Gender Bias in the United States Department of Veterans Affairs PTSD Program

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On my honor as a University Student, I have neither given nor received unauthorized aid on this assignment as defined by the Honor Guidelines for Thesis-Related Assignments

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Introduction/Research Question

Healthcare for veterans and active-duty military members is a component within the United States Department of Veterans Affairs (VA) that provides numerous medical centers, outpatient clinics, and other programs. Adequate services for the veteran and military population are quite complex because of the unique challenges associated with the nature of military combat. For example, blast trauma can cause severe volumetric muscle loss (VML) injuries, the treatment for which have low rates of cosmetic and functional recovery. Physical injury is not the only challenge affecting war fighters. Psychological disorders are extremely common in the veteran population, because of the traumatic events that military members are exposed to during combat. Posttraumatic stress disorder (PTSD) is a mental health problem developed by some individuals after experiencing or witnessing a life-threatening event (Post-Traumatic Stress Disorder (PTSD) - Diagnosis and Treatment - Mayo Clinic, n.d.). Due to the strong link between combat exposure and PTSD, treatment services for this are an extremely important element of veteran health care.

Services provided through the VA include mental health assessment and testing, psychotherapy such as Cognitive Processing Therapy, family therapy, group therapy for special needs and special residential or inpatient care programs (PTSD Basics - PTSD, n.d.). It is the understanding of the VA that these current services are adequate for meeting the care needs of veterans with this specific mental health diagnosis. However, national surveys of female veterans, and observational studies from nationally representative samples of veterans indicate that female veterans with PTSD or depressive symptoms have experienced barriers to VA healthcare and unmet medical needs (Lehavot et al., 2013, Tsai et al., 2015). As women's participation and roles in the military continue to expand and the female veteran population increases, failure to explore the design of the VA's PTSD care programs will result in continued unmet medical needs for female veterans. This paper uses Tomas Hughes' large technical system framework to explore the social aspects of VA healthcare that led to gender bias being implemented into the VA PTSD care system, and how it is contributing to barriers to care experienced by female veterans. Then, an ethical reflection is done on the consequences of the gender bias introduced into this care program.

Literature Review

Before diving into the barriers experienced by female veterans in the VA's PTSD program, it is important to understand the differences in PTSD between males and females, as this will provide an important context when exploring the history of the VA's healthcare services, and the specific barriers experienced by female veterans. It is well established in the literature that there are differences in PTSD diagnosis and symptoms between males and females. In a review of sex differences in trauma and PTSD, numerous comparisons were done between males and females on the frequency and severity of PTSD in various situations. The comparisons found that in male versus female accident victims, victims of nonsexual assault, victims of disaster or fire, participants who witnessed the death or injury of another person and victims of illness or unspecified injury, females exhibited a higher frequency of PTSD than males and showed significantly greater severity of symptoms. A comparison was done of PTSD in male in female participants who reported experiencing combat, war, or terrorism, and the study found that female participants had a significantly greater likelihood of PTSD in civilian populations, however there were no differences between likelihoods of experiencing PTSD between males and females in the military population (Tolin & Foa, 2006). In a quasi-prospective questionnaire survey assessing PTSD and related variables of individuals exposed to a traumatic event, results showed that when compared to males, females experienced higher levels of associated PTSD risk factors, and therefore experienced more PTSD symptoms than males. Notable among these risk factors were: more severe PTSD, high levels of physical anxiety and sensitivity, and negative thoughts about themselves (Christiansen & Hansen, 2015). Numerous additional studies have confirmed differences between males and females in regards to PTSD. It is important to be aware of these differences when investigating the cause of the gender bias in the VA's PTSD care program.

As mentioned previously, there is evidence that female veterans with PTSD or depressive symptoms experience barriers to medical care provided by the VA. Two sources were studied to gain insight as to the quality of care being given to female veterans at the VA, with specific focus on those suffering from PTSD. A national survey of women veterans compiled data on female veterans who experienced unmet medical need. The data provided information about the individuals who were interviewed, which allowed for comparison between those who did and did not use VA healthcare, and also distinguished between female veterans who screened positive for PTSD or current depressive symptoms. Comparing the many different aspects that were studied, this data showed that female veterans who screened positive for PTSD symptoms had the largest percentage of individuals who experienced barriers to care. Data also showed that female veterans who did not use VA healthcare indicated they thought they were ineligible for services, or had bad experiences with the VA in the past (Lehavot et al., 2013).

