5-1-1999

Sexual trauma: a case study

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SEXUAL TRAUMA: A CASE STUDY

Although much research has been done on group therapy and the male veteran, little attention has been given to female veterans in groups. Because of this, the researcher examined the extent to which an intervention based on group therapy decreased nightmares in a female veteran who was raped.

Using a single system AB design, over a fourteen week period, with the baseline and intervention phases each consisting of seven weeks, group therapy was used in the intervention phase to determine whether traumatic nightmares could be reduced. The veteran was selected because of the numerous times she had experienced nightmares during the week. Analysis of the result revealed that the intervention was not effective in reducing nightmares. Implications for these findings for future research and social work practice are discussed.
ACKNOWLEDGEMENTS

First and foremost, I would like to thank my Lord and Savior, Jesus Christ. Thank you for "opening the door and not letting me fall through." To my family: my mom, Annie Evans, thanks for being my number one fan; my husband, Kenneth, bless you for being so patient; my daughter, Brianna, you will always be my shining star. To my big brother, SFC Willie Lewis, thank you for letting me "be all I can be." To my dearest friends, Micki, Tameka and Felecia, thanks for all the cheerleading. To my mentors, Evelyn Wynn Dixon and Frank Nelson, may God bless and keep you always.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Significance of Study</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Purpose of Study</td>
<td>4</td>
</tr>
<tr>
<td>II.</td>
<td>LITERATURE REVIEW</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Therapeutic Stages</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Profile of a Sexual Trauma Female Veteran</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Group Therapy with Trauma Victims</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Research Questions and Hypothesis</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Theoretical Framework</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Definition of Terms</td>
<td>25</td>
</tr>
<tr>
<td>III.</td>
<td>METHODOLOGY</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Setting</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Design and Sample</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Measurement</td>
<td>31</td>
</tr>
<tr>
<td>IV.</td>
<td>RESULTS</td>
<td>32</td>
</tr>
<tr>
<td>V.</td>
<td>DISCUSSIONS AND IMPLICATIONS</td>
<td>38</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>Letter of Consent from VA Medical Center</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Thank You Letter to Participants</td>
<td>42</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td></td>
<td>43</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Record of Attendance at Group Sessions</td>
<td>35</td>
</tr>
<tr>
<td>2. Decrease in the Number of Nightmares Per Week</td>
<td>35</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table                                                                 Page
1. Decrease in the Number of Nightmares Per Week........36
2. Record of Attendance at Group Sessions.................37
Despite twenty years of public attention, the incidence of rape increases annually and our response to the victim remains largely unchanged. There are 100,000 rapes reported every year, which are only a hint of the actual number. Every hour in the United States, sixteen rapes are attempted and ten women are raped (Gamble, 1991). A look at the statistics reveals a chilling reality: 11 percent of women are raped by strangers, 25 percent by acquaintances, 21 percent by casual dates, 20 percent by steady dates, and 9 percent by family members. Rape continues to be the single most under reported major crime. Our society still vehemently denies the frequency of rape and persists in blaming victims for supposed carelessness, provocative behavior, and poor judgment. When the victims turn to professionals for help, their character and their morals, even their style of dress, are called into question (Madigan & Gamble 1991).

The problem of sexual assault presents a challenge to women serving in the military. At the Tailhook Association meeting in September 1991, Navy Aviators surrounded unsuspecting female guests, including 14 female officers,
and passed them down a "gauntlet," grabbing at their breast and buttocks, attempting to strip off their clothes while other aviators were cheering and taunting (Department of Defense 1992).

In 1995 a former school drill sergeant was found guilty of 18 to 19 counts of rape, 12 counts of indecent assault, one count of forcible sodomy, two counts of consensual sodomy, two counts of communicating a threat, three counts of cruelty and maltreatment of a subordinate. The drill sergeant used his power, access and control to rape six trainees and mistreat and abuse 16 others, over a 20-month period (Department of Defense 1995).

The movie "Casualties of War" presents a case of rape and assault during the Vietnam War. It indicates that some of the same military attitudes of power and justification of female victimization still exist today. In this movie, a platoon captures a young Vietnamese woman and several men in the platoon rape and physically abuse her. Some of the men in the platoon justify their actions by saying that death may be imminent and they should enjoy sexual release even if it means the subjugation of a woman. Another attitude portrayed in this movie is that all Vietnamese are enemies and they should be punished for the loss of American lives. Some of the men in this platoon are intimidated by their superior into following orders to rape and abuse female captives. They go against their own moral code to obey
authority and to be considered one of the boys (Brownmiller 1991).

Rape has a long history in the military, in medieval times, before women were allowed to join the military, opportunities to rape and loot were among the few "advantages" open to common foot soldiers. It was frowned upon by the more civilized kings and generals to the point of establishing a Code of Conduct, governing the behavior of male soldiers (Newman, 1994).

