# Providing Medical Care to Survivors of Sexual Assault and Harassment in the Military

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## Introduction

Experiences of sexual assault and sexual harassment during military service are addressed together in this chapter, because they are intimately intertwined and can have similar effects on survivors.[1] For example, at a most basic level, sexual assault in the military context is simultaneously workplace sexual harassment, given that the military environment is a workplace. Also, few people experience sexual assault in the military without also experiencing verbal or other nonphysical sexual harassment [1]. Finally, in the military, survivors work, live, and socialize in a relatively closed environment, potentially interacting with their perpetrator

[1]Note: Issues of sexual violence by enemy combatants and as a weapon of war are beyond the scope of this chapter. We also focus in particular on experiences of sexual assault and harassment occurring in the United States Armed Forces.


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V. Ades (ed.), *Sexual and Gender-Based Violence*,
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and his/her friends across multiple settings throughout the day. In this context, ongoing or repeated experiences of sexual harassment may create chronic fear and a sense of being trapped that is comparable to the reactions triggered by a single instance of sexual assault.

As we detail in this chapter, these types of experiences can have a profound impact on survivors' health and healthcare needs. Fortunately, medical professionals who are knowledgeable about the issues involved can provide strong support to survivors' recovery, by helping to ensure that their healthcare needs are addressed, by adapting care to be sensitive to the ways sexual assault and harassment may affect their experiences of healthcare, and by generally offering reparative experiences that stand in opposition to the devaluing, powerlessness, and helplessness that very often characterize experiences of sexual assault or harassment. To help medical professionals do this, this chapter provides an overview of issues pertinent to providing medical care to survivors of military sexual assault and harassment, including: (1) definitions, prevalence, and elements involving gender-based violence; (2) unique aspects of military sexual assault and harassment relative to other potentially traumatic experiences; (3) the impact of these experiences on survivors, including commonly associated conditions and effects on healthcare needs; (4) strategies for addressing this impact in a trauma-sensitive manner; and (5) key resources and ways to learn more. We hope that readers find this chapter a helpful introduction to the topic and an accessible reference that can guide ongoing care to survivors.

## Definitions

In this chapter we use the terms military sexual assault and sexual harassment (MSA/H) jointly to describe a continuum of unwanted sexual experiences occurring during military service. This includes experiences that are verbal in nature, such as threatening or offensive remarks about a person's body or sexual activities or repeated or threatening unwelcome sexual advances, and those physical in nature, such as unwanted touching or grabbing, or

nonconsensual sexual intercourse. Perpetrators may have been fellow service members, whether superiors, peers, or subordinates in the chain of command, or civilians. Experiences may have occurred on or off a military installation and while the victim was on or off duty. They may have occurred once or been time-limited, such as experiences in the context of hazing or initiation, or have been part of an ongoing pattern of harassment or coercion.

As with sexual assault/harassment in other contexts, victims of MSA/H may have been physically forced into sexual activities or drugged, intoxicated, or otherwise incapacitated and unable to consent. Beyond physical coercion, they may have been pressured or coerced into unwanted sexual activities with threats of consequences (like poor performance evaluations) or promises of rewards (like less-dangerous duty assignments). The military context can introduce unique elements to this sort of coercion. For example, even when threats are not explicit, survivors may have felt forced to comply, given the military's emphasis on hierarchy and obedience to command and de-emphasis of personal needs. Survivors also may have feared retaliation or consequences for being seen as someone who did not just "go along with things" or who disrupted unit cohesion. For example, they may have had concerns that peers or commanding officers might not have "had their back" during combat encounters or other life-threatening situations if they protested harassment or refused to engage in sexual activities.

In this chapter, we focus particularly on the experience of "veterans"—that is, individuals who were previously in the military. However, much of the content reviewed can also help professionals who treat service members currently serving in the military.

## Prevalence

Department of Defense data from 2018 revealed that 6.2% of current female service members and 0.7% of current male service members indicated that they had experienced a sexual assault in the previous 12 months, and 24.2% of current female service members and 6.3% of current male service members indicated

that they had experienced sexual harassment in the previous 12 months [2]. Insight into lifetime prevalence can be drawn from the Department of Veterans Affairs' (VA) universal screening program, in which every veteran seen for healthcare is asked about experiences of military sexual trauma (the term used by VA to refer to MSA/H). Current VA data from this program show that about 1 in 4 women and 1 in 100 men seen in VA screen positive for military sexual trauma [3]. Notably, although rates are higher among women, almost 40% of the veterans who screen positive are men due to the larger number of men in the military and among VA healthcare users. Rates are similar among new veterans as compared to those who served in earlier eras [4].