A second source provided additional information about the specific barriers that female veterans experienced compared to male veterans also receiving care from the VA. This was an observational study that gathered data from a nationally representative sample of 1,202 veterans who completed a Web-based survey about mental health service use and barriers to mental health care. The results from this survey found that approximately the same percentage of female and male veterans utilized VA health services for healthcare. However, female users had poorer general health and mental health, and had a greater incidence of military sexual trauma. Further analysis was done on the data collected about the barriers to care that women using the VA for psychological problems experienced. The top barrier was high cost of treatment, with 25% of their responses indicating this as a barrier. Males who took the survey had 25% indicate they experienced this barrier as well. The next four highest barriers to care for female veterans were related to what the patient's peers, friends, or family would think about her if she were to seek out treatment for a psychological related problem. These responses included: "I would be seen as weak" (20.2%), "People important to me would think less of me" (18.45%), "my peers might treat me differently" (17.3%), and "It would be too embarrassing" (16.2%). The percentage of male veterans using VA services that indicated these responses as barriers to care were significantly lower than the percentages of female veterans who experienced them (Tsai et al., 2015). This difference suggests underlying factors about perception of women seeking PTSD care within the VA compared to their male counterparts.

STS Framework

Evidence of sex differences in PTSD and the demonstrated barriers to care experienced by female veterans point to a gender bias imbedded in the care program. I analyzed how this gender bias was introduced, and why it is still affecting female veterans' care today. I argue that the barriers to care that female veterans seeking PTSD or other psychological care at the VA experience are the results of a gender bias put in place by several groups of influential stakeholders of the VA healthcare and PTSD programs. These stakeholders believed the design of the program was adequate for the needs of patients being treated. However, the construction of this program was influenced by a variety of social factors, including the views and perceptions of females in both civilian and military populations. To frame my argument, I will draw on the STS theory known as Large Technical System (LTS), which examines messy, complex, hierarchically nestled systems that contain not only technical aspects, but also social elements. This theory states that the system builders, such as inventors, scientists, or engineers, put in place a hierarchy, and their choices about who held power in this system can be noticeably political. As the system attempts to evolve and expand, a reverse salient limits the system's development. LTS also incorporates the theory of momentum, meaning the design of the system acquires inertia, and becomes difficult to displace (Bijker et al., 1987).

While bringing to light some of the social, political and cultural factors that have shaped the PTSD care program, it reveals the way that stakeholders and workers in this system exert power over female veterans seeking care. This unfair use of power raises ethical concerns about the creation and design of this technology, and who holds responsibility for the implemented gender bias. To address this, an ethical reflection was conducted using the STS theory known as Banality of Evil. This theory, set out by Hannah Arendt, claims that evils in this world were not committed by evil individuals, rather by ordinary people who participated in a certain event under the impression that their actions were normal. These are "nobodies" – individuals without motive, convictions, or wicked hearts. Rather, the evil that was committed was an outcome of the absence of thinking (Whitfield, 1981).

Method

To support my argument, I analyzed evidence from secondary sources – that is surveys, interviews, and historical facts from these institutions – because this provided information about how the PTSD care program was established, and the social factors surrounding it. I analyzed the history surrounding the establishment of the VA and their PTSD healthcare system. I then researched the history of women involvement in the military, to gain a better understanding of the perceptions of females serving in the military at different times in history, and to gain insight into the social and political factors that may have been at play while the stakeholders were designing the PTSD program. I also explored the history of the VA program in general, looking for evidence of certain factors playing into the design of different programs, and relating this to the timeline of female involvement with the military. In addition, I explored the history of the National Center for PTSD – the VA's PTSD program. Here I paid special attention to factors such as managerial issues, and hierarchies that were present during the program's design in an attempt to explore how a gender bias was implemented in the program. Exploring the history of these three systems – women involvement in the military, the VA program in general, and the VA's PTSD program – helped gain an understanding of who the constructers of these systems were, and what factors were implemented into the design. I also conducted an analysis of the metrics used to measure and diagnosis PTSD at the time that the National Center for PTSD was established, and how this has been changed or modified as more research has been done on PTSD care. Using data from studies about sex differences in PTSD, I was able to gain insight on the quality of the metrics used for female veterans and explore their contribution to the gender bias implemented in the PTSD program.