Why do rapes occur frequently in the military and are never reported? In basic training, the military brainwashes recruits in obeying the orders given to them. The concept of submissiveness is encouraged, assertiveness is not allowed, and authority is idealized. The military is viewed by the old guard as a man's arena. Women, according to the conservative view, should not serve in the military as soldiers but as support personnel or sex objects (Taube, 1990). Some men are angry that women have been allowed and encouraged to join the military (Brownmiller, 1991). Others feel as though women are not as competent as men, and some men are threatened by women's competence. Military cover-ups to protect the public image of the armed forces include social issues ranging from racism, an homophobia to sexism. Movies such as "Causalities of War" and national headlines of Tailhook gives a general view of how the armed services handles manifestations of sexism (Dancy & Defazio, 1994).
While military cover-ups regarding rape no doubt still occur, one encouraging factor is that today some perpetrators of rape who are in the military have been prosecuted both in public trials and in military trials (Department of Defense 1996). Veterans services to respond to women cohorts victim of sexism manifested in the form of rape.

**Significance of Study**

This practice based research is a case study of a victim of rape in the military. The intervention results will be useful to supervisors and clinical therapists who work with rape victims and in developing programs geared toward the sexual traumatized female veteran population. What services are in place now for the veteran? And what other services are needed?

**Purpose of Study**

Using a single system design, this study will evaluate the impact of group therapy with a sexually traumatize female veteran, suffering from PTSD.
CHAPTER TWO

LITERATURE REVIEW

The number of veterans who have been sexually assaulted and suffer from psychological problems are increasing. Studies show the number of these veterans have more than doubled over the past ten years. In 1982, there were about 740,000 women veterans; by 1996, that number had almost doubled to over 1.2 million. It is expected that by 2010, the number of women veterans will increase an additional 7 percent to 1.3 million, which would represent 6.4 percent of all veterans. Thus, it is possible that more women veterans will be diagnosed with PTSD and other mental health problems related to sexual trauma (Backhus 1998). Given that the large number of women veterans receiving sexual trauma counseling has quadrupled, from about 3,350 to about 10,000 between fiscal year 1993 and fiscal year 1998, research indicated that intensive case management and an aggressive outreach program is vital to gain a working knowledge of not only treatment programs that work, we must understand what causes trauma and what factors relate to successful treatment for this population (Neale & Rosenhach 1993).

The review of literature revealed a variety of programs and treatment modalities aimed at helping a sexually
traumatized veteran. Although various tools were used in order to bring about change, the researchers felt it was imperative that we also examine the characteristics, and the indicators of sexual trauma population.

The literature suggests a consensus among researchers that sexually traumatized female veterans have an increased likelihood of poor self-reported health, and utilization of medical services. In a study conducted by Koss and Golding (1994), sexual trauma veterans compared to non-assaultive veterans, reported poorer physical health and more physical health symptoms. Victims also showed increases in physician visits after victimization, relative to before victimization. A study by Paula Schurr (1996), focusing on sexual assault agreed with Koss and Golding that assaulted veterans were more likely than non-assaulted veterans to report a wide range of physical symptoms, both those that could be explained and those that could not. Assaulted and non-assaulted veteran did not differ in the likelihood of reporting at least one chronic disease, although reports of several diseases were higher among assaulted women (Schurr 1996).

The effects of trauma and PTSD are difficult to interpret in studies of female prisoners of war because of the injury and illness directly related to imprisonment. Friedman and Wolf (1996) found that there is good evidence for increases in self-reported poor health and service
utilization following exposure to trauma. Their study concluded, PTSD is the likely cause for a substantial part of the observed association between trauma and adverse health outcomes. A study by Wolf (1996), of female Vietnam veterans illustrates the "doing War-zone exposure and PTSD, by themselves, were associated with self-reports of poor health and numerous physical problems. But when both exposure and PTSD were simultaneously treated as predictors, the effects associated with exposure substantially diminished, whereas the effects associated with PTSD remained virtually unchanged." Path analysis of two of the primary outcomes (self-reported poor health and number of health problems) found that 50-70% of the effects of exposure were mediated by PTSD (Friedman & Wolf 1996).

Individuals with a primary diagnosis of Post Traumatic Stress Disorder, can be diagnosis terms of two main factors: the intrusion of painful, unacceptable recollections of the actual events of the trauma, and the characteristic defenses that the person develops to ward off these recollections (American Psychiatric Association 1994). Recollections can take a number of forms; the most common are (1) intrusive thoughts related to it, and (2) nightmares, in which events of the trauma are re-experienced, often in vivid detail. The pattern of nightmares tend to be episodic, showing a sharp increase during times of stress or the approaching anniversary of the traumatic event. A characteristic
pattern of sleep disturbance nearly always follows a psychological traumatization, even if the individual does not report having nightmares. The pattern manifests as a difficulty in going to sleep initially, and remaining asleep thereafter. It is not unusual for the individual to use alcohol or drugs as a means of "self-medicating" for the sleep disturbance. This is dangerous, since there is frequently a "rebound effect" in which nightmares become even more intense (American Psychiatric Association 1994).

