SWAN, 2010), which can create barriers to disclosing the information to medical and legal professionals. By seeking legal and medical help, the victim not only fears retaliation by her command, but she may also worry about harassment from colleagues (SWAN, 2010). Oftentimes, MST is under-reported because the victim fears that reports will jeopardize her military career. An estimated 33% of the 75% of women who did not report sexual assault did not know how to report the incident (SWAN, 2010). Additionally, many times anonymity is compromised in reporting cases of assault, as women must give their rank, gender, age, race and branch of service when submitting an assault report (SWAN, 2010). This makes reporting the case anonymously very difficult, which further outweighs the benefit of seeking medical or legal attention.

MENTAL HEALTH DISORDERS RELATED TO TRAUMA EXPERIENCE

Mood Disorders

Military women are at risk for developing anxiety and mood disorders, particularly those women deployed to combat areas (e.g., Fiedler, Ozakinci, Hallman, Wartenberg, Brewer, Barrett, & Kipen, 2006). Gulf War veterans who were exposed to combat reported higher rates of depression and anxiety than those not exposed to combat (Black, Carney, Peloso et al., 2004). A recent study of Iraq and Afghanistan soldiers revealed women were more likely to be diagnosed with depression than men (Haskell et al., 2010). Part of the gender differences are marked by female military members having more predisposing psychosocial risk factors for combat-related depression than military men, including greater prevalence of childhood abuse and adult sexual assault (Cox, Ghahramanlou-Holloway, Szeto, Greene, Engel, Wynn, Bradley, & Grammer, 2011). Additionally, gender differences can be attributed to military women having less social support than men (e.g., Vogt, Pless, King, & King, 2005). Women in the Reserves or National Guard may be at even greater risk as they have even less social networks and resources available than active duty service members (Cogan, 2011). Indeed, Smith and colleagues (Smith, Ryan, Wingard, Slymen, Sallis, & Kritz-Silverstein, 2008) found higher levels for PTSD for Reserve and National Guard members than active duty members, perhaps attributable to less social support. Thus, women in the Reserves or

National Guard may be at greater risk for developing mood disorders than women in other active duty branches.

Suicide rates and suicide attempts are also increasing (Yamane & Butler, 2009), particularly for younger active duty women (Wojcik, Akhtar, & Hassell, 2009). Weiner, Richmond, Conigliaro, and Wiebe (2011) found higher rates of suicide as cause of death for women in the military compared to women civilians; 25% of all female military deaths were attributed to suicide, which was the leading cause of death among military women. This is in contrast to a general female population prevalence of 1.6%. Suicide among men and women in the National Guard and Reserves has also increased between 2009 and 2010, again attributed to less access to military health care than their active duty peers, as well as reintegration issues that differ from active duty members (Goldstein, 2010). However, there is little research on suicide and related factors among branches of the military, and even less with regard to gender differences between branches.

Substance Abuse

Substance abuse, particularly of alcohol and prescription drugs, is a concern for women trying to cope with stressors and mental health disorders. Distinctive military conditions such as relocation overseas, separation from family, or a greater perceived acceptance of substance use, may foster higher rates among military personnel (Ames & Cunradi, 2004/2005). Although alcohol misuse is common during military enlistment, it seems to be more prevalent during times of pre-deployment (e.g., Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004), perhaps because substances are used as a coping mechanism. Deployment stress, and drinking to cope, may be a greater problem among members of the National Guard or Reservists, as they have less resources available for dealing with pre-deployment stress and have jobs and lives outside of the military (Ferrier-Auerbach, Kehle, Erbes, Arbisi, Thuras, & Polusny, 2009; Jacobson, Ryan, Hooper, Smith, Amoroso, Boyko, Gackstetter, Wells, & Bell, 2008). Burnett-Zeigler, Ilgen, Valenstein, Zivin, Gorman, Blow, Duffy, and Chermack (2011) found greater alcohol misuse among OIE/OIF National Guard men and women. Likewise, rates of postdeployment heavy alcohol use are higher for deployed men and women than for those who did not deploy (Federman, Bray, & Kroutil, 2000).

Gender differences exist with regard to alcohol and tobacco use. Military men drink more than their female counterparts (Ames & Cunradi, 2004/2005); however, among military women alcohol consumption is approximately 15% greater than alcohol consumption among civilian women. The difference between military men versus civilian men's consumption is approximately 7%. Bray and Marsden (2000) found that 5% of women in the military were heavy drinkers. A study of National Guard OIE/OIF men and women examining alcohol misuse found 23% of National Guard women reported harmful drinking (Burnett-Ziegler et al., 2011). Though gender differences were not reported, Jacobson et al. (2008) found Reserve and National Guard members who reported combat exposure to have significantly higher odds of new-onset heavy weekly drinking and binge drinking. Additionally, whereas only heavy drinking men were likely to use illegal drugs, even moderately heavy drinking women in the military are likely to

use them (Kao, Schneider, & Hoffman 2000). Thus, the difference between military and civilian women's drinking is higher than the difference between military and civilian men.