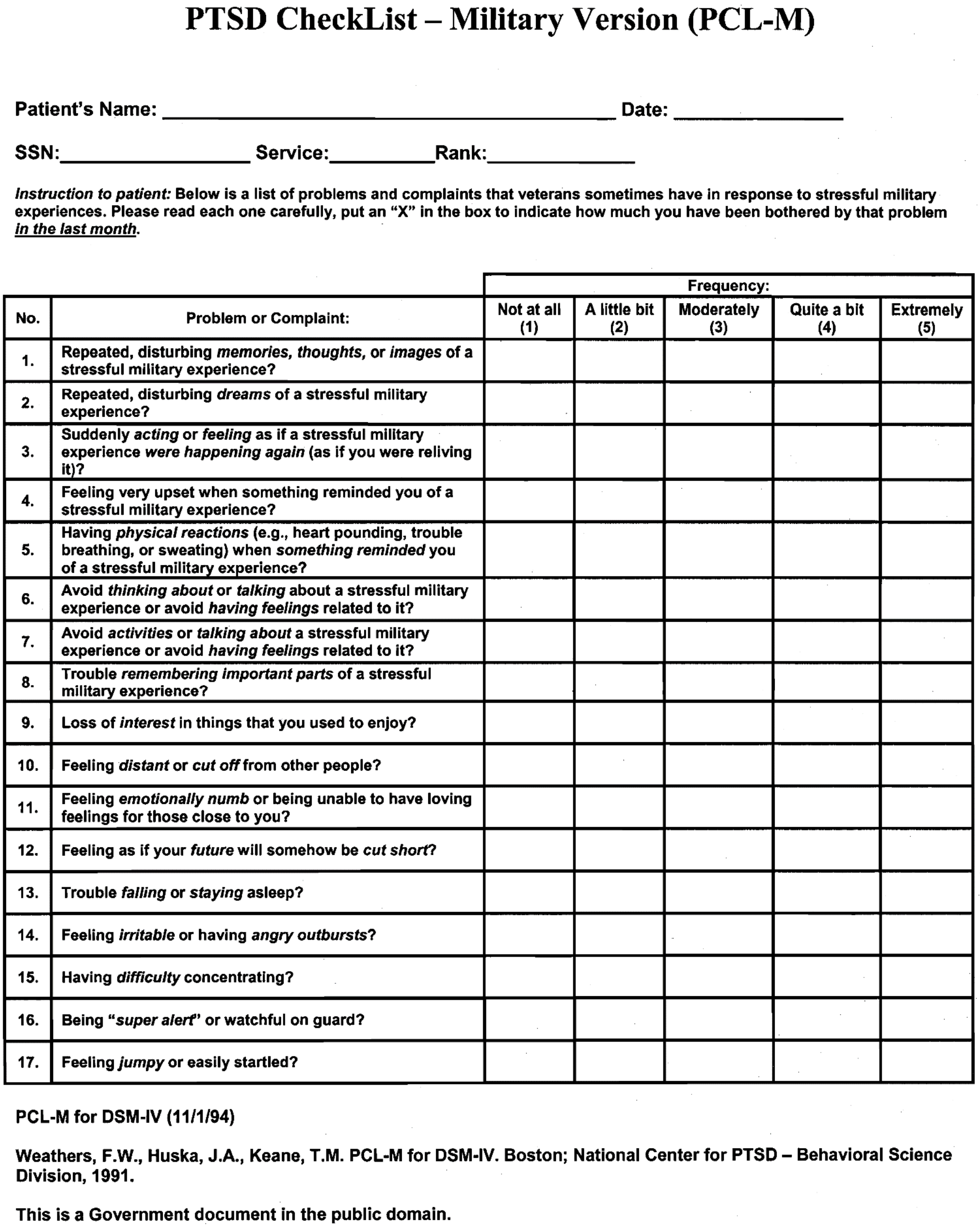
Data Collection and Analysis

Women have a long history of serving in the military, but it was not until 1948 when President Truman signed the Women's Armed Services Integration Act into law that women could train for active combat. This let women serve as full, permanent members of all branches of the military. While the act limited the number of women who could serve to 2% of any military branch, those restrictions were changed in later decades (Blakemore, n.d.). In the 1980s, about 5-10% of those serving in the military were female, and today about 16.5% of those serving are female (GAO Women, n.d.). The Veteran's Association established their Department of Medicine and Surgery in 1946, which later became the Veteran Health Administration (Administration, n.d.). This program was designed before women were allowed to serve in the military, which strongly suggests the social climate that was originally established at the VA's health administration would be catered towards men, since they were the specific set of users that the program was being created for. This resulted in the design of a system that explicitly discriminated against women for obvious reasons – they were simply not in the picture in regards to service in the military.

In 1989, the VA created the National Center for PTSD in response to a Congressional mandate that was created to address the needs of veterans and other trauma survivors with PTSD. The purpose of the Center for PTSD was to improve the well-being, status, and understanding of veterans in society. This mandate established a Special Committee that would assess the capacity of the VA to provide diagnostic and treatment services for PTSD to veterans eligible for health care, however this committee had no direct responsibility for patient care. It focused instead on the development of policies, and setting the agenda for research and education on PTSD (History of the National Center for PTSD - PTSD, n.d.). The disconnect between the committee's goals and patient care shows how the focus of the special committee was not on providing beneficial treatments for patients, and provided no way of determining whether the work being done was effective or not. In the past 30 years, scientific and clinical research on PTSD has grown at an exponential rate, however, as outlined previously, there is evidence that the PTSD care programs offered by the VA are far from adequate for female veterans. The Special Committee was established by the mandate signed into law during the 98th Congress. At the 98th Congress, there were eight Chairs and eight Ranking Members within the Veteran's Affairs Committee. All 16 of these members were male. ("98th United States Congress," 2021) In addition, at the time of the creation of the National Center for PTSD, women only made up 5-10% of active-duty military members (GAO Women, n.d.). With low numbers of female members at the program's creation, the lack of a female voice in the establishment of the committee, and no direct relation between the goals of the committee and patient care, there is clear potential for a program to have an imbedded gender bias without it being obvious to the designers or employees.