Intrusive recollections are less predictable than nightmares, partly because environmental stimuli are as likely to trigger them as are internal states of mind. Intrusive recollections are generally of brief duration, and in most cases the persons remains in touch with reality. More prolonged dissociative states, commonly referred to as "flashbacks," are generally symptomatic of more severe forms of traumatization (e.g.; physical brutalization, torture, incest). Regardless of the particular circumstances, dissociative flashbacks should be considered as a serious PTSD-related condition (Archibald 1998).

Trauma victims inevitably experience waves of powerful emotions when remembering or dreaming about the event. To cope with their anxiety around re-experiencing the trauma, these individuals often become "counterphobic" in an effort to avoid any situations that might remind them of the traumatic event. In individuals with chronic PTSD, such
counter-phobic behaviors, develop into a generalized withdrawal from, and diminished responsiveness to their environment (APA 1987). Conversely, the person may actively seek out situations similar to that which led to the trauma. According to Borros and Bourne (1990) the pattern can be found in Vietnam Veterans. The veteran an ex-infantryman will join a SWAT team; a nurse will take a job in the emergency room of a busy inner-city hospital. While there is some element of conscious choice in these behaviors, in individuals with PTSD there is generally a strong unconscious component maintained by the person's need to defend against anxieties or guilt feelings associated with the traumatic event (Horowitz 1988).

The Dancy and Defazio (1994) study also found that in individuals with more chronic or compound cases of PTSD, it is not unusual for the individuals to present with only the defensive symptoms characteristic of the "avoidance/denial phase" of this disorder. Characteristically, they will deny or downplay any connection between the traumatic event and their present problem, sometimes in the face of obvious evidence (e.g.; repeated avoidance of, or depressive or angry reactions to stimuli that remind them of the trauma). Even if they do admit to a connection, they may steadfastly, maintain that "talking about it can't change anything." If the traumatic event is brought up, the person either talks in vague generalities or describes what happened with a
complete absence of emotion. More often than not, the person will come in for treatment as a last resort, and only after considerable pressure has been brought by a family member or employer to seek help.

A final symptom that is helpful in the differential diagnosis of PTSD is fear of loss of control. Most individuals with PTSD fear being overwhelmed by the powerful images, emotions, and impulses evoked by the traumatic event (even though they may not connect these fears with the trauma). Because individuals with a primary diagnosis of PTSD tend to view themselves as responsible for their thoughts and actions, they find these autonomous impulses and emotions (e.g.; violent urges for revenge, returning feelings of helplessness as a victim, rage at the injustices of life) particularly disturbing. To ward off these unacceptable impulses and thoughts, these individuals frequently develop maladaptive, "over-controlled" patterns of behavior designed to "protect" themselves and others. In suppressing the urges and emotions connected with the trauma, the victims tend to suppress all forms of affect. Thus when these powerful emotions finally are expressed, they tend to be explosive and out of character (Edgenford 1990).

Post Traumatic Stress Disorder, however, does not occur in a vacuum. Every traumatized individual has a "pre-trauma personality," whether healthy or otherwise. PTSD is
frequently seen in otherwise normal individuals, but of course people with pre-existing mental disorders are at-risk for traumatizations as well, and their pre-trauma disorders can greatly complicate diagnosis and treatment (Edgenford 1990).

PTSD usually needs to be treated, at least initially, in an inpatient setting. Veterans with severe stress disorder are frequently impulsive, self-destructive, and/or addicted to one or more substances. After stabilization and detoxification, they may be prepared for one of the growing number of Veterans Administration inpatient treatment programs specifically for veterans. The prognosis for these veterans is guarded; many make great progress while in the inpatient program, but rapidly deteriorate when they return to their previous maladaptive support systems. The pre-existing condition will resurface with veteran, once he or she leaves the program. Coordinated outpatient follow-up, preferably through a Veteran Center (or contact provider designated by the Veteran Center) is vital if the veteran is to make a successful re-entry into the community. While many claims have been made for the short-term alleviation of PTSD symptoms in veterans, research indicates that PTSD requires longer term treatment—a year or more (Eisenhart 1997).

Some research suggests that there are no factors that separate assaultive female veterans, from non-assaultive
female veterans. While trying to determine exactly what
caus ed a female veteran to become sexually assaulted, John
Escobar and Barbara Litz (1997) found that compared with
non-veterans, female veterans were younger, vulnerable,
better educated and white. In general, these veterans
differ from non-veterans on any indicator of current social
functioning, physical health, mental illness, or substance
abuse.

