



Military Sexual Trauma Information for Behavioral Health Providers

Information from the National Center for PTSD

Military Sexual Trauma: Issues in Caring for Veterans

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What is Military Sexual Trauma?

Military sexual trauma refers to both sexual harassment and sexual assault that occurs in military settings. Both men and women can experience military sexual trauma and the perpetrator can be of the same or of the opposite gender. A general definition of sexual harassment is unwelcome verbal or physical conduct of a sexual nature that occurs in the workplace or an academic or training setting. Sexual harassment includes gender harassment (e.g., put you down because of your gender), unwanted sexual attention (e.g., made offensive remarks about your sexual activities or your body) and sexual coercion (e.g., implied special treatment if you were sexually cooperative). Sexual assault is any sort of sexual activity between at least two people in which one of the people is involved against his or her will. Physical force may or may not be used. The sexual activity involved can include many different experiences including unwanted touching, grabbing, oral sex, anal sex, sexual penetration with an object, and/or sexual intercourse.

People tend to think that only women experience sexual trauma, however, this is not the case. In 1995 the Department of Defense conducted a large study of sexual victimization among active duty populations and found rates of sexual harassment to be 78% among women and 38% among men over a one-year period. Rates of attempted or completed sexual assault were 6% for women and 1% for men. Rates of military sexual trauma among veteran users of VA healthcare appear to be even higher than in general military populations. In one study, 23% of female users of VA healthcare reported experiencing at least one sexual assault while in the military.

Does Military Sexual Trauma Occur during Wartime?

Sexual trauma in the military does not occur only during training or peacetime and in fact, the stress of war may be associated with increases in rates of sexual harassment and assault. Research with Persian Gulf War military personnel conducted by Jessica Wolfe and her colleagues found that rates of sexual assault (7%), physical sexual harassment (33%) and verbal sexual harassment (66%) were higher than those typically found in peacetime military samples.

Are There Unique Aspects of Sexual Trauma Associated with Military Service?

While there is almost no empirical data comparing experiences of military sexual trauma with experiences of sexual harassment and assault that occur outside of military service, there is some anecdotal evidence that these experiences are unique and may be associated with qualitatively or quantitatively different psychological outcomes.

Sexual trauma that is associated with military service most often occurs in a setting where the victim lives and works. In most cases, this means that victims must continue to live and work closely with their perpetrators, often leading to an increased sense of feeling helpless, powerless, and at risk for additional victimization. In addition, sexual victimization that occurs in this setting often means that victims are relying on their perpetrators (or associates of the perpetrator) to provide for basic needs including medical and psychological care. Similarly, because military sexual trauma occurs within the workplace, this form of victimization disrupts the career goals of many of its victims. Perpetrators are frequently peers or supervisors responsible for making decisions about work-related evaluations and promotions. In addition, victims are often forced to choose between continuing military careers during which they are forced to have frequent contact with their perpetrators or sacrificing their career goals in order to protect themselves from future victimization.

Most military groups are characterized by high unit cohesion, particularly during combat. While this level of solidarity typically reflects a positive aspect of military service, the dynamics of cohesion may play a role in the negative psychological effects associated with sexual harassment and assault that occurs. Because organizational cohesion is so highly valued within the military environment, divulging any negative information about a fellow soldier is considered taboo. Accordingly, many victims are reluctant to report sexual trauma and many victims say that there were no available methods for reporting their experiences to those in authority. Many indicate that if they did report the harassment they were not believed or encouraged to keep silent about the experience. They may have had their reports ignored, or even worse, have been themselves blamed for the experience. Having this type of invalidating experience following a sexual trauma is likely to have a significant negative impact on the victim's post-trauma adjustment.

What Type of Psychological Responses are Associated with Military Sexual Trauma Victimization?

Given the range of sexual victimization experiences that veterans report (ranging from inappropriate sexual jokes or flirtation, to pressure for sexual favors, to completed forcible rape) there are a wide range of emotional reactions reported by veterans in response to these events. Even in the aftermath of severe forms of victimization, there is no one way that victims will respond. Instead, the intensity, duration, and trajectory of psychological responses will all vary based on factors like the veterans' previous trauma history, their appraisal of the traumatic event, and the quality of their support systems following the trauma. In addition, the victim's gender may play a role in the intensity of the post-trauma reactions. While the types of psychological reactions experienced by men and women are often similar, the experience of sexual victimization may be even more stigmatizing for men than it is for women because these victimization experiences fall so far outside of the proscribed male gender role. Accordingly, men may experience more severe symptomatology than women, may be more likely to feel shame about their victimization, and may be less likely to seek professional help.

Among both men and women in the active duty military, sexual harassment is associated with poorer psychological well-being, more physical problems and lower satisfaction with health and

work. Female veterans who use VA healthcare and report a history of sexual trauma while in the military also report a range of negative outcomes, including poorer psychological and physical health, more readjustment problems following discharge (i.e., difficulties finding work, alcohol and drug problems), and a greater incidence of not working due to mental health problems. Studies of sexual assault among civilian populations identify posttraumatic stress disorder (PTSD) as a frequent outcome. Sexual assault victimization is associated with high lifetime rates of PTSD in both men (65%) and women (45.9%). Interestingly, these rates are higher than the rate reported by men following combat exposure (38.8%). Major depressive disorder (MDD) is another common reaction following sexual assault, with research suggesting that almost a third of sexual assault victims have at least one period of MDD during their lives. Victims of sexual assault may also report increased substance use, perhaps as a means of managing other psychological symptoms. One large-scale study found that compared to non-victims, rape survivors were 3.4 times more likely to use marijuana, 6 times more likely to use cocaine, and 10 times more likely to use other major drugs. In addition to these psychological conditions, victims of sexual trauma may continue to struggle with a range of other symptoms that interfere with their quality of life. Common emotional reactions include anger and shame, guilt or self-blame. Victims of sexual trauma may report problems in their interpersonal relationships, including difficulties with trust, difficulties engaging in social activities or sexual dysfunction. Male victims of sexual trauma may also express concern about their sexuality or their masculinity.

