Sexual Trauma in the Military (222)

Author: Susan Walters Schmid, PhD

Contact hours: 3

Course price: $29

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Course Summary

Sexual trauma in the military is a reflection of our sexualized society. The DoD and the VA have formed divergent definitions of sexual violence and harassment that complicate tracking incidents across populations. Reporting an incident of sexual violence is daunting and both women and men face many barriers to a successful outcome. Military sexual trauma manifests both physically and mentally, with treatment inadequate in many cases. It can continue after discharge and for many years as a veteran.

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80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

Course Objectives

When you finish this course you will be able to:

1. Discuss the ways in which the sexualized civilian society is reflected in the military and its effect on military life and discipline.
2. Distinguish between the DoD and VA’s guiding definitions of sexual violence and harassment in the military and discuss whether it would be more effective were they merged.
3. Explain the process for reporting incidents of sexual violence in the military (MSA) and list the barriers to such reporting.
4. Discuss the ratio of women to men in incidence of MST and compare the response of the military to reports of sexual violence.
5. Identify the mental and physical diagnoses associated with MST and list treatment options.
6. Summarize the issues and pitfalls involved in social reintegration for MST survivors.

A Sexualized Society

As a society, our view of, and attitudes toward, sexual violence—how we define it, how we treat its victims, how (or if) we punish the perpetrators, and what we try to do to prevent it—have been changing. In many people's minds, sexual assault is synonymous with rape (an act of unwanted sexual intercourse), an act perpetrated by males against females, and, while generally considered a crime, its investigation, prosecution, and punishment are often affected by variations in state laws, social mores, and local attitudes. Negative perceptions and judgments of victims have figured prominently in our social view of sexual assault.

More than one researcher has addressed the effect of **rape culture**, defined as "the normalization of rape based on negative attitudes toward gender and sexuality." It can be a strong deterrent to reporting rape because it places an undue burden of proof on the victim. Rape culture embraces arbitrary standards of personal behavior, such as requiring a victim to possess a "pristine sexual history" in order to be believed and supported (Dastagir, 2017; Robinson, 2017; Zaleski, 2015).

Sexual violence and its aftermath presents a complex and multi-faceted problem. Researchers have found that what happens after a sexual assault varies depending on gender and on ethnic background (white, black, Latino/a, Asian, or Native American). Rates of victimization vary across ethnic groups, and cultural and historical influences play a role in those variations (Robinson, 2017).

Gender differences and cultural differences in attitude toward sexual assault affect victim self-perception, willingness to report an assault, perception of the victim by outsiders, physical/medical issues and treatment, mental health responses and treatment, and even the personal consequences when mental health issues cause other problems with employment, living situation, and relationships (Robinson, 2017). And, as this class will explore, there can be significant differences between the experiences of civilians and those of members of the military.

As our society engages more fully with the problem of sexual violence, we must confront the reality that sexual violence and sexual trauma are far more widespread than we like to admit and that they encompass many things besides the act of rape; these include actual or attempted physical assault (oral, vaginal, anal, using body parts or objects), threats of assault, and harassment of a sexual nature. Victims are both women and men, as are perpetrators, and perpetrators may be of the same or opposite gender as the victim (VA, 2017a).

Sexual violence is not confined only to certain socioeconomic or occupational groups. It has become evident that the nuances of the problem vary widely among different populations. This is perhaps nowhere more apparent than within the U.S. military where, according to research by the American Civil Liberties Union (ACLU), acts of rape, sexual assault, and sexual harassment "occur nearly twice as often. . . as they do in civilian society" (ACLU, 2013a).

The Military's Two-fold Challenge

The military faces a two-fold challenge because it must confront and deal with sexual violence that occurs among those on active duty and it must also deal with the results of that sexual violence as they manifest among those who have left active duty and joined the community of veterans. Survivors still on active duty and veterans face similar yet different effects, and complications of sexual trauma can affect physical health, mental health, working relationships and career trajectories, personal relationships, and even the ability to acquire and retain food and shelter—the basic needs of life.

For those on active duty there is a mechanism for reporting sexual violence but many victims do not make reports, for a variety of reasons that will be discussed here. All veterans who seek care at VA health centers are screened for experiences of sexual violence while they were on active duty. Whether or not incidents were reported at the time they happened can affect later outcomes for the survivors, positively and negatively.

For the military, the point at which the problem is being addressed will affect how it is defined and who is responsible for managing it, as well as the range of responses available.

Department of Defense (DoD)

Sexual violence involving active duty service members is handled by one of several Department of Defense programs. If the report is one of **sexual assault** by an adult against an adult then the Sexual Assault Prevention and Response (SAPR) program is the responsible entity. Sexual assault between spouses or intimate partners comes under the Family Advocacy Program (FAP). Complaints of sexual harassment are handled through the Office of Diversity Management and Equal Opportunity (ODMEO) (SAPRO, 2017; SAPRO, n.d.-4).

Definitions Used by DoD

The Sexual Assault Prevention and Response Office (SAPRO) establishes the broad policy for DoD "guided by five critical focus areas": prevention, victim assistance, investigation, accountability, and assessment. Prevention is a critical element of the wider policy because it is seen as the means to end sexual violence of any kind and comply with the "zero tolerance" directive given by the secretary of defense in 1994 (SAPRO, 2017; VA, 2004).

Sexual assault includes rape, sexual assault, forcible sodomy, aggravated sexual contact, abusive sexual contact, and attempts to commit these offenses.

Sexual harassment involves unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

- Submission to such conduct is made either explicitly or implicitly a term or condition of a person's job, pay, or career, or
- Submission to or rejection of such conduct by a person is used as a basis for career or employment decisions affecting that person, or
- Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creates an intimidating, hostile, or offensive environment (SAPRO, 2017, Appendix H).

The DoD makes the distinction between sexual assault and sexual harassment because, while acknowledging that there is a clear relationship between the two, "behaviors that constitute sexual harassment do not always rise to the level of criminal misconduct" and it "requires a different response than the crime of sexual assault" (SAPRO, 2017).

Department of Veterans Affairs (VA)

When service members who were affected by sexual violence while on active duty retire and seek care at any facility of the Department of Veterans Affairs (VA) Veterans Health Care Administration (VHA), VA is the responsible agency.

Definitions Used by VA

Military Sexual Trauma (MST) is "experiences of sexual assault or repeated, threatening sexual harassment that a Veteran experienced during his or her military service." This definition is taken from federal law (Title 38 US Code 1720D), and is "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training." Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character" (VA, 2015).

MST includes any sexual activity where the service member was involved against his or her will. This includes having been:

- pressured with threats of negative consequences or implied better treatment, or
- unable to consent (such as when intoxicated, asleep, or unconscious), or
- physically forced into sexual activities.

Other experiences that are considered MST include unwanted sexual touching or grabbing; threatening, offensive remarks about a person's body or sexual activities; and threatening and unwelcome sexual advances.