Although sexually assaulted veterans were found to be
better educated and had been married in the past, these
advantages did not appear to protect them from sexual
assault. Self-defense and rape prevention instructors
repeatedly hear that sexual assault does not happen to
"women like us." Women often claim that they are married
and their husbands will protect them, or that they do not
put themselves in "that kind of situation," so they are not
in danger (Erikson 1988). Women and men often believe that
anyone who is sexually assaulted "was asking for it" in some
way; that the victim brought it upon herself and was
responsible for her own victimization. This false belief
system ("it can't happen to me") is the way in which most
women protect themselves, both from having to face the
horror of sexual assault or the responsibility of learning
prevention (Shapiro 1992).
Factors that place veterans at risk for sexual assault tend to be about the same for the general population, what is unique to a sexual trauma veteran is her military service. Military service introduces psychological socialization, in which recruits are commanded to obey, these factors play a role in creating an atmosphere of accepting the commands and denial among servicewomen of sexual assault (Shapiro 1992).

The victim experiences the trauma and its disruptions in all areas of her life physically, socially and psychologically. Holding on to a dark and loathsome memory can wreak havoc on one's entire being. Denial and suppression of feelings may result in the pelvic pain, pain during intercourse, and even migraines. In an effort to manage the emotional pain, individuals may abuse food and/or drugs and or alcohol. Substance use/abuse and eating disorders become a way to regain control and numb the pain (Wenzel 1993).

The victim often becomes more attentive to her surroundings and protective of her own personal space. She may become hyperalet, startle easily or burst into tears if frightened, even for "no apparent reason." Feeling constantly at risk and vulnerable to attack is physically taxing, and the stress of living that way often is seen in physical signs and symptoms. The emotional/psychological impact of the assault creates a number of problems. The
victim may experience sleep disturbances. She may have difficulty falling asleep; she may awaken at the time the rape occurred; she may have nightmares. If she was raped in her own bed, it is very likely that she will be unable to sleep there. Women have sold their furniture, moved from their home, burned clothing, slept with a weapon, slept with a night light on, asked friends to stay with them or asked to stay with friends. These responses are not over-reactions. In the mind of the victim, the rapist is omnipotent. The victim fears he may "slither" through the woodwork to get her (Futterman 1994).

Another common manifestation of psychological trauma is the "flashback." Flashbacks occur with some frequency for sexual assault victims. These are waking memories of the violence, wherein the victim is unable to distinguish what is real: she sees before her the scene she is recalling. It has all the makings of a psychotic break; however, it is short-term, temporary, and memories evoked are of the specific trauma (Newman 1994).

In aiding a person through her healing process, it is important to begin where she is and to understand her world. To have knowledge of the specific trauma is important, but to have information about the individual's interpretation of that trauma is essential. The stages are meant only as a "guide" for treatment. Some individuals have reported that they went through all of the stages in two weeks.
Generally, it will take about eight months to move through all six stages, the goal is to assist the person in her healing. The individual is moving through a three-step process. First, she identifies herself as the victim: "I am a victim of sexual assault." Second, she acknowledges that the healing has begun by stating: "I am a survivor." Third, the healing is moving toward completion. It is not enough to have "survived," she wants more: "I was a victim." In the course of treatment for sexual assault victims, six therapeutic stages have been identified.

Therapeutic Stages

Stage One: Denial

Denial begins during the ordeal of the sexual assault in the form of "this isn’t really happening to me." In more than 1,000 interviews conducted at the Veteran Center, sexual assault victims consistently describe themselves during the assault as if they were watching themselves from a distance of three or four feet. Once the assault is over they look back at it from the distance they imposed in an attempt to convince themselves that it did not really happen. During this stage, it is important that the individual talk about in detail, what happened. She allows herself to speak the horrible words that lend reality to her nightmare. As this occurs, her fear level will heighten, she will become more in touch with her pain, and she will
experience relief; she will understand that there is a reason for this confusion/disorientation.

Stage Two: Catharsis

At this point, she begins to experience some catharsis. It can be a tremendous relief for her to begin to identify and clarify her emotions and for her to receive validation for those emotions. She is experiencing some relief from her initial symptoms. The goal of this stage is to assist her in discussing what happened and in recalling detail as she is able to handle it.

Stage Three: Guilt

The third stage is the "point of guilt": She feels responsible for what happened to her. It is an inadequate coping mechanism, one that one-hundred percent of the women interviewed at the Veteran Center have reported experiencing. Blaming herself is a way for her to feel power and control over what happened to her. Group therapy is a very powerful setting for confronting one's own guilt. The victim hears other women blaming themselves and is able to see their faulty analysis. Once she begins to let others "off the hook," she will soon relate it back to herself.

Stage Four: Loss of Control

Once the victim has dealt with most of her feelings of guilt, she is faced with the fact that she had absolutely no control over what happened to her. As this occurs, she
begins to move into the fourth stage of her process, the loss of control. This is the point at which her tears really begin. During this stage, pain and losses are being grieved, guilt feelings are being resolved and new questions are arising. As she stops criticizing herself, she begins to examine her view of the world.