Although these rates convey how widespread experiences of MSA/H are, it is important to remember that some survivors may not disclose their experiences even when asked directly, so it is impossible to know with certainty which of your veteran patients may have experienced MSA/H. As such, it is best to approach all veteran patients in a manner sensitive to the possibility that they may have a history of sexual (or other) trauma experiences.

## Military Sexual Assault/Harassment as Gender-Based Violence

With regard to this book's focus on gender-based violence, the relevance of sex and gender to MSA/H is immediately visible in the elevated prevalence among women relative to men. Studies have shown that the risk factor most strongly and consistently associated with military sexual assault/harassment is being a woman [5]. Women's lower sociocultural power in the military and other factors contribute to this risk, but other factors related to gender, beyond just the fact of being a woman, also may be influential (see Bell et al. [6] for a review of additional risk factors for experiencing MSA/H). For example, Franke et al. conceptualized sexual harassment as a means of enforcing traditional gender roles, describing how it can be a means of punishing women who deviate from traditional feminine gender role behaviors and men who deviate from traditional masculine gender role behaviors [7].

In the military, the emphasis on gender role conformity may be paired with the promotion of highly masculine norms (e.g., physical strength, lack of emotionality, and self-sufficiency) for both men and women [8]. Thus, sexual victimization may function as a punishment for a woman not being “woman enough” (while simultaneously expected to be “man enough”) or a man not being “man enough,” which also may help explain data showing that transgender veterans are more likely than matched controls to have experienced MSA/H [9]. Lesbian, gay, and bisexual service members, who may be perceived to be gender nonconforming or to otherwise violate expectations for how women and men “should be,” also appear to be at increased risk [6]. Potential contributors to and amplifiers of the primacy of gender roles in the military include: (a) a culture valuing extreme forms of masculinity; (b) a high ratio of men to women; and (c) a history of exclusionary policies or practices related to women and individuals who do not conform to proscribed gender norms, such as transgender people or individuals who identify as (or are suspected to be) lesbian, gay, or bisexual. For a more in-depth review of these issues, please consult Burks, Castro et al., and Turchik and Wilson [10–12].

## Unique Aspects of Military Sexual Assault/ Harassment

Relative to other potentially traumatic experiences, including other forms of interpersonal violence and other military traumas (e.g., combat), MSA/H may have particularly toxic effects on health. For example, sexual assault in the military appears to be more strongly associated with posttraumatic stress disorder (PTSD) and other health consequences than civilian sexual assault, and is comparably or more strongly associated with negative mental health consequences than is combat exposure [13–16]. Bell and Reardon review factors that may contribute to this toxicity, but in brief, some key factors include [17]:

- *Military environment and ongoing contact with perpetrator.* The nature of the military environment means that military

personnel often find themselves interacting with the same group of individuals in both work and home life. Survivors may need to live, work, and socialize with perpetrators over an extended period of time, leaving them feeling trapped, helpless, and vulnerable to additional experiences of MSA/H or other revictimization. In the case of MSA/H occurring during combat deployments, survivors may have additional concerns about increased risks of physical harm or other forms of retribution if they try to refuse or report these experiences. This can further heighten the ongoing stress that can be associated with experiences of MSA/H and their aftermath.

- *Military culture and values.* The dissonance between MSA/H and core values promoted by the military can be very difficult for survivors to reconcile and can challenge their sense of themselves, others, and the world in profoundly destabilizing ways. For example, in the military, tremendous value is placed upon loyalty, teamwork, and functioning as a cohesive group with a shared mission. Military culture also prioritizes being strong, tough, and physically powerful, and these attributes can become a central part of veterans' self-identity. MSA/H requires survivors to confront the idea that betrayal is possible even from deeply trusted others and that even those who are strong, tough, and self-sufficient may not be able to protect themselves from victimization. With these core beliefs thrown into question, survivors often understandably do not know what to believe about trust, safety, and control in any context or with any individual, including themselves. Losing this fundamental sense of control and predictability can be disruptive to well-being and daily functioning.
- *Limited social support.* Many survivors of sexual trauma in any context lack social support [18], but unique aspects of the military environment can create additional complications for accessing support. For example, service members may be deployed or otherwise far from home at the time of the MSA/H or may be reluctant to reach out to formal sources of help for fear that this may mean "going public." They may also believe

that being strong means they should be able to cope on their own and "soldier on," particularly to the extent that MSA/H is perceived to be a less legitimate stressor than combat. They may also remain silent because of concerns about unit cohesion and fears of being ostracized for speaking out about another service member. Social support is one of the strongest and most consistent predictors of recovery from traumatic and stressful experiences [19], so MSA/H survivors' tendency to lack support, particularly in the immediate aftermath of the experiences, may be a significant contributor to the particularly negative impact of MSA/H on health and well-being.