"The identity or characteristics of the perpetrator, whether the service member was on or off duty at the time, and whether he or she was on or off base at the time, do not matter. If these experiences occurred while an individual was on active duty, active duty for training, or inactive duty for training, they are considered by VA to be MST" (VA, 2015).

VA is careful to point out that "MST is an experience, not a diagnosis." VA's focus is on providing trained screening for MST and offering a range of appropriate treatment options for any veteran who was affected by MST regardless of the veteran's disability status (VA, 2015).

Key Events of the Last Thirty Years

Military sexual violence is, of course, not new, but a changing social focus and the steadily increasing participation of women in all branches of the service fueled a new interest in what the military was or was not doing to deal with that violence.

Key Events for DOD and VA since 1990/1991	
Year	Event
1991	US Navy Tailhook scandal
1992	Hearings before the Senate Veterans Affairs Committee
	Veterans Health Care Act of 1992 (Public Law 102-585) mandated free counseling for women Veterans with MST (contains definition of MST)
1994	Veterans Health Programs Extension Act of 1994 (Public Law 103-452) extended services to men; required VA to screen all veterans for MST
1994	Secretary of Defense establishes a "zero tolerance" policy for sexual harassment and all branches had to make their policies compliant
1996	Scandals at: Army's Aberdeen Proving Ground in Maryland, Ft. Leonard Wood in Missouri
2003	Scandal at the Air Force Academy in Colorado
2004	Veterans Health Program Improvement Act of 2004 (Public Law 108-422) made treatment services for MST a permanent benefit; extended benefit to those who had been on "active duty for training"
2004	Secretary of Defense directs a review of DoD's process for treatment and care of victims of sexual assault throughout the military and by the end of the year task force recommendations are implemented and in
2005	Sexual Assault Prevention and Response Office (SAPRO) is formed as the DoD's single point of authority for enforcing the policy across all branches of the military
2011	Ike Skelton National Defense Authorization Act for Fiscal Year 2011 (Public Law 111-383) requires DoD to provide Congress with an annual report on the number of sexual assaults in the military
2012	Release of documentary *The Invisible War*
	2012 National Defense Authorization Act requires a standardized response to victims and more professionalized victim advocacy roles
2013	Scandals at West Point, the Naval Academy, and an Air Force Joint Base in Texas

Key Events for DOD and VA since 1990/1991	
Year	Event
2014	National Defense Authorization Act for Fiscal Year 2014 includes more protection for whistleblowers, extension of victims' rights, and numerous other changes

Sources: (VA, 2004; SAPRO, n.d.-1; Lawhorne-Scott et al., 2014; CRS, 2013; Anderson & Suris, 2013; Tilghman, 2016; Kimerling et al., 2007).

In 1991 the U.S. Navy's Tailhook incident and the subsequent 1992 hearings before the Senate Veterans Affairs Committee brought to the fore the issue of female veterans who had been traumatized by sexual harassment and assault while on active duty. In 1992 legislation was passed mandating healthcare services for women who had experienced MST, and in 1994 the law was extended to cover men who had experienced MST. In 1999 a new law extended the VA authority to provide counseling and treatment for sexual trauma through December 31, 2004, and mandated that the Military Sexual Trauma Program in VA continue (VA, 2004).

Also in 1994, the Secretary of Defense established a zero tolerance policy for sexual harassment, and all branches of the service had to evaluate and, if necessary, modify their policies against sexual harassment to make them compliant with the new guidelines. Additional scandals in 1996 at the Army's Aberdeen Proving Ground in Maryland, and at Ft. Leonard Wood in Missouri, and again in 2003 at the Air Force Academy in Colorado, signaled a continuing problem.

In February 2004, the Secretary of Defense directed a review of the DoD's process for treatment and care of victims of sexual assault in all branches of the military. A task force gathered information and submitted recommendations. Another task force was established to be the single point for accountability in creating a new sexual assault policy.

Acting on recommendations from the original task force and a congressional mandate, the DoD sent a comprehensive policy on prevention of and response to sexual assault to Congress in January 2005. The policy became permanent in October and the task force transitioned into the Sexual Assault Prevention and Response Office (SAPRO), which is the DoD's single point of authority for enforcing the policy across all branches of the military, as well as a resource point and training provider (SAPRO, n.d.-1).

Most improvements to the program came about in 2012 and later (DoD, 2017) with at least some of them pushed along by the release of an award-winning documentary entitled *The Invisible War*, which focused on sexual assault in the U.S. military. It helped to highlight the wide disparity between reported incidents and actual incidents and also between incidents reported and perpetrators convicted. The film argued that in most cases the military promised far more than it delivered in terms of solving the problem and caring for its victims. Additional scandals in 2013, including at West Point, the Naval Academy, and an Air Force Joint Base in Texas, led to public outrage, Congressional hearings, and more pledges to improve (Lawhorne-Scott, 2014).

Legislation proposed in Congress in 2013 would have removed prosecution of sexual assault cases from the chain of command but it met with opposition from the military and was never passed. However, new regulations were put in place that were intended to offer more support to alleged victims, standardize handling of cases, and ensure that senior commanders were made aware of every reported incident (Lawhorne Scott, 2014).

After the Persian Gulf War, more attention was focused on the kinds of stress that impact women service members—both from military service itself and as related to sexual harassment and abuse. A 1998 study that included women service members from World War II, Korea, Vietnam, and the Persian Gulf era, suggested that "both sexual stress and duty-related stress contribute separately and significantly to the development of PTSD. The researchers noted that their findings were consistent with their earlier study of Vietnam War female service members and with other studies for the Persian Gulf era (Fontana & Rosenheck, 1998).

The renewed focus on sexual trauma in the military (among active duty personnel and veterans) is linked to events in the larger society, raises important questions and concerns, yet has also reinforced knowledge that the problem has existed for a long time and has affected a great many male service members over the years. In *Understanding and Treating Military Sexual Trauma*, Kristen Zaleski observes that "The political attention of military sexual trauma (MST) experiences a kind of 'episodic amnesia'" in this country and that leaders—political and military—only act when pressured by "scandal or media scrutiny" (Zaleski, 2015).

Military Sexual Assault

SAPRO's instructions for someone who has been, or thinks they have been, sexually assaulted are as follows:

1. Go to a safe location away from the perpetrator.

2. Preserve all evidence of the assault. Do not bathe, wash your hands or brush your teeth. If you are still where the crime occurred, do not clean, or straighten up, or remove anything from the crime scene.
3. Contact a Sexual Assault Response Coordinator (SARC) or Sexual Assault Prevention & Response Victim Advocate (SAPR VA). Contact DoD Safe Helpline for live, one-on-one support and information.
4. Seek medical care as soon as possible. Even if you do not have any visible physical injuries, you may be at risk of becoming pregnant or acquiring a sexually transmitted disease. Ask the healthcare personnel to conduct a sexual assault forensic examination to preserve forensic evidence. If you suspect you have been drugged, request that a urine sample be collected.
5. Make a decision about reporting. Military members usually have an option about how to report the crime.
    - Unrestricted Reports allow the victim to participate in the military criminal justice process.
    - Restricted Reports are kept confidential, and command and law enforcement are not notified. However, when the victim reports the crime to someone in the chain of command, a Restricted Report is no longer an option.
6. Write down, tape, or record by any other means all the details you can recall about the assault and your assailant (SAPRO, n.d.-2).