Stage Five: Anger and Rage

As she realizes she was not protected from the violence, she becomes outraged. Anger in stage five is the healing process. She asks: Why didn’t someone tell me about this? This stage is marked by rageful feelings. She will need assistance in healthy directions for these feelings.

Stage Six: Integration and Acceptance

As she moves towards the end of this stage, a calmness begins to be noticed. She begins to feel more comfortable, more in control, and less need to control. In the sixth stage, she integrates and accepts the experience. She has learned to manage her fear, to use it to move to anger, then into action. Her anger is less reckless, more clearly directed. She has taken a horrible, violent, painful experience and turned it around to make herself more powerful, stronger, and self-reliant (Glass 1996).

Although only a handful of outcome studies have been published, all have suggested that participation in specialized clinical programs can facilitate movement of
some other occurrence caused the particular outcome (Taube 1990). Overall the literature review revealed that sexual traumatized females suffer from PTSD. The researcher’s case study will focus on a female veteran who was raped in the military and who presents the symptoms of PTSD.

Profile of a Sexually Traumatized Female Veteran

This case focuses on a female veteran who was raped while in the military. The veteran is 36 years of age, white, a high school graduate and single with no children. Client will be referred to as Ms. V.

This female veteran joined the military at eighteen, because "it seemed like a good idea." It was a way to get some training, see the world, and grow up and get away from home. Ms. V. states, "Before the plane had landed, other recruits were telling horror stories about what they had heard was in store for us. We hadn’t even stepped off the overloaded elbow-to-eye and armpit-to-nose bus when a deep, horrifying voice was scaring everyone. I was terrified. I knew I was no longer my own person but belonged to the government."

Ms. V learned what to do and what not to do, during basic training. Ms. V states, "If the drill sergeant said, 'Speak,' I spoke; if he said 'Jump,' I asked how high; if he said, 'Get down,' I got down fast. I soon learned that signing that paper and raising my right hand meant giving up myself to the man who wore the sergeant’s stripes."
Ms. V passed basic training and was sent to another base for special school. The school was an eight-week course, but veteran’s stay turned out to be six months of no school and as Ms. V states, "A living hell."

During the fourth week of school Ms. V states, "I was moving at a fast pace, but for some reason I was unable to satisfy the sergeant in charge of the course. He was always finding something wrong with my projects, he told me, 'If you scratch my back, I’ll scratch yours, and maybe you’ll get out of here faster than the others.'" Ms. V wasn’t sure what he meant, and the thought crossed her mind that maybe he meant a sexual gesture but didn’t want to believe it.

Ms. V contends that during cleanup, the sergeant assigned her to clean up the ladies room. Upon arrival veteran realizes that the bathroom was not in use, and turns to walk out but is greeted by her sergeant who tells her to lock the door. Ms. V states, "I asked why, and he said, 'If you ever want to get out of here, lock the door.'" The sergeant then ordered Ms. V to unbutton her pants. Ms. V states, "I begged him not to do this to me and wouldn’t unbutton my pants." The sergeant became aggressive with Ms. V shoving her against the wall and ripping her pants open. Ms. V’s neck was held against the wall by the sergeant’s hands and he penetrated Ms. V between her legs.

Ms. V states, "I was numb, and didn’t feel him penetrate, he told me to just walk out of there calm and act
like nothing happened or he would tell everyone he was disciplining me and I cried rape." He told her to join the others, and she started picking up cigarette butts. Ms. V states, "I felt numb, like none of this had really happened, then a few hours later, he was leading a formation, and kept looking at me."

Ms. V returned to her barracks, where everyone was chatting and getting ready to go to lunch. Ms. V states, "I felt sick and just kept walking around trying to figure out what to do." Ms. V confided in her squad leader about the rape, noting that, "It felt good to tell someone." The squad leader told the commanding officer who confronted Ms. V. Ms. V states, "I lied and told them that a black man had come out of the woods, held a knife to my throat, and raped me in a little shed by the edge of the woods." Ms. V contends she was driven to a hospital many miles away from her assigned base, made to dress in civilian clothes and was not allowed to call her mother.

Ms. V states, "My story got more and more complicated, and I knew I was in deep shit when they investigated the shed that I said he had raped me in and they found bloodstains there. Since I had no punctured wounds, I became highly nervous about my story. Later it was discovered that a maintenance man had cut himself and left bloodstains. My story was inconsistent, and I began to get more and more uneasy with the lies. I cracked and told the
truth after being awakened in the middle of the night at 2 or 3 a.m., by the interrogation." The military police suggested to Ms. V that sex was consensual and discovered she was pregnant and yelled raped. Ms. V was told little about the investigation, but was reassured that the sergeant had been shipped off the base and she wouldn’t have to see him again.