In 1990, the National Center for PTSD developed the PTSD checklist, which is a 17-item self-report scale that corresponds to the 17 DSM-IV symptoms of PTSD. Responders use a 5-point scale to rate how much they have been bothered by each symptom during the past month (Assessment and Diagnosis of Posttraumatic Stress Disorder, n.d.). This checklist, displayed in **Fig. 1,** was specifically created for use by military members, because of the differences in exposures and experiences than civilians. Another PTSD Checklist exists for civilian population. The test which uses this checklist yields a continuous measure of PTSD symptom severity. The checklist has been widely adopted by the VA's systems. Despite its extensive evaluation and validation for a variety of trauma populations, upon analysis of the questions on the survey, it is evident that the use of this list has been shown to cause misdiagnosis of PTSD in women. This is because there is significant overlap between PTSD and the symptoms of both depressive disorders and borderline personality disorder. These are two disorders that women are often diagnosed with when clinicians are working to identify psychological problems in their female patients. All three of these disorders (borderline personality, depressive, and PTSD) are characterized by general emotional distress and can cause significant reactions including

Fig. 1. PTSD Military Checklist developed by the National Center for PTSD in 1990.



PTSD CheckList – Military Version (PCL-M)

Patient's Name: ________________________________ **Date:** ______________

SSN:______________ **Service:**_________**Rank:**___________

Instruction to patient: **Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.**

		Frequency:				
No.	**Problem or Complaint:**	**Not at all (1)**	**A little bit (2)**	**Moderately (3)**	**Quite a bit (4)**	**Extremely (5)**
1.	**Repeated, disturbing *memories, thoughts,* or *images* of a stressful military experience?**					
2.	**Repeated, disturbing *dreams* of a stressful military experience?**					
3.	**Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?**					
4.	**Feeling very upset when something reminded you of a stressful military experience?**					
5.	**Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience?**					
6.	**Avoid *thinking about* or *talking* about a stressful military experience or avoid *having feelings* related to it?**					
7.	**Avoid *activities* or *talking about* a stressful military experience or avoid *having feelings* related to it?**					
8.	**Trouble *remembering important parts* of a stressful military experience?**					
9.	**Loss of *interest* in things that you used to enjoy?**					
10.	**Feeling *distant* or *cut off* from other people?**					
11.	**Feeling *emotionally numb* or being unable to have loving feelings for those close to you?**					
12.	**Feeling as if your *future* will somehow be *cut short*?**					
13.	**Trouble *falling* or *staying* asleep?**					
14.	**Feeling *irritable* or having *angry outbursts*?**					
15.	**Having *difficulty* concentrating?**					
16.	**Being "*super alert*" or watchful on guard?**					
17.	**Feeling *jumpy* or easily startled?**					