Reporting

Generally, an active duty service member (and their adult dependents) has two reporting options: Restricted Reporting and Unrestricted Reporting, each of which has pros and cons and slightly different procedures.

Restricted reporting is for those "who wish to confidentially disclose the crime to specifically identified individuals without triggering the official investigative process or notification to command." A restricted report is initiated in one of three ways:

- Sexual Assault Response Coordinator (SARC)
- SAPR Victim Advocate (VA)
- Healthcare provider or personnel

Each of these individuals can then see to it that the victim receives medical and mental health services, advocacy services (from a SARC or SAPR VA), and legal advice (from a Special Victim's Counsel). The installation commander is advised that "an assault" has happened but is not given any details that would allow an easy identification of the victim.

SAPRO offers the following as pros and cons of **restricted reporting**:

Benefits

- It is crucial to your recovery that you receive healthcare (medical and mental health) and victim advocacy as soon as possible after you are assaulted.
- Provides personal space and time to consider your options and to begin the healing process.
- Empowers you to seek relevant information and support to make more informed decisions about participating in the criminal investigation. Allows you time to get legal advice from a Special Victims' Counsel.
- You control the release and management of your personal information.
- You decide whether and when to move forward with initiating an investigation.

Limitations

- Your assailant cannot be held accountable and may be capable of assaulting other victims.
- You cannot receive a military protective order.
- You cannot request an Expedited Transfer to allow you to move to a different unit or base.
- You will continue to have contact with your assailant, if he or she is in your organization or billeted with you.
- Evidence from the crime scene where the assault occurred will be lost, and the official investigation, should you switch to an Unrestricted Report, will likely encounter significant obstacles.
- You should not discuss the assault with anyone, to include your friends, because they may be mandatory reporters. The only exceptions would be chaplains, healthcare personnel, your assigned SAPR VA or SARC, and Special Victims' Counsel.

Unrestricted reporting

This option is recommended for victims of sexual assault who desire an official investigation and command notification in addition to healthcare, victim advocacy and legal services. **Unrestricted Reporting** follows one of the current reporting channels:

- Law Enforcement/MCIO (initiates an investigation and starts a “report of investigation”)
- Commander (immediately contacts the MCIO to start a “report of investigation”)
- Sexual Assault Response Coordinator (SARC) (fills out DD Form 2910 and victim elects a reporting option)
- SAPR Victim Advocate (SAPR VA) (fills out “DD Form 2910)
- Healthcare personnel (immediately contact the SARC to fill out DD Form 2910)

Upon notification of a reported sexual assault, the SARC will immediately assign a SAPR VA and inform the victim of their right to speak to a Special Victims’ Counsel/Victims’ Legal Counsel (SVC / VLC). At the victim’s discretion or request, the healthcare personnel shall conduct a sexual assault forensic examination (SAFE), which may include the collection of evidence. Details regarding the incident will be limited to only those personnel who have a legitimate need to know (SAPRO, n.d.-4, n.d.-5).

Benefits

- Victims feel a sense of closure or healing which can aid recovery.
- Ability for Military to hold the offender appropriately accountable.
- Ensure the safety of the victim and of others, who may be victimized by the same suspect.
- Ability to request a Military Protective Order.
- Ability to request an Expedited Transfer to move to a different unit or base (SAPRO, n.d.-4; Lawhorne Scott, 2014).

Very detailed information about these processes, the pros and cons, and sample timelines are available online at www.sapr.mil/index.php under “Victim Assistance” (SAPRO, n.d.-4; Lawhorne Scott, 2014).

Investigation

The nature of the investigative process can be stressful for victims of sexual assault even with the best efforts of law enforcement, staff judge advocates, and other personnel entrusted with holding offenders appropriately accountable. All service members who are victims of sexual assault are eligible to have a Special Victims’ Counsel, who is their own attorney and can help them understand the process and safeguard their victims’ rights.

Investigators must carefully collect evidence, and the process from investigation to courts martial or some other form of punishment may take many months. Investigators often ask very precise and probing questions because generally there are no eyewitnesses to provide crucial details. A victim may not feel ready to answer questions right after being assaulted, but investigators need to perform interviews while memories are fresh. Patience is critical. A victim should be kept well informed of any investigative actions taken in response to the reported sexual assault.

Commanders should ensure that, at a minimum, a victim receives a monthly update regarding the current status of any ongoing investigative, prosecution, or command proceedings regarding the sexual assault. Monthly updates are required until the final disposition of the reported assault. **Final disposition** means the conclusion of any judicial, non-judicial, and administrative actions (including separation actions and no action).

The SVC/VLC, SAPR VA, and Victim/Witness Assistance Program (VWAP) personnel are to assist victims through the process and provide support (SAPRO, n.d.-4, n.d.-5; Lawhorne Scott, 2014).

Prosecuting Sexual Assault Cases

In order to navigate a legal process that even the DoD admits "can often be daunting and confusing," the department created a legal support function for sexual assault victims to provide legal advice and guidance and to maintain a victim's confidentiality. This is a counter to the fact that most JAG (Judge Advocate General) officers (military lawyers) work for commanders and must keep them informed of all incidents in their command. A victim of sexual assault can access the special legal support function regardless of the type of report they filed.

Professionals in the legal support function are known as Special Victim's Counsel (SVC) in the Army, Air Force, National Guard, and Coast Guard, while the Navy and Marine Corps refer to them as Victims' Legal Counsel (VLC). Regardless of name, they are lawyers with military and civilian trial experience, and they understand and can guide victims through the legal process (DoD, 2017; SAPRO, n.d.-5). Each branch of the service has detailed procedures, forms, etc. available online (sapr.mil/index.php/svc-vlc).

The DoD observes a Victims' Bill of Rights much like the Federal Crime Victims' Bill of Rights and law enforcement and legal personnel are required to observe its contents. The entire process of investigation, prosecution, and confinement is documented in writing and detailed forms are available outlining each step (sapr.mil/indes.php/victims-bill-of-rights) (SAPRO, n.d.-6).

Outcomes

Unfortunately, all the best planning and organizing may not result in the most desirable outcomes. A May 2016 *Military Times* article pointed out that, according to its own report, the military in 2015 received 6,000 reports of sexual assaults but only about 250 resulted in a court-martial and conviction on a related crime. Many reports resulted in no punishment of any kind, for a variety of legal reasons. The director of SAPRO observed that the services have not provided enough staff and resources to investigate reports in a timely manner, although that is changing (Tilghman, 2016; see SAPRO, 2016 for the report itself).