Ms. V was told the sergeant was not pleading guilty and that the one piece of convincing evidence from the medical examination revealed some of his pubic hairs were caught in the buttons of Ms. V’s pants. There was also evidence of forced penetration, since veteran had not engaged in any sexual contact for months previously.

Ms. V states, "the case was closed, he kept changing his story and failed a lie detector test three times, so they discharged him from the military service. I don’t know what really happened to him or where he is. He knows my name, and I have this fear that he might look me up and kill me because I told. After all, maybe I ruined his career." Ms. V continues to have nightmares about the rape, and is seeking services to cope with the nightmares. Veteran began group therapy September 11, 1998.

The multiple factors surrounding the rape and investigation were obtained in the initial interviews. In addition, Ms. V reported feeling depressed, having anger and hostility towards family members and poor eating habits.
Ms. V revisits the rape during the nightmares in which she finds herself fighting off rapists, being attacked by enemies and fleeing from her rapists. The symptoms Ms. V presents warrant her participation in group therapy. Ms. V seeks to decrease nightmares and regain her power.

Group Therapy with Trauma Victims

Specialized groups are generally seen as a treatment of choice for victims of trauma (Herman and Scharlow 1990). A time limited sexual abuse focus group, used in conjunction with individual psychotherapy, can be quite effective.

The group, which meets three times a week for approximately fourteen weeks, is based on the model described by Herman and Scharlow (1990). It is a problem-solving group focused on cognitive restructuring of the sexual violence from a feminist perspective and exploration of psychodynamic issues secondary to the abuse. It is intended to demystify the powerlessness experienced by sexually traumatized females.

After each group member has told her story, several weeks were devoted to prominent themes that group members have in common, such as anger, sexuality, or relationship with the offender. Participants are asked to give feedback associated with the theme; the attention during the intervening week tends to enhance the quality of feedback brought to the sessions.
Through group disclosure Ms. V will be able to confront and shed those feelings of alienation and humiliation. Sharing traumatic experiences fosters a reevaluation of her perception of herself as deserving abuse.

Research Questions and Hypothesis

Based on the foregoing literature review, theoretical framework and the general purpose of study, below are the research questions and hypothesis of this study.

Q1: To what extent will a veteran with Post Traumatic Stress Disorder decreased her traumatic nightmares during an intervention consisting of group therapy.

H1: It is hypothesized that at the completion of the intervention of group therapy, the veteran will decrease her nightmares by participation in group therapy sessions.

Theoretical Framework

As discussed previously in this paper, many factors make up the whole, of many given situations. The female veteran is no exception to this point; many parts and many systems make her a "whole" being. Thus, this study emerges from a system theory perspective. In systems theory the emphasis goes beyond the presenting problem of a person or
situation and extends to assessing and exploring the interrelatedness of problems, building from concepts such as wholeness, relationship and homeostasis.

It is only after one understands the complexity and multifacetedness of problems, that effective methods of intervention may be implemented. In the case study best internal and external systems are involved however attention is focused on internal changes to empower one to cope with the external environment. Also, it is discussed how PTSD may present itself in different forms, with the worst effect being nightmares.

Definition of Terms

The following terms will be utilized for this study.

Veteran: Male or Female who served in the Armed Forces.

PTSD: Post Traumatic Stress Disorder diagnostic criteria includes a history of exposure to a "traumatic event" and symptoms from each of three symptom cluster: intrusive recollections, avoidance/numbing symptoms and hyperarousal symptoms. Trauma - an event conceptualized as a catastrophic stressor that was outside the range of usual human experience.
CHAPTER THREE

METHODOLOGY

Setting

In 1993, the Department of Veteran Affairs initiated a comprehensive sexual trauma counseling services at all of its 172 hospitals and 62 of its 206 Veterans Centers. Four of the VA hospitals offer specialized trauma counseling programs through Women Veterans Stress Disorder Treatment Teams. These counseling programs provide care to women veterans who have been more severely affected by their traumatic experiences. VA has also conducted a number of outreach efforts to increase staff awareness and inform women veterans about available sexual trauma counseling. These efforts have included segments on a national television program and letters to women veterans. Finally, to facilitate accessibility to sexual trauma counseling, the VA has provided a toll-free number for women veterans to obtain information about available counseling services and has designed women veteran coordinators at medical facilities and Veterans Benefits Regional offices to assist women veterans in obtaining these services (Department of Defense 1993).
VA offers sexual trauma counseling services at all of its 172 hospitals. Within VA hospitals, sexual trauma counseling is available in the mental health clinic, psychiatry department, psychology department, or both—or in the women's clinic. Sexual trauma counseling is generally provided both individually and in-group counseling sessions. Four of the VA hospitals—Boston, Massachusetts; Brecksville, Ohio; Loma Linda, California; and New Orleans, Louisiana also have Women Veterans Stress Disorder Treatment Teams, which are specialized programs that provide sexual trauma counseling.