## Impact of Military Sexual Assault/Harassment

Although MSA/H can be particularly toxic relative to other potentially traumatic events and significant life stressors, individual survivors vary in their reactions. Many are tremendously resilient and go on to lead healthy lives without significant long-term difficulties. Others may have some areas of continuing impact, whether in one or more ongoing physical or mental health conditions or in strong emotional reactions when encountering reminders of their experiences. Still others may struggle more profoundly and be significantly impaired in daily functioning. Given this variability, it is important both to be watchful for and to actively assess for potential health concerns that may have developed secondary to experiences of MSA/H, even when those conditions or their effects may not be immediately evident, and yet also to not make assumptions about survivors' current functioning and treatment needs. In this section, we review some of the most common physical and mental health conditions and psychosocial impacts that may arise after experiences of MSA/H, including how they may show up during medical encounters and impact these encounters. Although many of these issues are common after experiences of sexual trauma in any context and interpersonal trauma more generally, when possible we include information about ways in which the specific nature of MSA/H may be influential.

## Associated Physical and Mental Health Conditions and Psychosocial Effects

Regarding physical health impact, survivors may have medical conditions directly resulting from MSA/H, such as physical injuries and conditions resulting from a sexual assault (e.g., contusions, bone fractures, joint dislocations, pelvic, gynecological, or rectal pain, sexually transmitted diseases, sexual dysfunction), and long-term chronic sequelae arising from such injuries, particularly if they went untreated at the time. Medical conditions may also arise secondary to a survivor's behavioral reactions to or attempts to cope with MSA/H. These include the following:

- Conditions associated with drug or alcohol abuse, such as liver disease
- Conditions associated with smoking, such as chronic obstructive pulmonary disease or cardiovascular disorders
- Conditions associated with disordered eating, such as obesity or severe weight loss
- Conditions associated with unprotected sexual behavior, such as HIV/AIDS

Finally, medical conditions such as headaches, chronic pain, or gastrointestinal problems may arise or be exacerbated by physiological changes secondary to undertreated mental health conditions and traumatic stress.

VA data show that the specific medical conditions most commonly associated with military sexual trauma among veterans seen for VA healthcare are liver disease and chronic pulmonary disease (among women and men), obesity, weight loss, and hypothyroidism (among women), and HIV/AIDS (among men) [20]. More generally, other studies have documented increased odds of poorer overall physical health and more physical symptoms among MSA/H survivors as compared to nonsurvivors [21–23].

Survivors' mental health can also be negatively affected by experiences of MSA/H. The most common mental health conditions seen in VA associated with MSA/H are PTSD, depres-

sive disorders, anxiety disorders, and substance use disorders [20]. Research has also documented increased rates of dissociative disorders, eating disorders, and personality disorders [16, 24], and increased sexual health concerns such as difficulties with arousal, pain, or decreased sexual activity, desire, or satisfaction [25, 26]. Survivors also have increased rates of suicide and risk factors for suicide, even after accounting for the effects of mental health conditions such as depression and PTSD [27–29].

In terms of psychosocial impact, survivors may also struggle with a range of interpersonal issues such as difficulties with forming or maintaining relationships, negotiating self–other boundaries, or being appropriately assertive. Parenting may involve additional challenges for survivors as compared to nonsurvivors due to these and other issues. MSA/H is also associated with unemployment and difficulties at work or school and increased risk for homelessness [22, 30].

## Issues in Medical Care and Encounters

As noted earlier, survivors' healthcare needs and their experiences of medical encounters are often affected by MSA/H. Even veterans who are doing well in general may still have difficulties in certain situations or with certain aspects of their medical care. For example, physical exams and procedures may be especially anxiety-provoking, because they can be physically intrusive, provoke feelings of being vulnerable or not in control, or mimic physical sensations or experiences reminiscent of MSA/H experiences. Specific procedures that may be particularly difficult include: rectal exams; urologic exams; pelvic exams and Pap tests; breast exams and mammograms; invasive procedures such as endoscopies or colonoscopies; dental exams; and any procedure that involves physical restraint, sedation, or standing behind or over patients.