The total number of reports in 2015 was similar to that for 2014. As in civilian society, "it's widely believed sexual assaults. . . are vastly under-reported." Low conviction rates are blamed in part on the nature of the criminal justice system and the rights of the accused. A breakdown of the results of the 6,083 reports for 2015 is illuminating.

Approximately 1,500 were Restricted Reports for which the victim refused to participate in any criminal investigation. Also, no cases could be made where the attackers' identity was unknown, the attacker had separated from the military, or the attacker was a civilian. The remaining 2,783 cases sent to military commanders for action fell out as follows:

- 770 – deemed not enough evidence to pursue
- 576 – misconduct unrelated to sex assault substantiated
- 1,437 – misconduct related to sex assault substantiated
- 511 – resolved without court-martial (nonjudicial punishment, administrative discharge, or other action)
- 926 – court-martial proceedings initiated
    - 159 – closed when perpetrator resigned from military
    - 111 – closed after pretrial dismissal
    - 543 – went to court-martial
    - 130 – not guilty
    - 413 – convicted
        - 161 – of charges unrelated to sex assault
        - 254 – of sexual assault–related offense
    - 113 – still pending at end of 2015 (Tilghman, 2016).

In an article analyzing the statistics from the previous year, the author noted a very similar breakdown of cases (Tilghman, 2015). These kinds of results occur in civilian society as well, where, out of every 1000 rapes, 994 perpetrators will walk free (RAINN, 2016). This is very discouraging to victims and provides no impetus to endure the grueling process of investigation and prosecution, which has itself been described as **re-victimization** (Zaleski, 2015).

As one of many pieces of proposed legislation intended to assist military sexual assault victims, Senator Kirsten Gillibrand (D-NY) worked for three years on legislation that "would shift sexual-assault prosecutions from the chain of command to military lawyers, in part to remove victims' fears of retaliation for reporting attacks," but she has been so far unsuccessful. Strong opposition from the military and disagreement and bureaucratic issues on the Senate Armed Services Committee have both played a role in this (Brune, 2016). Military opposition remains strong but not always accurate. In 2016 the Pentagon was found to have misled Congress with charges that even fewer prosecutions would happen if civilian law enforcement officers were involved (Lardner, 2016).

Barriers to Reporting

Barriers to reporting can involve concerns about the immediate situation or the future or a combination of both. A primary barrier to reporting acts of sexual violence is the fear of retaliation or retribution—by the perpetrator or by other members of the unit. Retaliatory actions can endanger the reporter's physical safety, mental health, or current or future employment situation.

At a posting or deployment location where facilities are limited or nonexistent, another level of difficulty may be introduced. There is usually no crisis clinic, often no female officer to request (if desired), and law enforcement officers may have no specialized training in sexual assault. Concerns about being believed or perhaps not wanting to believe it themselves add to fears of what is known to be a notoriously grueling and unpleasant investigation and prosecution process. And, in the end, there is a very real possibility that the perpetrator will get off scot free, in which case retaliation and retribution could again be concerns (Zaleski, 2015; Tilghman, 2016, 2015; Lawhorne Scott, 2014).

The benefits and limitations to reporting as framed by SAPRO assume a system working perfectly with all players focused on following the rules within an environment guided by a zero tolerance for sexual violence. Both academic research and anecdotal reporting suggest this is often not reality.

It is suggestive that SAPRO's website lists benefits and limitations for Restricted Reporting but only benefits for Unrestricted Reporting. While there is nothing incorrect about what is *in* the lists, what is missing may be critical.

Such measures as protective orders and transfers can be requested with Unrestricted Reporting, yet there are no guarantees they will be granted—or in what time frames. Retribution or retaliation remain real possibilities, as do adverse actions by command. Personal safety may also remain a concern.

From another perspective, while Restricted Reporting is confidential, there will be situations where, practically speaking, that is not possible. Enough data must go to command even with Restricted Reporting so that in units with few women it may be immediately clear who the reporter is.

In the end, when all the issues are weighed, a victim (military or civilian) may not perceive reporting to be in their own best interests.

Military Sexual Trauma (MST)

Military sexual trauma (MST) is the term that the VA and VHA use to refer to sexual assault or repeated, threatening sexual harassment that occurred while the veteran was in the military. As defined in the Veterans Health Care Act of 1992, it is "psychological trauma, which in the judgment of a mental health professional. . . resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment, which occurred while the veteran was serving on active duty." **Sexual harassment** is "repeated unsolicited verbal or physical contact of a sexual nature which is threatening in character." As discussed earlier, the terminology used by the VA differs somewhat from that used by DoD programs.

The majority of published literature deals only with sexual assaults (attempted and completed) and does not address sexual harassment (Anderson & Surís, 2013). It has been argued that the current definition of MST "conflates two related but vastly different phenomena" and that a number of the terms subsumed in the definition have specific legal meanings that can vary within state laws as well. A refinement of the terminology would result in more comparable data across research projects and potentially enable improved treatment for victims of sexual trauma across the board (Shale, 2014).

In 1994 legislation mandated the VA screen all veterans for MST, and in 2004 the VHA began national MST screening for men and women in VA facilities. In 2011, 2.5% of the 4.8 million veterans screened nationally at VA Medical Centers indicated experiencing MST. For women, it was 23% and for men 1.2%. Among the 2.6 million screened at outpatient facilities, the rates were 22.5% for women and 1.1% for men (Anderson & Surís, 2013).

According to VA, currently 1 in 4 women and 1 in 100 men report being the victim of MST, so the percentages have not really changed. A key point often overlooked is that, in terms of overall numbers, there are so many more men in the military that there are in fact significant numbers of both men and women affected by MST. Over 40% of men seen in VA report experiencing MST (VA, 2017).

It is also important to keep in mind that not all veterans receive their medical care at VA facilities. In general, veterans are enrolled in VA healthcare services according to a priority system that takes into account service-connected disabilities and income requirements, with returning combat veterans eligible to enroll in VA health care for 5 years after discharge regardless of disability status or income (CRS, 2016, 2014). In addition, veterans may be eligible for free MST-related care even if they are not eligible for other VA services (VA, 2017).

A recently released VA report indicates that between late 2001 and 2015, approximately 62% of the 1.9 million veterans of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) utilized VA health care (VA, 2017b), which means that the actual numbers of victims of MST are likely even higher when survivors who are not being treated or are being treated under private medical care are taken into account. This also supports the argument that there needs to be sharing of research and experience between civilian and VA clinicians who are treating veterans for MST-related health issues (Kimerling et al., 2007).

VA Response to Military Sexual Trauma (MST)

Each VA hospital must have a designated MST Coordinator who oversees MST screening and assessment, and standardized training materials are available for VHA providers. Every veteran seen at a VA medical facility is screened for MST and any who have experienced MST can get treatment. Treatment does not depend on disability status and those who are not otherwise eligible for healthcare at VA are able to get treatment for MST-related health issues (mental and physical). A variety of requirements for VA facilities address screening, treatment availability and protocols, special treatment centers (including some for women only and others for residential treatment), staff training on MST, and outreach (Kimerling et al, 2007; VA, 2017; Lawhorne Scott, 2014).