PCL-M for DSM-IV (11/1/94)

Weathers, F.W., Huska, J.A., Keane, T.M. PCL-M for DSM-IV. Boston; National Center for PTSD – Behavioral Science Division, 1991.

This is a Government document in the public domain.

dissociation, suicidal thoughts, anxiety, flashbacks, negative self-worth, emotional outbursts, and struggles to develop healthy interpersonal relationships. While there are common struggles that those with these disorders share, they can be distinguished from each other by exploring the root causes of these issues – looking at patient reactions to similar feelings. For example, self-harm is uncommon in those with PTSD, but is very prevalent in those with borderline personality disorder. Those with PTSD are more likely to avoid interpersonal relationships out of fear, while those with depressive disorders are more likely to avoid them to evade feelings of abandonment. The metric developed by the National Center for PTSD is inadequate for distinguishing between PTSD and other commonly diagnosed disorders in females, despite its development during a time when females were serving in active-duty military roles. In contrast, when men seek care for psychological problems, they are diagnosed with antisocial personality disorder and schizophrenia at similar rates that women are diagnosed with borderline personality disorder and depressive disorders. Both antisocial personality disorder and schizophrenia are easily differentiated from PTSD (Borderline Personality Disorder VS Complex Post-Traumatic Stress Disorder, 2020).

To gain insight as to why the National Center for PTSD did not attempt to change these metrics, or adopt other methods that were supported by ongoing PTSD research, interviews with the PTSD Clinic Directors about their perceptions on delivery of evidence-based PTSD treatment was analyzed. A complete list of the 120 VA PTSD specialized programs across the US was used to randomly select 42 clinics, and emails were sent to the program directors of these health centers. The program directors were mostly psychologists, with a smaller amount being social workers or psychiatrics. 50% of the program directors who responded were female. The interview consisted of questions related to the treatments offered, how the programs were run, and challenges to delivery of new treatments (Sherrieb, 2015). Results regarding the barriers to the implementation of new PTSD treatments from well-designed scientific studies, known as evidence-based treatments, were analyzed. Several directors described the shift to newer evidence-based treatments as a “culture change … (where providers) are slowly sort of leaning more towards the idea that folks can move on”. They also responded about clinic providers, noting concerns such as, “Nonevidence based people, people that have very biased inaccurate views about evidence-based care … they don’t refer people to treatment because they say they are not ready.” (Sherrieb, 2015) These responses point to a culture within the VA that is resistant or very slow to adopt new treatments for PTSD, despite extensive data supporting their efficacy, and is a reasonable explanation for why the metrics for PTSD diagnosis previously discussed had not been changed.

Discussion/Conclusion

The data presented provides evidence and insight as to how the gender bias was implemented in the PTSD care program. Using Thomas Hugh’s LTS framework, I argue that the gender bias was put in place by groups of influential stakeholders in the VA healthcare and PTSD programs, and this gender bias has caused continued barriers to care female veterans. The National Center for PTSD was created in response to the Congressional mandate which established a special committee to assess the capacity of the VA to provide PTSD services to veterans. When established, the Veterans Affairs Committees in the Senate and the House of Representatives were run by 16 males. There were no female representatives in charge of picking the members for the Special Committee that oversaw the VA’s abilities to provide care for PTSD patients. These men were the system builders; they constructed the VA’s PTSD care program, and while doing so embedded technical and social elements into the design. When the VA was established, women were not allowed to serve in the military, and years later when the VA’s

Center for PTSD was being established, only 5% of the active-duty military was female. This context led to the social elements of gender bias that were imbedded within the PTSD care program. By examining data from studies that identified specific barriers that female veterans experienced, the fear of being seen as weak if a woman were to seek out psychological care reflects the program's design with the ideas that women were not capable of serving in combat.