In addition, survivors' interpersonal interactions with medical professionals may be complicated. This is because even the most

supportive patient–provider relationships can at times entail some elements that are also involved in victim–perpetrator interactions, such as the following:

- Power differential
- Exposure and touching of body parts
- Physical pain or discomfort
- Uncertainty about what will happen next
- Feeling vulnerable and not in control

Because of this, even routine healthcare encounters may trigger intense emotional or other reactions or amplify any interpersonal or emotional concerns survivors may have. Readers are encouraged to consult Bell, Turchik and Karpenko, Street et al., and Street, Bell and Ready for more information [31–33]. Four critical areas to be sensitive to are:

- *Difficulties with trust.* The betrayal associated with MSA/H can negatively affect survivors' ability to trust others, particularly individuals perceived to have power or control. The inherent power differential involved in healthcare, where medical professionals have authority and specialized knowledge and control access to treatment and other resources, can be associated with feelings of helplessness. Survivors may disengage emotionally during an appointment or avoid treatment entirely if they feel too emotionally or physically vulnerable. Difficulties with trust can also manifest in a reluctance to answer questions or admit to symptoms, in excessive concern about the chosen treatment approach, or in a need for repeated explanations that does not seem to be due to memory issues or lack of understanding. Survivors also may place heightened emphasis on secrecy or privacy and attend intently to nonverbal cues and behaviors that seem to indicate someone's predictability and dependability. For example, they may have strong reactions to any procedures they perceive as lax or behaviors that may impact perceived privacy and confidentiality.

- *Shame and self-blame.* Shame and self-blame haunt many survivors of MAS/H and can result in long-lasting mental health and relationship difficulties [34]. Deeply held beliefs from military service about the importance of being strong, independent, and never weak or vulnerable can add an additional dimension and intensity to shame and self-blame. Survivors may blame themselves for their own reactions or others' responses during or after the experience or think they should have been able to prevent it [35, 36]. These feelings can be amplified for survivors who received negative or blaming responses from others when disclosing their experiences or seeking help. During medical encounters, self-blame can take the form of evasiveness, avoiding eye contact, or intense emotional reactions to perceived criticism.
- *Power and control.* MSA/H involves an abuse of power. In an effort to protect themselves from future harm, survivors may be exceptionally sensitive to potential signs that others may coerce, manipulate, or hurt them. This hypervigilance can be particularly strong in settings where they feel vulnerable (such as during medical appointments) and with individuals who are in a position of power and authority (such as medical professionals). To counteract these feelings of vulnerability, survivors may attempt to assert control over a situation, such as by being quick to anger or by making demands for information, procedures, or accommodations that seem significantly beyond what is warranted, even in light of the flexibility and sensitivity called for given their history of MSA/H.
- *Emotional and cognitive dysregulation.* Survivors may struggle with difficulty regulating emotions, evidenced as extreme or sudden emotional "highs" or "lows," difficulty modulating emotional responses, or emotional numbing or flatness. In medical settings, intense or sudden emotional reactions to pain, to perceived missteps on the part of a professional, or to feeling vulnerable may also occur. Survivors may have significant anxiety and shame or self-blame, though sadness and anger may be more likely to be expressed. Men are even more likely than women to express intense anger or use substances to manage emotions [37, 38]. This may be because sadness

and anger are also natural reactions to the experience, or because they may feel easier to express or more socially acceptable than shame or anxiety. Survivors also can have difficulties with attention, concentration, and memory, which can interfere with their ability to participate fully in medical encounters and/or manage follow-up recommendations.

When aspects of a medical encounter intersect with these areas, it is common for survivors to have an MSA/H-related reaction during the appointment. Such reactions can include:

- Appearing highly anxious, agitated, or “jumpy”
- Appearing tearful, with no obvious cause
- Physically withdrawing or becoming very quiet or “frozen”
- Having difficulty concentrating or seeming very distractible or disoriented
- Minimizing or denying symptoms that might require an intrusive exam
- Refusing needed care
- Exhibiting strong emotional reactions (e.g., crying, panic, irritability, anger) to interactions that may seem benign
- Appearing to dissociate (looks “checked out”)

These reactions can be confusing or challenging, and some professionals may initially assume they are driven by lack of motivation or interest, hostility, or a rejection of help. However, when viewed in light of the impact of MSA/H, these behaviors can be understood as natural reactions to the triggering aspects of the medical environment. Fortunately, as discussed at the end of this chapter, these reactions can often be mitigated with simple interventions that can help restore a patient’s sense of safety and control over what is happening.