It has been a struggle for those affected by sexual violence in the military to be taken seriously and get the care they need. It took two Freedom of Information lawsuits filed by the Service Women's Action Network (SWAN), with support from the ACLU of Connecticut and the Veterans Legal Services Clinic at Yale Law School, to obtain critical data from the VA about disability claims and benefits for PTSD and two other conditions related to MST. That information was used to push for reforms (ACLU, 2013).

The VA and VHA have been criticized in recent years for severe scheduling delays at many facilities and the deaths of at least 19 veterans due to such delays. Problems at the VA go back to its beginnings, but the increasing number of female veterans entering the system bring new concerns about how to provide appropriate care for them (Pearson, 2014; Kehle-Forbes, 2017). A recent study found that, even though VA has been making changes to provide more gender-sensitive and gender-specific care, there are still problems. Women who have PTSD and those who experienced MST are a particularly high-risk group when it comes to healthcare disparities at VA facilities (Kehle-Forbes, 2017).

Women veterans report feeling "unwelcome" at VA facilities, and many perceive VHA providers to be "under-skilled" and "relatively insensitive" when it comes to treating women. Among women utilizing mental health services, less than 50% felt their needs were well met by the VA. Women who have experienced military sexual trauma can find it particularly disturbing to be placed in a therapy group that is all male or forced to endure lengthy times in waiting rooms full of men. A need to avoid unwanted interactions that raise anxiety levels or act as "triggers"—such as cat calls, flirting, or being propositioned or told they don't belong at the VA—causes some to forgo treatment at a VA facility (Kehle-Forbes, 2017).

Screening for MST

In order to comply with its mandate, the VA employs universal screening for MST accomplished with onscreen forms and reminders in its patient tracking computer system. A 2007 study noted that in civilian life only a minority of patients were screened for violence by their healthcare providers, although anecdotal evidence suggest that 10 years later that is changing. While universal screening is often contraindicated, the same study found that for MST screening it was not only feasible but yielded valuable information for VA providers (Kimerling et al., 2007).

The study found that screening reached 70% of all patients and the data collected demonstrated that MST is prevalent among veterans seeking care at VA—thus making it an important issue for VHA facilities (Kimerling et al, 2007).

The nature of MST requires that the questions used for screening be constructed so as to be appropriately sensitive and most likely to yield usable responses. It is best to avoid loaded words such as *rape* or *sexual harassment* because they can be perceived as too intrusive and may have different meanings from one person to the next (VA, 2017a).

The VA screening instrument has proven useful; it asks, “While you were in the military: (a) Did you receive uninvited and unwanted sexual attention, such as touching, cornering, pressure for sexual favors, or verbal remarks?; (b) Did someone ever use force or threat of force to have sexual contact with you against your will? (Kimerling et al, 2007; VA, 2017a).

Followup assessment employs detailed questionnaires, of which there are at least two commonly used but none that are specifically target for military sexual trauma assessment (VA, 2017a).

Responses to and Effects of MST

Some common responses to MST that may be seen in both male and female survivors include:

- strong emotions—depression; intense sudden emotional reactions; feeling angry or irritable all the time
- emotional numbness —feeling emotionally “flat”; difficulty feeling emotions such as love or happiness
- trouble sleeping—difficulty falling asleep or staying asleep; disturbing nightmares
- difficulties with attention, concentration, and memory
- problems with alcohol or other drugs—drinking excessively or using drugs on a daily basis; using alcohol or drugs to deal with memories or emotional reactions; drinking to fall asleep
- difficulty with reminders of the trauma—feeling edgy or jumpy; not feeling safe; excessive avoidance of possible triggers
- difficulties in relationship—feeling isolated or disconnected from others; abusive relationships; difficulty with authority figures or employers; difficulty trusting others
- physical health problems—sexual difficulties, chronic pain, weight or eating problems, GI tract problems (VA, 2015)

The type, severity, and duration of responses to MST in a particular individual can be affected by many things, including:

- Prior history of trauma

- Responses from others at the time of the event
- Whether the mst occurred one time or was repeated
- Gender
- Race/ethnicity
- Religion
- Sexual orientation
- Other cultural variables (VA, 2015)

The connection between the development of psychiatric sequelae, physical health issues, and poorer quality of life is consistent across the research (Anderson & Surís, 2013). The most common diagnoses associated with MST are post traumatic stress disorder (PTSD), depression and other mood disorders, and substance use disorders (VA, 2015). Other strongly associated diagnoses include anxiety disorders, dissociative disorders, eating disorders, and personality disorders. A mental health diagnosis is two to three times more likely in victims of sexual assault in the military, and women veterans with MST are nine times more likely to develop PTSD than are women veterans who did not experience MST (Anderson & Surís, 2013; Kimerling et al., 2007).

There are unique characteristics of MST that distinguish it from experiences of sexual trauma in civilian life. First, MST happens when a person is on active duty and thus virtually always where they live and work, and usually they are forced to continue working and living with or near the perpetrator. Unlike a civilian, they cannot simply quit their job and go someplace else.

Second, the perpetrator may be someone who outranks and/or supervises them, thus threatening their ability to get the immediate support and care they need, maintain personal security, or advance in their job.

Third, strong unit cohesion is highly valued in the military and critical to its success. Making a report threatens that cohesion and a person may feel they risk being ostracized if they do so. In some cases, victims have been warned not to make reports and cause trouble.

Finally, speaking up and/or seeking mental health services are perceived to threaten the ability to deploy and/or career advancement (VA, 2017a; Hall, 2016; Anderson & Surís, 2013).

Sexual violence in the military can be affected by other factors as well. In a culture that encourages being "tough" and self-sufficient, minimizing the effects of sexual trauma can make it hard for the victim and others to identify and manage emotions. The relatively young age of many in the military can lead to developmental issues that affect later personal relationships. Limited social support and prior trauma experiences (childhood and/or pre-military) also play a role in military sexual trauma (Hall, 2016).

Other characteristics of MST are very similar to those of civilian victims of sexual trauma. In both arenas, victims are unlikely to make official reports to authorities. How authorities (legal, medical, or other formal sources of assistance) respond can make a great deal of difference for victims. If authorities negate a victim's experience, mental health difficulties are usually exacerbated and victims may be less likely to seek treatment or confide in family or friends. Positive responses, on the other hand, can reduce some of the effects of MST (VA, 2017a).

Gender Differences

Only a few studies of MST have included males, but in those that have, gender differences have been observed (Anderson & Surís, 2013). Because the experience of sexual victimization is so far outside the norm for men in the typical male gender role, they feel even more stigmatized. This in turn may make their symptoms more severe, increase feelings of shame, and make them less likely to request professional help (VA, 2017a). Men may experience more trauma symptoms and longer lasting sexual problems than do women (Anderson & Surís, 2013).