How Has the VA Responded to the Problem of Military Sexual Trauma?

Given the alarming prevalence rates of sexual harassment and sexual assault among military veterans, it has been necessary for the VA to respond actively to the healthcare needs of veterans impacted by these experiences. In July 1992, a series of hearings on women veterans' issues by the Senate Veterans Affairs Committee first brought the problem of military sexual trauma to policy makers' attention. Congress responded to these hearings by passing Public Law 102-585, which was signed into law in November of 1992. Among other things, Public Law 102-805 authorized health care and counseling to women veterans to overcome psychological trauma resulting from experiences of sexual assault or sexual harassment during their military service. Later laws expanded this benefit to male veterans as well as female veterans, repealed limitations on the required duration of service, and extended the provision of these benefits until the year 2005. Following the passage of these public laws, a series of VA directives mandated universal screening of all veterans for a history of military sexual trauma and mandated that each facility identify a Military Sexual Trauma Coordinator to oversee the screening and treatment referral process.

Are there Screening, Assessment or Treatment Issues That Are Unique to Sexual Assault and Harassment?

Screening

It is important to screen all veterans for a history of sexual harassment and assault. Not only is universal screening mandated by VA, it also represents good clinical practice given the high prevalence rates of military sexual trauma among male and female veterans and the reluctance of many sexual trauma survivors to volunteer information about their trauma histories. Screening for all forms of trauma exposure should be approached with compassion and sensitivity, but screening for a history of sexual trauma requires particular care because of the stigma associated with this type of victimization. For accurate screening, good rapport with the veteran is essential, as is close attention to issues of confidentiality (e.g., not screening in the presence of other

providers or family members). Regardless of the care taken by the interviewer, the victims' shame and self-blame may prevent or delay disclosure, particularly for male victims or for victims who have experienced punishment or disbelief following previous disclosures.

When screening for a history of sexual trauma it is important to avoid words like "rape" and "sexual harassment." Asking the question, "While you were in the military, were you ever raped?" assumes that the victimized person knows how rape is defined and perceives what happened to them as a rape. Additionally, these words are "loaded terms" for many people and a victim may respond negatively in order to avoid the social stigma that goes along with being a rape victim. A method of screening that is likely to yield fairly accurate results without being perceived by the veteran as too intrusive involves two general questions that use descriptive, non-judgmental wording (i.e., While you were in the military did you ever experience any unwanted sexual attention, like verbal remarks, touching, or pressure for sexual favors?; Did anyone ever use force or the threat of force to have sex with you against your will?).

Assessment

At this time, there are no published measures specifically designed to assess sexual trauma that occurs as part of military service. While most checklist measures that assess for trauma exposure include at least one question about sexual assault, generally these measures do not assess sexual harassment. However, there are a number of existing self-report measures and structured interviews specifically designed to assess sexual harassment and/or sexual assault. The Sexual Experience Questionnaire by Louise Fitzgerald is the most widely used measure of sexual harassment. One of the most widely used measures of sexual assault, the Sexual Experiences Survey by Mary Koss and her colleagues, is a self-report measure that assesses a variety of unwanted sexual experiences including those associated with substance use. An example of an interview developed for the purpose of assessing sexual assault is The National Women's Study interview developed by Heidi Resnick and her colleagues. It includes a series of behaviorally specific questions that ask about a variety of unwanted sexual experiences.

Treatment

While the consequences of sexual harassment and assault can be severe and complex, there are treatments available that can significantly reduce psychological symptoms and improve a victim's quality of life. There is very little empirically-based information on the treatment of sexual harassment or on the treatment of any sexual trauma associated with military service. However, there is a wealth of information available on the treatment of sexual assault in civilian populations that can be used to inform treatment of veteran populations.

Interventions for sexual trauma often involve addressing immediate health and safety concerns (particularly in the case of an acute trauma), normalizing post-trauma reactions by providing education about trauma and psychological reactions to traumatic events, providing the victim with validation, supporting existing adaptive coping strategies and facilitating the development of new coping skills, like muscle relaxation or deep breathing. Treatment interventions may also include exploring affective and cognitive reactions including fear, self-blame, anger and disillusionment, some form of exposure therapy and/or some form of cognitive restructuring. Clinicians looking for more in depth information on the treatment of sexual trauma are referred to Foa and Rothbaum ¹ and Resick and Schnicke. ²

There is no set reaction to MST. Reactions include fear, shame, anger, embarrassment, guilt, lack of trust in providers/people. Responses may be immediate or delayed.

After MST sometimes there is an increase in physical symptoms such as headaches, diarrhea, chronic fatigue, or gynecological problems. People with MST also have more medical problems such as arthritis, diabetes, and obesity.

After MST people may feel depressed or have PTSD. If the depression or PTSD is severe, people may become suicidal. Some people have problems with anxiety and may have panic attacks. Other people may use drugs or alcohol to cope with their problems.

References

1. Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD*. New York: Guilford.
2. Resick, P. S., & Schnicke, M. K. (2002). *Cognitive processing therapy for rape victims: A treatment manual*. Newbury Park, CA: Sage.

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