## Effects of Identity and Cultural Variables

We have described some of the impacts of MSA/H for many survivors, regardless of their gender, ethnic/racial background, sexual orientation, religion, socioeconomic background or other

factors. However, aspects of identity and culture such as these can amplify and/or intersect with that impact. For example, consider how being raised in a conservative religious tradition that forbids sexual contact before marriage may amplify a survivor's sense of shame, self-blame, and reluctance to disclose an experience to others or seek help. Or, how MSA/H can add additional complexities to the recovery process and help seeking for individuals from a group that is a numerical minority or historically marginalized and who feels or has been told that they do not belong. For these individuals, MSA/H may feel like an attack on or shaming of their identity, a reinforcement of feelings that they are "less than," or a sign that they need to be hypervigilant for future victimization. Even if the MSA/H is not perceived to have occurred because of their identity, general societal stigma or perceptions of their cultural group still may create challenges. For example, lesbian, gay, and bisexual service members who are victimized often need to overcome additional barriers to come forward or get support, since seeking help may involve disclosing their sexual orientation and negotiating negative reactions from others.

Among the variables listed above, gender may be an especially salient one, particularly given the focus of this book. For a more comprehensive review of issues related to gender and MSA/H, see Bell et al. and Bell, Turchik and Karpenko [6, 31]. Briefly however, experiencing MSA/H and any problems afterward can feel like weakness, so they may violate men's most basic view of what it means to be "a man." This can result in struggles with their gender identity or sexual orientation and beliefs that they experienced MSA/H because they "weren't man enough" [31, 37]. For women, MSA/H may intensify their sense of vulnerability living in a world where women often have less social power. They may feel even more of a need to be "twice as good" as male military peers or a stronger sense that no matter what they do, they are not good enough. Transgender women and men may have MSA/H-related concerns consistent with their gender identity, their assigned birth sex, or their sense of belonging to a highly stigmatized minority group.

These issues also may shape disclosure and help-seeking in the medical context. For example, research has shown that men are less likely than women to disclose sexual trauma experiences,

including MSA/H, and to access formal sources of help, such as by making reports to authorities or seeking mental health or medical treatment. This is likely influenced not just by men's reduced healthcare use overall but also by gender-specific influences on recovery from MSA/H and sexual trauma.

Importantly, not all veterans with a given combination of identity and cultural variables will have additional struggles or concerns like those described above. However, being attuned to the possible influences of these variables can help you provide the most effective treatment to survivors from a range of different backgrounds.

## Key Principles for Addressing the Impact of Military Sexual Assault and Harassment

Fortunately, much of what you already know about addressing the effects of other forms of gender-based and/or interpersonal violence applies to providing care to survivors of MSA/H. This section reviews six key principles for doing this.

### Principle 1: Interact with All Patients in Trauma-Sensitive Ways

Because you will not know with certainty who among your veteran patients experienced MSA/H, or which encounters or procedures may be particularly challenging for a given patient, it is best to adopt a "universal precautions" approach and interact in trauma-sensitive ways with all patients. For example, when possible and still consistent with appropriate professional boundaries, do what you can to reduce the power differential between you and them. Seek to establish an environment that reduces patients' feelings of vulnerability and promotes a sense of control over what is happening to them. You can accomplish this with simple strategies:

- Sit at the same level as patients, preferably without a desk in between you and them
- Make good eye contact

- Have them remain fully dressed during appointments and exams whenever possible
- Give options and choices whenever possible
- Be transparent, explaining your reasoning for choosing or suggesting certain courses of action
- Recognize them as experts on their own bodies and functioning
- Attend carefully to patients' identified concerns and respond sensitively and compassionately when they disclose concerns to you.

Resources with additional strategies for caring for patients in trauma-sensitive ways are detailed in the table at the end of this chapter. Efforts such as these can reduce the chances of patient distress during appointments, foster a stronger and more effective patient–provider relationship, and enhance the positive effects of medical care.

