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Research report

Women's mental health clinic: A naturalistic description of the population attended in the San Diego VA Health Care System during a one year period

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ABSTRACT

Background: Due to specific gender predispositions to present certain illnesses, increasing incorporation of women in the U.S. military system represents an important challenge to both medical and mental health providers. The aim of this report is to describe the main characteristics of the population attended in a mental health women's clinic at the San Diego Veterans Administration (VA) health care system.

Method: Present study is a comprehensive clinical report based on a retrospective analysis of data. The authors searched the San Diego VA Health Care database to find the main epidemiological and clinical characteristics of the population attended during a one year period. Epidemiological and clinical features of the sample are presented. Authors also describe, using clinical examples, the most important psychopathological expressions.

Results: The most prevalent psychiatric diagnosis was major depressive disorder ($n=28$; 19.51%) followed by dysthymic disorder ($n=8$; 19.51%) and bipolar disorder ($n=3$; 7.31%). Authors discuss the importance of three variables: social isolation, quality of adaptive mechanisms and the role of self-stigmatization as crucial factors related to patient's clinical outcomes.

Limitations: The main limitation of this review derives from its naturalistic and descriptive methodology.

Conclusions: The majority of patients treated in our clinic experience some type of affective disorder. Main factors associated to recovery are: social integration and spiritual support, utilization of mature defense mechanisms and upper-level coping strategies and psycho-educational interventions directed to prevent self stigmatization. Clinicians should be aware of these factors in order to promote "upper-level coping strategies".

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1. Introduction

Gender-differentiated predispositions to certain illnesses are present in patients seeking medical and psychiatric care. From a mental health perspective, women have an increased risk for: major depression, bipolar depression, seasonal affective disorder and eating disorders (Parry, 1995). Furthermore, events associated with the reproductive cycle may induce affective changes in predisposed individuals such as those associated with the menstrual cycle currently known as Premenstrual Dysphoric Disorder (PMDD) (APA, 2004), depression associated with oral contraceptives (Parry and Rush, 1979), postpartum depression, and perimenopausal depression (Parry, 1995, 2008).

During the last decade, and as a result of social changes and political decisions, the role of women serving in the U.S. military continues to grow. By 2001, female representation in the U.S. military had increased to 15% of the active-duty enlisted force (Center for Military Readiness Policy Analysis, 2004; Office of the Assistant Secretary of Defense, 1998). Thus, the massive incorporation of women in the U.S. military system represents an important challenge to both medical and mental health providers. This population presents distinct vulnerabilities and psychopathological expressions when confronted with the demands of their duty. One study presenting the results of mental health screening data for 2882 soldiers seeking services at a military facility outpatient behavioral health clinic found that women in a military system were more prone to present the following diagnoses: major depression, anxiety, panic disorder and high amounts of hostility compared with men. The study also reported no gender differences in the risk of post traumatic stress disorder (PTSD) (Gahm and Lucerno, 2007). Another study (Riddle et al., 2007) described the prevalence of mental disorders in a U.S. military cohort that represents 11.3% of the 2.2 million men and women in service as of October 1, 2000. According to this study, populations at greater odds of mental disorders included younger, single women with less education and short-term service.

Abbreviations: PTSD, Post-traumatic stress disorder; GAD, Generalized anxiety disorder; NOS, No otherwise specified

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Another important issue to consider regarding the mental health care of military populations is the real or perceived stigmatization of mental diseases and the role of these beliefs as an important barrier in seeking psychiatric help. An interesting study in four U.S. combat infantry units before their deployment and after their return from combat duty in Iraq or Afghanistan revealed that only 23% to 40% of those participants whose responses were positive for a mental disorder sought mental care health (Hoge et al., 2004). This group was especially concerned about possible stigmatization. The main diagnoses based on screening criteria were major depression, PTSD, and alcohol abuse with significantly higher scores after deployment. With respect to the perceived barriers to seeking mental health services among participants who met screening criteria for a mental disorder, the most important concerns that they reported for their reluctance to receive mental health counseling were: (1) "I would be seen as weak" (65%), (2) "my unit leadership might treat me differently" (63%), (3) "members of my unit might have less confidence in me" (59%), (4) "there would be difficulty getting time off work for treatment" (55%), (5) "my leaders would blame me for the problem" (51%), and (6) "it would harm my career" (50%).