Military women serve in a male-dominated work environment, which itself is a risk factor for heavy drinking (Wallace, Sheehan, & Young-Xu, 2009). While working in a male-dominated environment is a risk factor for civilian women as well, women in the military experience additional stressors that civilian women may not (e.g., combat and related traumatic events) (Wallace et al., 2009). Military women are also less likely to use traditional coping mechanisms that civilian women are more apt to utilize to cope with stressors (Norwood, Ursano, & Gabbay, 1997). Additionally, after returning from being deployed, women who were deployed were almost three times as likely to report alcohol misuse than women who were not deployed (Federman et al., 2000). Military women also have a higher prevalence of using tobacco (45%) than men or than civilian women, and the same rate as military men of heavy smoking (30%) (Bray, Fairbank & Marsden, 1999). Substance abuse programs such as TRICARE's smoking cessation program (ucanquit2.org) and a changing culture in the military that discourages heavy drinking and alcohol abuse as well as underage drinking (Wallace et al., 2009) are helping to lower rates of misuse and increase treatment options. Still, rates remain high.

Eating Disorders

Eating disorders are highly comorbid with substance use disorders, PTSD, and mood disorders (Streigel-Moore, Garvin, Dohm, & Rosenheck, 1999). Studies of service members suggest males and females participate in bulimic behaviors more than civilians (Peterson, Talcott, Kelleher, & Smith, 1995). Additionally, McNulty (1997) found a higher prevalence of anorexia, bulimia and eating disorder NOS among active duty Navy nurses than among civilians. A more recent study reported higher disordered eating patterns in enlisted women than enlisted men, and more so for soldiers who had had previous psychiatric treatment for other disorders (Warner, Warner, Matuszak, Rachal, Flynn, & Grieger, 2007).

A high percentage of enlisted women develop abnormal eating patterns or eating disorders, at a rate higher than the general population (Lauder, Williams, Campbell, Davis, & Sherman, 1999). A survey of active duty military women found 33.6% of women met criteria for being "at risk" of an eating disorder, and 27% of those at risk had a diagnosable eating disorder. Overall, there was an 8% prevalence rate of eating disorders (anorexia nervosa, bulimia nervosa and binge eating disorder) in the military, higher than the general population at about 6% (Hudson, Hiripi, Pope, & Kessler, 2007; Lauder et al., 1999).

More recent research on disordered eating among deployed military women reported no significant correlation between deployment and disordered eating (Jacobson, Smith, Smith, Keel, Amoroso, & Wells, 2009). However, women who were exposed to combat were almost twice as likely to develop disordered eating patterns and more than two times as likely to lose an extreme amount of weight, compared to men and women who were not exposed to combat (Jacobson et al., 2009). One explanation may be that women

serving in the military feel similar pressures as women athletes, to maintain certain body size and be physically active; likewise, women serving in active duty may feel similar societal pressures to be “thin” as women not serving in the military (Lauder et al., 1999). Furthermore, enlisted soldiers have fitness testing and weigh-ins periodically, and studies have shown disordered eating patterns increase around these times, including bingeing and purging, laxative use, and fasting (Garber, Boyer, Pollack, Chang, & Shafer, 2008). Carlton, Manos, and Van Slyke (2005) reported high rates of disordered eating among enlisted Navy women and men, with behaviors increasing before weigh-ins (“making weight”) and fitness tests. Another reason for higher prevalence among women serving in the military is using disordered eating patterns and exercise as a way to gain control over their lives and cope with stressors (Jacobson et al., 2009).

There is limited research related to eating disorders among military men and women in active duty. Moreover, few studies have been conducted specifically examining differences among branches of the military, including National Guard and Reserve components. Lauder and Campbell (2001) found that 20% of women in the Reserve officer training corps (ROTC) cadet examined had reported abnormal eating behaviors, putting them at risk for developing an eating disorder. Thus, eating disorders among women in different branches of the military remains an important area to investigate.

SOCIAL ISSUES FOR NATIONAL GUARD AND RESERVE COMPONENT MILITARY WOMEN

Reintegration into civilian life is a difficult challenge for most veterans and PTSD may increase the likelihood of readjustment problems (Sayer, Noorbaloochi, Frazier, Carlson, Gravely, & Murdoch, 2010). The Department of Defense has recognized the need for reintegration plans for active duty service members by having an established system to assist members in their transition to civilian life. However, National Guard and Reserve components had minimal plans in place for reintegration (U.S. Government Accounting Office [GAO], 2005). In 2008, congress recognized that reintegration and access to services can be particularly challenging for reserve components and so they funded the Yellow Ribbon Reintegration Program (YRRP) through the National Defense Authorization Act. Despite the growing numbers of female service members in both active duty and reserve components, many of these reintegration plans fail to incorporate services that meet distinct needs of female service members (Business Professional Women Foundation [BPW], 2007). Furthermore, the differences between components result in different reintegration needs for each.