Men are often reluctant to acknowledge they have been victims of MST. Many are not aware that sexual assault has much more to do with power and dominance than it does with sexuality or sexual orientation and may see it as something that only happens to women. Thus, sexual assault may affect their self-perception of being a man, and trying to prove their masculinity may lead to promiscuity and unfaithfulness to a partner. Male veterans who survive MST may also experience confusion about their sexual identity and wonder if they were targeted because the perpetrator thought they were gay. Others, believing their perpetrator was gay, may develop an extreme (but often unwarranted) hatred of gay men (Anderson & Surís, 2013).

Both men and women on active duty who are victims of sexual harassment have poorer psychological well-being, more physical problems, and lower satisfaction with health and work. Female veterans using VA healthcare who report sexual trauma also report poorer health (psychological and physical) and greater adjustment problems (difficulties finding work or the development of alcohol or drug problems), and they are more likely to have been unable to work because of mental health issues (VA, 2017a).

When compared with female veterans who did not experience MST, those who did have more physical symptoms that include headaches, chronic fatigue, pelvic pain, menstrual problems, and gastrointestinal symptoms (Anderson & Surís, 2013). Two recent studies of women veterans focused on eating disorders, which are strongly associated with trauma. In the first, eating disorders were found to be twice as likely among those who had experienced MST, but were not associated with combat exposure (Breland et al., 2017); the second study also found connections between the disorders and military trauma (Arditte Hall et al., 2017).

Among both male and female survivors of MST, liver disease and chronic pulmonary disease are shown to have a moderate association, while obesity, hypothyroidism, and weight loss are significantly associated in women, and with AIDS in men (Anderson & Surís, 2013). Most of the medical disorders associated with MST have an important behavioral component, which suggests the importance of providing mental health services (Kimerling et al., 2007).

Mental health conditions also present gender differences, with most showing a relationship to MST in both men and women, but generally an even stronger link in one or the other; for example, the association of PTSD to MST is strong in both men and women, but it is almost three times stronger among women than among men.

The link between MST and adjustment disorders is stronger among men, and, while both alcohol and anxiety disorders are more common among men and women who report MST, the link is stronger among women than among men. On the other hand, the relation of MST to bipolar disorders and schizophrenia or psychoses while strong among both men and women, is stronger among men.

Interestingly, dissociative, eating, and depressive disorders, which are typically reported as more common in women, occur equally in men and women when associated with MST (Kimerling et al., 2007).

Prevalence

Figures for the prevalence of military sexual trauma vary due to many factors, including how the data was collected, why it was being collected, and among whom the data was sought. While one literature review in 2008 found prevalence rates from 0.4% to 71%, the majority of studies found rates that range from 20% to 43%. In the civilian population, the lifetime average prevalence rate of sexual assault is 25%; however, military prevalence rates are usually based on a time period of 2 to 6 years (periods of active duty), thus suggesting a much higher prevalence rate and risk for assault among active duty military personnel (Anderson & Surís, 2013; Johnson et al., 2015).

As noted earlier, VA records indicate prevalence rates among those screened for MST in VA health centers and outpatient facilities of approximately 23% for women and a little over 1% for men. There are no studies available that indicate prevalence rates of MST among those veterans who do not receive their care at VA facilities. And, because of the differences in the definitions used by VA and DoD, it is not possible to make direct comparisons of the prevalence data each of those entities collects (Anderson & Surís, 2013).

Health Diagnoses and Treatment Options

Survivors of MST are at high risk for a variety of physical and mental health disorders that often co-occur. Recent work has suggested the positive value of fully integrated treatment plans for veterans who may be suffering both physical and mental effects related to military sexual trauma (Johnson et al., 2015).

Mental Health Disorders

Post traumatic stress disorder (PTSD), depression and major depressive disorder (MDD), other mood disorders, and substance use disorders are common diagnoses in veterans who experienced sexual trauma. The severity and duration of symptoms varies among survivors for many reasons, and the best treatments consider the individual and those variations.

Posttraumatic Stress Disorder (PTSD)

> Post traumatic stress disorder . . . can occur after you have experienced a traumatic event. PTSD symptoms usually start soon after the traumatic event, but may be delayed several months or years. Symptoms also may come and go over many years.
>
> If the symptoms last longer than 4 weeks, cause you great distress, or interfere with your work/home life, you probably have PTSD. Symptoms of PTSD include reliving the event, avoiding places or things that remind you of the event, a shift to more negative thoughts and feelings, feeling numb, and feeling keyed up (also called hyper arousal).
>
> VA, 2016

Rates of PTSD are high in both civilian and military victims of sexual assault, and PTSD is the psychiatric disorder most highly associated with MST (Anderson & Surís, 2013). The rates of PTSD associated with military sexual assault victimization are 65% in men and 45.9% in women. It is notable that the rate reported by men following combat exposure is significantly lower (38.8%) (VA, 2017a).

Clinicians in VA and DoD facilities are guided by the VA/DoD Clinical Practice Guideline and by the VA's Uniform Mental Health Services handbook, which requires that any veteran with PTSD have access to cognitive processing therapy (CPT) or prolonged exposure therapy (PE), the evidence-based treatments of choice for PTSD (Anderson & Surís, 2013; VA, 2017c; VA, 2015a/2008).

Cognitive Processing Therapy (CPT) works by giving patients skills to handle distressing thoughts and memories that may leave them feeling stuck and unable to make sense of the trauma they experienced. CPT helps patients come to terms with how the trauma changed the way they view themselves, the world, and others. By becoming aware of thoughts and feelings, and then changing the thoughts, one can change the feelings.

Prolonged Exposure Therapy (PE) involves repeated exposure to thoughts, feelings, and situations that the patient has been avoiding. PE includes four parts: education, breathing retraining, real world practice (in vivo exposure), and talking through the trauma (imaginal exposure).

These two treatments continue to be found effective for treating PTSD (Cook & Wiltsey Stirman, 2015) but another therapy, EMDR—is now being used as well.

Eye Movement Desensitization and Reprocessing (EMDR), which has four parts: identification of a target memory, image and belief about the trauma; desensitization and reprocessing; installing positive thoughts and images; and body scan to change how the patient reacts to memories of the trauma.

The use of medication, especially selective serotonin reuptake inhibitors (SSRIs) has proven effective for veterans with PTSD. A number of other therapies have been or are being tested. As with the ones in use now, some treatments involve active confrontation of the traumatic experiences while others deal with the effects of the experiences. Not all treatments work equally well for all survivors and there are clinicians who feel the VA and DoD should consider other approaches altogether (Zaleski, 2015).