To help ensure that these veterans receive the counseling care and services they require, the Congress enacted the Veterans Health Care Act of 1992 (P.L. 102-585), which in addition to authorizing new and expanded health care services, authorized VA to provide sexual trauma counseling for women veterans through 1994. The sexual trauma counseling provisions of this act were amended by the Veterans Health Program Extension Act of 1994 (P.L. 103-452), which extended sexual trauma counseling care services to all eligible veterans, not just women, through December 2000 (Department of Defense 1995).

This case study will be conducted at the local Veterans Administrative Hospital in Decatur, Georgia. The hospital has over five services specifically addressing various problems of female veterans. The sexual trauma center
follows the psychotherapy model in which individual and group therapy counseling are provided. It is in this center that the researcher engaged in treatment of a female veteran.

Design and Sample

This research is based on a single system design. This veteran was selected because of the numerous times she had experienced nightmares. The AB design was selected due to its suitability for direct practice, the provision of a baseline from which improvement may be measured, and for the high degree of internal validity it offers.

Ms. V should attend group therapy three times per week for fourteen weeks, from 12-1:30 p.m. for treatment. Ms. V nightmares were severe enough that she avoided sleep, instead stayed up all night watching television. The measurements of change are twofold: (1) record of attendance at group sessions; (2) decrease in the number of nightmares per week. The reconstructed baseline data collected will be data over a seven-week period. By using the group attendance log, the total number of sessions that were attended will then be recorded by the researcher.

The intervention phase was over a seven-week period. The researcher will collect data at the end of each week. The researcher will then record the total of sessions that
were attended. The intervention will take the following form:

Week One

Discuss PTSD with the veteran, the symptoms of PTSD, the benefit of group, and the importance of taking any medication prescribed by doctor to offset symptoms. Discuss issues of commitment, confidentiality and the effect that change may have on her mental status. Ms. V reports she had five nightmares this week in which she is fighting off her attacker.

Week Two

Do a family session with the veteran and her immediate family. Have discussion about their expectations and attitudes about group therapy. Provide alternative strategies for coping with nightmares both for veteran and other family members. Discuss the importance of themes within the group setting. Reports someone is chasing her, nightmares five times this week.

Week Three

Trusting others and self will be the theme for week three. Pair the veteran with a veteran on similar background. This veteran attended group and was able to alleviate her nightmares. Start a buddy system with both veterans, to remind each other of group meetings. The veteran will begin focusing on how she sees herself, and
what needs she has such a social support. Ms. V report four nightmares and is giving as assignment to keep a journal of activities before she goes to bed.

Week Four

Revisiting the trauma will be the theme in week four. Specific issues of trauma and recovery are addressed, such as survivors unrealistic self-blame for what has occurred. Ms. V reports only four nightmares.

Week Five

Moving forward is the theme for week five. Meet with veteran on an individual basis to discuss her feelings so far about the group and to prevent relapse and to allow for extensive relapse prevention planning, as well as to address behaviors, which lead to relapse. Ms. V reports four nightmares in which she is drowning. Ms. V haven’t been able to keep journal entries.

Week Six

Bringing closure is the theme for week six. Veteran discusses nightmares in treatment setting; veteran demonstrates understanding of nightmares as a way for the mind to integrate trauma memories into her view of self-world. Ms. V reports three nightmares.
Week Seven

Responsibility will be the theme for week seven. Draw up contract with veteran and the sexual trauma clinic. Veteran and social worker will be authors of the contract. The contract will be based on the veteran's responsibility to the clinic and vice versa. Ms. V reports having four nightmares.

After an intervention period of seven weeks, data will again be collected over a seven-week period. The records will be observed and then data will be analyzed. The effects of group therapy will then be evaluated.

Measurement

The veteran's nightmares, the dependent variable of the study, were measured by the number of sessions the veteran attended the quality of participation, talking about the rape, identifying and clarifying her view of self and world and the integration and accepting of experience.
CHAPTER FOUR

RESULTS

In this research study, descriptive statistics and chi square were used to analyze the study variables. To determine whether to accept or reject the hypothesis of the study, an alpha level of .05 was used.

Figures 1 & 2 reveal descriptive statistics and pattern of non-participation and no decrease in the incidence of nightmares for the study period. During week one and two the baseline phrase, the veteran had 100% rate of participation and a high incidence of nightmares. The veteran attended the medical center, three days each week, in which the veteran participated the most. During week three, the veteran attended the clinic only two out of a possible three days and reported only four nightmares. The veteran attended the medical center three out of a possible three days during week four and five, which was a 100% rate of participation and experienced four nightmares each week. During week six, the veteran attended the medical center two out of a possible three days reported three nightmares. During week seven participation went back up to three days in which veteran reported four nightmares.
The intervention phase started during week eight. The veteran was present for group two days during week eight in which she reported two nightmares. The figure shows that in week nine, she participated 100%, reported four nightmares but during week ten she attended only two times and reported three nightmares. She participated 100% again in week eleven and reported two nightmares. For weeks twelve through fourteen, there was a pattern of being present for two days reporting four nightmares and in week fourteen, two days and reporting three nightmares.