Work

Popular media has reported on the condition of female veterans’ unemployment and career reintegration challenges (e.g., Thiruvengadam, 2011). According to the U.S. Department of Labor (2011) Gulf War II veterans, those who have served since September 2001, have an unemployment rate of 11.5%; however female Gulf War II veterans have a slightly higher unemployment rate of 12%. The U.S. Department of Defense provides the Transition Assistance Program (TAP) for reintegration back into civilian life, including some services for reserve component service members (U.S. GAO,

2005). However, these services are limited for reserve component members due to the shorter demobilization period they have and the distance from TAP services, which tend to be near major military installations (BPW, 2007). Active duty female veterans report that the TAP services are helpful acquiring a job, but long-term support is lacking where it is needed (BPW, 2007). YRRPs do provide some employment and career assistance, however neither TAP or YRRPs are mandated to provide specific programs for female service members.

Other federal programs have also been implemented to address employment issues for veterans. For example, the Department of Labor established America's Heroes at Work, a website dedicated to educating and preparing employers for hiring veterans with traumatic brain injuries or PTSD (U.S. Department of Labor, 2011). A PTSD diagnosis can greatly impact one's employability and ability to work. PTSD symptom severity tends to impact female veterans' ability to work and satisfaction with work; that is, as symptom severity increases, so do impairment and dissatisfaction (Schnurr & Lunney, 2011). Unemployment and PTSD symptoms are risk factors for homelessness in female veterans (Washington, Kleimann, Michelini, Kleimann, & Canning, 2010), which is a serious issue considering that one in four female veterans are homeless (Gamache, Rosenheck, & Tessler, 2003).

Social Network

Social support is an important aspect affecting the risk of developing PTSD among veterans. Vogt et al. (2011) report that social support is a greater mediator of PTSD symptoms for female veterans than for male. Related to post-deployment social support, veterans who reported more concern for relationships during deployment were also strongly related to PTSD symptoms and this is, again, stronger for female veterans (Vogt, Smith, Elwy, Martin, Schultz, Drainoni, & Eisen, 2011). Relationship concerns may be valid for some female service members; the rate of divorce is higher for female service members than it is for male service members (Karney & Crown, 2007). This increased rate is stable across service component and rank (Karney & Crown, 2007). Overall, the divorce rate is higher among military service members (Karney & Crown, 2007), but marriage in the armed forces differs compared to civilian marriage patterns (Hogan & Furst-Seifert, 2009). Military personnel with active-duty experience are three times more likely to marry between the ages of 23 and 25 compared to civilians, and military personnel who have served more than two years in active duty are significantly more likely to be divorced (Hogan & Furst-Seifert, 2009).

Members of the National Guard and Reserve often *volunteer* for deployments, as opposed to being called for duty, which further increases partners' stress. They typically do not associate themselves as being a "military family" which alienates them from the military culture and also their access to support (Huebner et al., 2010). Faber, Willerton, Clymer, MacDermid, and Weiss (2008) suggested Reserve component families experienced role confusion during the member's deployment and military family support groups provided assistance to families while adjusting to deployment and reunification. Resources that help families adjust and cope with deployment are often not available because Guardsmen and Reservists are "geographically dispersed" throughout their states

and are typically not close to their duty stations (Huebner, Mancini, Wade, McElhaney, Wiles, Butler, & Ford, 2010). This could potentially reduce the amount of resources available to the family because they are less likely to have access to services and programs and may not be able to associate with a network of people who are experiencing the same deployment frustrations (Huebner et al., 2010).

Access to Care

Women have repeatedly reported that the VA system lacks appropriate services for women's health (Kelly, Vogt, Scheiderer, Ouimette, Daley, Wolfe, et al., 2008). Throughout the last four decades, reforms have been introduced in order to meet the rising demand for female-centered care. The number of female service members is at an all-time high, which has resulted in an even greater demand for appropriate care. Despite reforms, gender disparities still exist at the expense of women's health.

As noted, the impact of MST has resounding effects on female veterans' access to health care and general health. Repeated violence against female veterans was linked to an increased use in health care (Booth, Falk, Segal, & Segal, 2004). Women who experience MST also report a greater difficulty in readjustment, compared to female members without a history of military sexual trauma (Katz, Bloor, Cojucar, & Draper, 2007). Despite the detrimental impact of sexual trauma, female veterans reported a greater perceived difficulty in accessing VA health care and they cited impediments to receiving quality care, such as problems with VA staff and a lack of services fit for addressing the needs of female veterans (Kelly et al., 2008).