A critical element in the treatment of PTSD is the issue of avoidance, especially when employing trauma-focused therapies. Survivors may try to avoid the distress they feel over the memory of the sexual trauma. The temporary reduction of distress and anxiety may seem like a reward for that behavior, thus fueling the temporary sense of control they feel over the anxiety. However, in reality, that continued behavior reinforces the negative situation and makes the distress worse (Anderson & Surís, 2013).

Treatment can be very difficult for many, and the fear of reliving the event is a very real concern. Missing appointments or dropping out of a treatment program are not uncommon, and positive results from treatment depend on well trained and highly aware clinicians. Official guidelines call for VA facilities to provide same-sex counselors for MST treatment whenever indicated, although male MST survivors do not usually want male therapists (Anderson & Surís, 2013).

Healthcare providers can learn more about PTSD in Veterans by taking an interactive course, PTSD 101: PTSD Overview, available at the National Center for PTSD.

The website includes a professional section for those who work with people who have experienced trauma or who have PTSD.

Afterdeployment.org offers trainings for healthcare providers on the topic of PTSD and special populations, including PTSD and aging; African American, Hispanic, Asian American and Pacific Islander veterans; and cross cultural considerations (http://afterdeployment.dcoe.mil/providers/continuing-education).

Other Mental Health Diagnoses

Depression and **major depressive disorder (MDD)** are also highly associated with MST and research suggests that almost one-third of sexual assault victims experience at least one period of MDD in their lifetimes. Other mood disorders and substance use disorders are also associated with having survived MST. As with PTSD, guidelines for treatment of each of these disorders have been established for use in VA and DoD facilities. While there is considerable research and guidance available for assessing and treating sexual and other trauma, there is little available yet that is focused specifically on military sexual trauma (Anderson & Surís, 2013).

Physical Health Disorders

Male and female active duty personnel and veterans who have experienced MST report more physical health problems than those who have not. The most critical issue for veterans may be encouragement and support in understanding and making use of the healthcare services available to them. Recent research emphasizing a holistic approach to physical and mental health treatment for those who have survived MST makes a great deal of sense (Johnson et al., 2015).

For both men and women, liver disease and chronic pulmonary disease are shown to have a moderate association with MST. AIDS is significantly associated in men (Anderson & Surís, 2013).

For women, physical health issues include obesity, weight loss, and hypothyroidism. Sleep disturbances and chronic pain also are mentioned frequently by female veterans (Johnson et al., 2015). When compared with female veterans who did not experience MST, those who did have more physical symptoms that include headaches, chronic fatigue, pelvic pain, menstrual problems, and gastrointestinal symptoms (Anderson & Surís, 2013). The connection between MST and eating disorders was noted earlier.

Understanding that a patient has experienced MST informs the clinician and allows him or her to check for known frequent co-morbidities, address known risk factors and behavioral components, and offer referrals or suggestions for other possible treatments.

Although confidentiality is a critical part of healthcare today, victims of MST often have special concerns about it and a healthcare provider may want to consider how they broach certain topics and what assurances they give to patients.

Reintegration

A major concern for all military personnel and their families is how they will fit back into life at home after deployment—and ultimately back into civilian life when they retire from the military. Having endured and survived sexual trauma while on active duty adds another layer to that already challenging process.

Still on Active Duty

For those still on active duty, work environment issues are one challenge, especially if the perpetrator is still part of the unit and/or other members of the unit blame the victim for what happened. If the chain of command is unsympathetic, opportunities to advance may become limited. Even if none of those are problems, concern for personal safety may be high, especially if the person is dealing with PTSD.

Obtaining treatment for PTSD or other mental health issues may not be something the person wants others in their unit to know about, so there may be reluctance to pursue treatment. Inability to concentrate can affect work performance, as can time missed from work. And, while such problems can affect self-confidence and self-esteem, with unsympathetic co-workers or command it can also affect job performance ratings and future job opportunities.

Veterans

For veterans making the adjustment to civilian life, challenges may be similar even if venues are different. Healthcare for MST-related problems is available regardless, but the veteran must still get connected to the local VA system and obtain appointments with providers.

Looking for a job is seldom simple—and if the veteran is also trying to cope with personal safety concerns, concentration problems, gastrointestinal problems, anger and irritability, or any of the myriad other known possible effects of MST, the challenge may be insurmountable. If alcohol or drug use has become a coping mechanism, it can further complicate life and potentially open up opportunities for negative encounters with the law.

There is, of course, a domino effect between having a job and having money to pay rent, buy food, and pay for transportation, and fears about finding a job add to the stress. Support from family and friends can be a significant help in these situations but reestablishing intimate relationships can also be affected by the experience of MST.

Single Parents

Female veterans often face the added challenge of being single parents, which can complicate the search for housing and employment, especially if childcare is needed. As of 2010, 30,000 single mothers had deployed to Iraq and Afghanistan, so this is no small problem (NCHV, n.d.).

Homelessness and MST

A 2013 study determined that, of the homeless veterans in the VHA system, 39.7% of females and 3.3% of males had experienced MST. Homeless veterans who have experienced MST had a much higher (3 to 4 times) likelihood of being diagnosed with at least one of the major mental health problems already linked to MST (Pavao, 2013; NCHV, n.d.).

A study released in 2016 found that nearly 1 in 10 veterans who had experienced MST became homeless within five years. The study considered a national sample of 601,892 veterans of Iraq and Afghanistan discharged between 2001 and 2011. Among those reporting MST, the rate of homelessness was twice what it was among those not reporting MST, and males were slightly more likely than females to be homeless (Pauly, 2016).

Men are particularly vulnerable because, on top of the issues surrounding the experience of MST and concerns about masculinity, sexuality, and self-concept, men may be less likely to pursue mental health treatment, contributing to a worsening of their situation (Pauly, 2016).

The researcher noted that low social support, poor interpersonal relationships, and re-victimization are all possible consequences of MST and that “these types of problems may compromise employment and put one at risk for financial instability” (Pauly, 2016).

As to women, the National Coalition for Homeless Veterans notes that women are now 8% of the total veteran population and 14.6% of the active duty military. The latter number is expected to be 16% by 2035, so the veteran population can be expected to rise as well. In 2006 there were 1,380 homeless female veterans and by 2010 the number had more than doubled to 3,328 (NCHV, n.d.).

Conclusion

As noted earlier, the military very much wants to increase reporting of sexual violence. It hopes that increased reporting will, along with prevention and other efforts, move it toward the goal of reducing military sexual violence to (near) nonexistence. All the rules and procedures the military has instituted have clear ties to the identified problems, yet the numbers fluctuate and sometimes do not seem to indicate success. Perhaps the critical dilemma is that truly eliminating sexual violence in the military requires accomplishing a major culture change (Kehle-Forbes, 2017; SAPRO, 2017; CRS, 2013).

At the higher echelons, this need for culture change is understood and talked about, although even there not everyone is prepared to take the steps needed. As an example, military juries, usually composed of senior officers, often hand out extremely light punishments in the legal cases that actually make it to a penalty decision. Even more disheartening is that in recent years a few incidents of sexual misbehavior have actually involved high-level officers, including one who ran the Air Force’s SAPRO (Lawhorne Scott, 2014; Martinez, 2013).