The key to making sense of psychopathology is to understand adaptive mechanisms. Under this paradigm much of what underlies clinical expressions reflect a healing process (Vaillant, 1995) and patients' defense mechanisms and coping strategies depend on his/her stage of maturation as well as on psycho-social factors (Erikson, 1950). In this regard, the ability to recover from a mental illness will depend not only on neurobiological factors, quality of primary relations with parental figures or personality traits, but also and more importantly, on the ability to use adaptive mechanisms, and to maintain an adequate social support from significant figures. Since Freud's first reference to defense mechanisms (Freud, 1894), many authors have described different ways to cope with stressors (Fenichel, 1946; Kolb, 1968; Symonds, 1970; Leventhal et al., 1993; Mc Adams, 1998). We analyzed the most prevalent psychopathological expressions found in the study sample through the description of the main diagnoses and the observation of the defense mechanisms and coping strategies utilized in three typical cases. For this purpose, we used Vaillant's classification of eighteen defense mechanisms organized in four levels according to their relative theoretical maturity and pathological import (Table 1) (Vaillant, 1995) as well as the concepts developed by Leventhal et al. and discussed by Cramer, regarding a theoretical vertical hierarchy for coping strategies (Table 2) (Leventhal et al., 1993; Cramer and College, 1998).

The aim of this report is to describe the main characteristics of the population attended in a mental health women's clinic at the San Diego Veterans Administration (VA) health care system in the U.S. during a one year period. The authors discuss some specific clinical considerations regarding women as part of a military system, including their major vulnerabilities, psychopathological expressions, and barriers that prevent this sub-group of patients from seeking psychiatric help and complying with suggested therapies.

Table 1
Vaillant's defense mechanism. Adapted from Vaillant G. E., "Adaptation to Life". Harvard University Press, 1995.

Level I (psychotic defenses): Psychotic denial, distortion and delusional projection.
Level II (immature defenses): Fantasy, projection, passive aggressive behavior, hypocondriasis and acting out.
Level III (neurotic defenses): Intellectualization, reaction formation, repression dissociation and displacement.
Level IV (mature defenses): Humor, sublimation, suppression, altruism, anticipation.

Table 2
Theoretical hierarchies in coping strategies. Adapted from Leventhal et al., (1993).

Upper level: Problem solving strategies, self-care strategies (social support, altruistic activities, avoidance from direct stressors), metacognition (awareness of stressors, possible coping strategies and anticipation of solutions), spiritual coping.
Intermediate level[a]: Overlearned coping strategies or habits (excessive sports activity, compulsive overeating, overwork, emotional over reactions).
Lowest level: Less controlled emotional displays (anger/ hostility, consciously involvement in risk taking or self damaging activities such as alcohol abuse or drugs).

[a] Intermediate level coping strategies or habits still a controversial issue in the study of adaptational processes. They represent a "semiconscious" activity, sharing some features in common with defense mechanisms, namely their intermittent lack of consciousness and intentionality.

2. Methodology

The authors searched the San Diego VA Health Care database to find the main epidemiological and clinical characteristics of the population attended during a one year period (from October 2007 to October 2008). The sample is described in terms of some key data such as: total number of patients, mean age, most prevalent axis I psychiatric diagnosis based on DSM-IV and average number of visits per patient. We also describe the most important psychopathological expressions in terms of the defense mechanisms and coping strategies expressed by the patients using three typical cases from the sample.

3. Results

3.1. Description of the sample

The women's mental health clinic is a specific resource for psychiatric evaluation and treatment available since 2004. It not only provides psychiatric care to the patients, but also serves as a "bridge" to connect them with other therapeutic resources (e.g., a women's support group, PTSD clinic and a clinic for military sexual trauma). During the one year period reviewed, 41 patients were attended for a total number of 125 visits. The most prevalent psychiatric diagnosis was major depressive disorder ($n=28$; 19.51%) followed by dysthymic disorder ($n=8$; 19.51%) and bipolar disorder ($n=3$; 7.31%) all of them corresponding to bipolar disorder type II. The presence of at least one form of anxiety disorder or anxiety symptom among the entire sample was high (n:25; 60.97%) and all of them were a secondary diagnosis related to one of the three most prevalent affective disorders already mentioned. Thus, the number of patients presenting a comorbidity with some form of anxiety disorders or anxiety symptoms were 14 for the major depressive disorder group (50%), 8 for the dysthymic disorder group (100%) and 3 for the bipolar disorder type II group (100%). Only 8 cases of Premenstrual Dysphoric Disorder (PMDD) were found in the entire sample and all of them were considered as a secondary diagnosis, 6 cases were found within the major depressive disorder group (21.42%) and 2 cases were found within the bipolar disorder group (66.66%). The mean age of the sample was 43.07 years (S.D.=11.84) and the average number of visits per patient was 3.04 (S.D.=1.93). Table 3 provides a detailed description of the diagnoses. The arithmetical difference between the total number of patients classified by diagnosis (n: 48) and