Table 1 shows the results of the cross tabulation analysis of no decrease in the incidence of nightmares. Of the seven observations in the baseline phase, .64 represented decrease in nightmares and 4.14 represented an increase in nightmares. For the treatment phase, the low was .83 and 3.14 represented a high incidence of nightmares.

Table 2 shows the results of the cross tabulation analysis of participation by phase type. Of the seven observations in the baseline phase, .45 represented low participation, and 2.71 represented high participation. For the treatment phase, the low was .49 and 2.43% represented high participation.

The probability of level for Fisher's exact test indicated that there was no difference in participation between the baseline phase and the treatment phase. Therefore, the hypothesis that states there would be a
significant difference between the level of participation in the baseline phase and a decrease in nightmares in the treatment phase is rejected.
Figure 1. Record of Attendance at Group Sessions

![Graph showing attendance over weeks with peaks and troughs.]

Figure 2. Decrease in the Number of Nightmare Per Week

![Graph showing decrease in nightmares over weeks with a downward trend.]

Table 1. Decrease in the Number of Nightmares Per Week

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Table 2. Record of Attendance at Group Session

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CHAPTER FIVE
DISCUSSIONS AND IMPLICATIONS

The major finding of the study was that an intervention of group therapy did not decrease the veteran's nightmares. The intervention was assumed not to have worked, there were many factors that presented the veteran from being present for group. Many times the veteran did not have transportation or the money for transportation.

It is believed that the importance of group participation was realized between the researcher and veteran, when veteran seemed aware of the state of health, in regards to the nightmares, and the importance of being present for group therapy. However, the veteran felt hopeless about her circumstances. She felt that if she had a job she would be able to afford a car or take the train to the medical center.

The length of the observation period (fourteen weeks) was another possible reason why the intervention did not produce significant changes. It would be more useful in the future to have a longer observation period in both the baseline and treatment phases. This would give the researcher more time to observe patterns in the veteran's participation and decrease in nightmares.
The study's findings are not inconsistent with other researchers' results that study the effects of group therapy and nightmares. In four reported studies on participation (Glass, 1996; Caton, 1990; Backhus, 1991; and Cobb, 1995), it was found that there was a significant decrease in a veteran's nightmares after group therapy was used as an intervention for PTSD. It is suggested that this is caused by the fact the veteran participation in group is determined not only by the knowledge of their illness, but also by factors such as transportation, family support, and their life circumstances (Dance and Defazio 1994).

This study's findings and implication for the micro level of practice, for all social workers, revealed that the practitioner could have individual weekly sessions with the veteran, prior to the veteran going to group. This could help to develop a trusting relationship with the veteran. The veteran would relate more to the practitioner, who in turn may be able to assist the veteran with factors that may be hindering participation. For example, referrals could be made before the treatment phase begins so the veteran could get transportation.

At the macro levels of practice, social workers could implement policies that would assist veterans who have factors that cause them not to attend group. The VA Medical Center staff could have a government van. This would help veterans who don't have transportation to group.
There are also implications for future research. As this study was a single system AB design, only having A and B phases, it does not have high internal validity. It would be more useful in the future to use true experimental designs or multiple single systems designs that include more phases and veteran groups to enhance the internal validity. Veterans and practitioners could think of ways to prevent a veteran for not participation. Veterans could help each other with external factors that may be hindering them from attending group. For example, another veteran may be able to offer a solution to one who is having a problem with transportation. Therefore, there are several recommendations for future research. They include 1) individual counseling; 2) family therapy; 3) veteran's education. There is definitely a need to expand further research on treating veterans in a group setting.
To whom it may concern:

Jacqueline L. Smith, a graduate student in Clark Atlanta University's School of Social Work, has been granted permission by the Readjustment Counseling Center of the VA Medical Center to conduct a study of sexual trauma and the female veteran. This study will be conducted during group therapy sessions on Mondays, Tuesdays and Thursdays for a period of fourteen days.

The data obtained for this study will be aggregated, analyzed and used solely for the purpose of thesis completion. If you have any questions about this study, please feel free to contact me.

Sincerely,

Linda Landry, LCSW

Readjustment Counseling Services
Dear Veteran:

This letter is to thank you, in advance, for participating in this study. This study will help all mental health care personnel in the field of Sexual Trauma to become more knowledgeable about treating female veterans in groups. All the information will be confidential and will not be used against you in any way.

Sincerely,

Jacqueline Smith
BIBLIOGRAPHY