There are numerous multi-generational personnel layers in the military, and the time frame to succeed in making such a culture change may be decades. Solving the problem likely requires perseverance over time and across the organization and, because it is a situation with deep roots in our society, it may not be just the military that has to make that culture change.

A bright spot may be that colleges and universities are starting to deal with sexual violence issues and are finding some success at raising awareness and changing attitudes among young people (MIT, 2014). In their arsenals of prevention, both schools and the military have begun using bystander training programs as part of their prevention efforts—also with some indications of success (MIT, 2014; SAPRO). (n.d.-7). Encouraging people to take responsibility for sexual behavior and to step up when someone is acting irresponsibly is just a piece of the culture change needed to fix a problem as seemingly intractable as sexual violence.

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Post Test: Sexual Trauma Military

Use the answer sheet following the test to record your answers.

1. The specific designation of military sexual trauma (MST) is used by the:

    a. Department of Defense (DoD).
    b. Department of Veterans Affairs (VA).
    c. Office of Diversity Management and Equal Opportunity (ODMEO).
    d. Family Advocacy Program (FAP).

2. Military sexual trauma (MST), as used by the VA and VHA, includes which of the following not included in the Department of Defense (DoD) definition:

    a. PTSD.
    b. Domestic violence.
    c. Sexual harassment.
    d. Child abuse.

3. The two kinds of reports that can be made for military sexual assaults are:

    a. Open and closed.
    b. Restricted and Confidential.
    c. Closed and Unrestricted.
    d. Restricted and Unrestricted.

4. For military sexual assaults that are reported, the percentage that go to court-martial and end in punishment:

    a. Is very low.
    b. Approaches 100%.
    c. Varies greatly from one year to the next.
    d. Is not possible to know.

5. Which one of the following is NOT a barrier to filing a report of sexual assault:

    a. Concerns about retaliation.
    b. Lengthy and invasive investigation process.
    c. Rank.

d. Concerns about loss of job opportunities.

6. Strong emotions and trouble sleeping are common responses to MST in:

    a. Women only.
    b. Men only.
    c. Active duty survivors.
    d. Both men and women.

7. The type, severity, and duration of responses to MST in an individual can be affected by:

    a. Sexual orientation, gender, ethnicity.
    b. Gender, race, success in school.
    c. Support during trauma, race, occupation.
    d. Economic status, sexual orientation, religion.

8. The experience of sexual trauma in the military is similar to that in civilian life:

    a. True
    b. False

9. Which one of the following is true about survivors of MST:

    a. Men are more likely to seek professional help.
    b. Women veterans report fewer health problems.
    c. Men are often reluctant to acknowledge they have been victims.
    d. Active duty men and women report greater job satisfaction.

10. Treatment for PTSD associated with MST utilizes:

    a. Only trauma-focused therapies.
    b. A variety of therapies and/or medication.
    c. Only medication.
    d. Only nontrauma-focused therapies.

11. Women who have experienced MST report more physical health problems than those who have not:

    a. True
    b. False

12. Homelessness among veterans reporting MST is:

a. Declining.

b. The same as for those not reporting MST.

c. Slightly more likely for males than females.

d. Proving impossible to track.

Answer Sheet

Sexual Trauma in the Military

Name (Please print your name): ____

Date: ______________

Passing score is 80%

1. _______
2. _______
3. _______
4. _______
5. _______
6. _______
7. _______
8. _______
9. _______
10. _______
11. _______
12. _______

Course Evaluation: Sexual Trauma Military

Items with asterisks * are required.

- 1 = Strongly agree
- 2 = Agree
- 3 = Neutral
- 4 = Disagree
- 5 = Strongly disagree

* Upon completion of the course, I was able to:

a. Discuss the ways in which the sexualized civilian society is reflected in the military and its effect on military life and discipline.

○1 ○2 ○3 ○4 ○5

b. Distinguish between the DoD and VA's guiding definitions of sexual violence and harassment in the military and discuss whether it would be more effective were they merged.

○1 ○2 ○3 ○4 ○5

c. Explain the process for reporting incidents of sexual violence in the military (MSA) and list the barriers to such reporting.

○1 ○2 ○3 ○4 ○5

d. Discuss the ratio of women to men in incidence of MST and compare the response of the military to reports of sexual violence.

○1 ○2 ○3 ○4 ○5

e. Identify the mental and physical diagnoses associated with MST and list treatment options.

○1 ○2 ○3 ○4 ○5

f. Summarize the issues and pitfalls involved in social reintegration for MST survivors.

○1 ○2 ○3 ○4 ○5

* The author(s) are knowledgeable about the subject matter.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

* The author(s) cited evidence that supported the material presented.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

* This course contained no discriminatory or prejudicial language.

○ Yes ○ No

* The course was free of commercial bias and product promotion.

○ Yes ○ No

* As a result of what you have learned, do you intend to make any changes in your practice?

○ Yes ○ No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

- ○ Yes, within the next 30 days.
- ○ Yes, during my next renewal cycle.
- ○ Maybe, not sure.
- ○ No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

- ○ Yes, definitely.
- ○ Possibly.
- ○ No, not at this time.

* What is your overall satsfaction with this learning activity?

1 2 3 4 5

* Navigating the ATrain Education website was:

- Easy.
- Somewhat easy.
- Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

- 60 minutes (or more) per contact hour
- 50-59 minutes per contact hour
- 40-49 minutes per contact hour
- 30-39 minutes per contact hour
- Less than 30 minutes per contact hour

I heard about ATrain Education from:

- Government or Department of Health website.
- State board or professional association.
- Searching the Internet.
- A friend.
- An advertisement.
- I am a returning customer.
- My employer.
- Other
- Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- 18 to 30
- 31 to 45
- 46+

I completed this course on:

- My own or a friend's computer.
- A computer at work.
- A library computer.
- A tablet.
- A cellphone.
- A paper copy of the course.

Please enter your comments or suggestions here: ____

____

____

____

Registration Form: Sexual Trauma Military

Please print and answer all of the following questions (* required).

* Name: ______________________
* Email: ______________________
* Address: ______________________
* City: ______________________ * State: ________ * Zip: ________
* Country: ______________________
* Phone: ______________________
* Professional Credentials/Designations:

____

* License Number and State: ______________________
* Please email my certificate:

○ Yes ○ No

(If you request an email certificate we will not send a copy of the certificate by US Mail.)

Payment Options

You may pay by credit card or by check.
Fill out this section only if you are **paying by credit card.**
3 contact hours: $29

Credit card information

* Name: ______________________

Address (if different from above): ______________________

* City: ______________________ * State: ________ * Zip: ________
* Card type:

○ Visa ○ Master Card ○ American Express ○ Discover

* Card number: ______________________

* CVS#:________________

* Expiration date:________________