Military members of both genders reported a perceived lack of competence of military health care services, though female members specifically emphasized a lack of female centered knowledge (Jennings, Loan, Heiner, Hemman, & Swanson, 2005). Washington, et al. (2007) reported that female veterans lack an awareness of VA health care entitlements and access and they also reported they felt the VA health care system lacked gender specific sensitivity and competence. Female veterans' perceptions of gender-specific care has been reported in VA mental health care as well; that is, female veterans with PTSD have reported that women-centered treatment was the most important factor contributing to their comfort with VA services (Fontana & Rosenheck, 2006).

Gender differences exist in issues related to VA mental health care services in addition to those reported for the health care system at large. Proportionately, women have slightly more mental health concerns than men (Hoge et al., 2006) and women veterans' mental health diagnoses differ in type (Fontana, Rosenheck, & Desai, 2010). Congruent with reports that women experience more MST during service, women attributed their PTSD most often to MST, whereas men reported combat related exposure as the most prevalent cause for PTSD (Fontana et al., 2010). Service access differs between genders, in that women tend to seek services on an outpatient basis especially women who have comorbid physical and mental health problems (Frayne, Yu, Yano, et al., 2007). Though a body of literature is beginning to accumulate regarding female veterans' experiences with the VA health care system, fewer studies have specifically

focused on women in reserve components or reserve members' families. Reserve component members reported more health concerns, referrals to mental health care, interpersonal conflicts, PTSD, depression, and other mental health risks than active duty members (Milliken et al., 2007).

Among existing resources and programs provided to reserve members and their families is the YRRP. The program was created to support service members and their families through each phase of deployment: Pre-deployment, during deployment and Post-deployment. Additionally, programs for communities and service members' employers upon re-deployment or release from active duty are offered to help with successful reintegration (National Guard Bureau Joint Support Services, 2010). Services include education and assistance with TRICARE, the military's insurance plan, and Veterans Affairs Benefits such as health services, classes in anger management and substance abuse prevention, personal safety education including domestic violence awareness and services, along with more specialized issues which are unique to married and single service members (National Guard Bureau Joint Support Services, 2010). Additionally, the National Guard Bureau offers a Psychological Health Program, developed to focus on the challenges unique to National Guard service members. Because National Guard armories and wings are typically more community-based and not located near military treatment facilities (e.g., Veterans Administration hospitals and services), programs such as the Psychological Health Program provide these necessary services. The uniqueness of the National Guard members' lives as civilians prior to and after deployment necessitates reliance on community resources to help them reintegrate and adjust from military life to civilian life (National Guard Bureau Joint Support Services, 2010).

WHERE DO WE GO FROM HERE? A RESEARCH AND SERVICE AGENDA

This paper has highlighted issues that women serving in the Reserve Component and National Guard experience that are unique to other women in the military. Though these women encounter some similar issues as their male counterparts, they are at risk for additional problems including sexual assault, interpersonal violence, higher rates of eating disorders and substance use disorders. Similarly, women in these two military branches experience more difficulties than active duty women with regard to social supports, access to healthcare, and higher rates of suicide and other mental health issues.

Military women, particularly those in the National Guard and Reserves, also have fewer services available to them than men. The need exists for more specialized services to women, more research on women's substance misuse, mental health and sexual assault issues. There needs to be a more gendered approach to services, as the number of women who will use VA services is projected to double within five years (Maze, 2010). Additionally, there needs to be an increase in the awareness focused on the unique needs of military women, particularly those serving in branches like the National Guard and Reserves where many military health and support services are not available or easily accessible.

Social workers are important to improving service availability and utilization. Social workers who work within the VA system, as well as those in the general population who are not specifically oriented to veterans or military members' issues, need to be educated on the unique mental health concerns of all military women, while serving in the military and after deployment. Social workers need to provide services or referral mechanisms for women to reintegrate to their lives after deployment. These services can include helping women cope with PTSD and combat-related anxiety, MST-related PTSD and depression, family issues, financial concerns, substance misuse, eating disorders, traumatic brain injuries, and other physical injuries. Social workers are particularly well suited to conduct community-based group therapy sessions, family therapy sessions, psychoeducation programs, and workshops that can help military women heal.

Federal funding agencies are beginning to understand the need for more research into military health and mental health, but more focus needs to be placed on gender differences and women-specific issues. Women's issues have not been researched well or extensively; while there is quite a substantial body of literature on military men's mental and physical health issues and the effects of combat and deployment on men, there is a paucity of research with regard to women. As more data exists from women's more extensive military service in the past two decades, we need to examine the effects of military life on women. Similarly, as the OEI/OIF wars marked the first time National Guard and Reservists were deployed for active service during combat, much research is needed that will focus on the unique challenges these women face predeployment and upon returning home.

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