In addition to this social element of gender bias, the constructors also implemented technical elements to the PTSD healthcare system, mainly the PTSD checklist. This checklist was designed in a way that makes it more effective for diagnosing PTSD in male patients, and can be ineffective at distinguishing between PTSD, borderline personality disorder, and depressive disorder in female patients. This causes a misdiagnosis of PTSD in female patients, and suggests that an assumption was made that veterans seeking treatment for PTSD would be male, despite females serving in the military at the time of its design. It is clear from the sex differences in PTSD cited in the literature that PTSD care is not a one-size-fits-all treatment, and instead needs to be more personalized on the basis of gender.

The design of this system by its constructors had a political means of construction – the constructors implemented this gender bias because of their own ideas and perceptions about women in combat. As a result, female veterans were excluded from this technology, because they lacked access to the same quality of care as male veterans did. I argue that after this system was put in place, it gained momentum and acceptance which created an environment in which people did not question what type of care was being given. The program became resistant to change, and was not being influenced by different social factors from the outside world, only those of the constructors. As the female veteran population grew, the VA's PTSD program did not take adequate steps to improve on its care services and provide acceptable care for female veterans. There is evidence of this in the goals of the Special Committee that were established when it was being created. The committee had no connection or responsibility for patient care, and this lack of accountability enabled the special committee to remain oblivious to the barriers to care that female patients were experiencing. There is also evidence of the resistance to change from the study of PTSD clinic directors, many of which gave responses to a survey which indicated that several providers within the VA were not open to adopting new PTSD treatments, even when there was scientific evidence showing they were effective. Even with the vast amount of published information about sex differences in PTSD, the climate that was created within the PTSD care program, which is reflected by this survey, is reluctant to change its ways even when scientific evidence is present.

This reluctance to change or adopt new ways, as well as the PTSD Checklist which has the potential to misdiagnose female veterans, can be classified as reverse salients in this system, elements that are preventing the system from achieving the goal of providing sufficient PTSD care to male and female patients. Until the staff of the PTSD care clinics are willing to accept evidence-based treatments and begin to adopt them into their care programs, the PTSD care program will not be able to achieve the goal of providing care to all veterans. Likewise, the use of the current PTSD checklist puts female veterans in a place where PTSD is often misdiagnosed. Until a more robust metric can be developed, female veterans will continue to to be misdiagnosed with PTSD. Based on this evidence and analysis, a strong argument can be made for the continued gender bias in the PTSD program being a result of societal and stakeholder view about women serving in combat which constructed the VA and its future programs.

In bringing to light the power that the stakeholders had over female patients by constructing a program that discouraged them from seeking PTSD care, ethical concerns arise. Drawing on the STS theory of Banality of Evil, the environment created within the VA's PTSD care program seemed to be normal, and the employees and workers were unaware of their actions in discouraging female veterans from seeking PTSD care. The factors that played into the discouragement of female veterans from seeking care for PTSD were being done by the medical staff providing treatment, however they were not aware of the gender bias that had been in place in the institution. Evidence in the interviews with PTSD directors in which they admitted that staff was often unopen to change or altering the care plans, and the way that the program's special committee was separate from patient care suggests that there was an absence of thinking about the actual PTSD care being provided, and whether it was effective for all groups of users. Because of this, the gender bias in the program was an outcome of an experience or situation that the staff perceived as ordinary, because of the way the staff had been conditioned to resist new ideas about treatment, which stemmed from the social and political ideas of the original stakeholders, and the setup of the organization.

By analyzing evidence about the design and implementation of the PTSD program, it is clear that social factors about women's involvements and capabilities in combat constructed the care program in place at the VA. The stakeholders who created this program and served on the special committee dominated the standards of the program, implementing a system with a gender bias that has continued to be a barrier to female PTSD care today. It is clear from the data analyzed that PTSD treatment is not one-size-fits-all, but is rather a sociotechnical system that requires treatments backed by scientific evidence, and social support from peers and healthcare providers. The data suggests that the environment within the PTSD program is resistant to change, and one that caters to the treatment of male patients due to an absence of thinking about the social factors that were implemented in this program. Until this environment within the VA can change, employees and providers will continue to unknowingly discourage female veterans from seeking PTSD care.

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