In addition to specific strategies, providing trauma-sensitive care also involves adopting a strengths-based mindset and conceptualizations. This may be especially appreciated by veterans, as they often have personal identities that are aligned with strength, resilience, and independence. From a strengths-based perspective, survivors' struggles and any confusing or challenging behaviors can be interpreted as reflecting their best attempts to reestablish safety and internal stability in the aftermath of MSA/H. For example:

- Angry or aggressive outbursts may be a way to feel more in control of a situation or stay safe by pushing others away
- Reacting to benign details or interactions as if they have life-or-death significance can be an attempt to prevent bad things from happening again
- Downplaying or denying symptoms, or not seeking out needed healthcare may be ways to be a "good warrior" or to avoid feeling weak or vulnerable
- Self-blame may be a way to avoid accepting that we sometimes have limited control over bad things happening to us and that we can be hurt by deeply trusted others, even in a system (the military) that one may have a deep respect for and connection to.

In short, while they may seem confusing or challenging to others, these behaviors help survivors to meet an important need, often related to safety, power and control, or personal identity. It may not be an optimal way to meet the need in the long run, but it still reflects strength and a drive to recover. Honoring and building on this strengths-based mindset while also providing corrective and reparative experiences can be particularly helpful when working with veterans and may make a significant contribution to their recovery.

## Principle 2: Screen for Unwanted Sexual Experiences and Veteran Status

Because many survivors of sexual assault or harassment occurring at any point in their lifetime do not spontaneously disclose their experiences to professionals, it is important to include questions about sexual trauma in general (not just MSA/H) in your routine initial assessment process [39, 40]. This can be as simple as asking, "Have you had any sexual experiences during your life that continue to bother or upset you today, like unwanted sexual experiences or being touched or spoken to in ways that made you uncomfortable?" and "What would be helpful for me to know about that experience, to make sure I'm providing you with the care you need and that you feel comfortable during our appointments?" You do not need to discuss the experiences themselves in detail; however, getting a general sense of how recent or remote the experiences are and any significant impact they are having on current functioning will shape your sense of the acuteness of intervention needed. When there is time and/or a clinical indication that it would be beneficial, additional assessment of when experiences occurred (e.g., childhood, adulthood, military or civilian life), the scope of their current impact on functioning, health, and well-being, any related treatment needs, and any concerns patients have about procedures or healthcare visits (e.g., small spaces, interacting with unfamiliar people, having someone standing behind or over

them) can also help. Responding empathically and supportively to the information provided is crucial.

Asking all patients whether they served in the military is beneficial in identifying potential risks for a variety of service-linked problems and conditions and so is a general best practice. Ask "Have you served in the military?" as opposed to "Are you a veteran?" because some individuals, particularly women who served in an earlier era, may not realize that certain forms of service qualify them for veteran status or alternately, may not have formal veteran status. Specific to MSA/H, knowing whether an individual served in the military will also cue you to ask, if appropriate, whether any sexual trauma they disclosed occurred during their military service. This in turn will allow you to be mindful, as needed, of the information reviewed earlier about the impact of MSA/H relative to civilian sexual trauma.

Additional key principles for asking about MSA/H and sexual trauma more generally are reviewed in Table 5.1 and in Bell and Reardon and Street, Bell, and Ready [17, 33].

## Principle 3: Monitor Health Impact, Key Risks, and Personal Reactions

In addition to assessing the health impact and risk issues described above when a patient first discloses a history of MSA/H, you should also monitor these issues on an ongoing basis. This is because symptoms or difficulties can fluctuate over time, particularly in response to acute life stressors, and/or arise in a delayed fashion. Alternatively, a survivor may not feel ready to acknowledge the extent of current difficulties when initially asked.

Be particularly vigilant in assessing and monitoring risks for suicide, revictimization, substance use, homelessness, or disordered eating. Suicide risk assessment and suicide prevention strategies are especially critical; see the final section of this chapter for key resources that can help. For example, veterans

**Table 5.1** Screening for military sexual assault and harassment. (Adapted from Bell and Reardon [17])

| Steps | Key elements | Example |
|---|---|---|
| 1. Establish a comfortable climate for disclosure | Conveying comfort with the topic and your sense that this is an important issue | Ensure it is a private setting without interruptions; adopt a nonjudgmental stance, unhurried speech, and good eye contact |
| 2. Provide a rationale for asking | Normalizing the topic | *"Many of the patients I've worked with have had upsetting experiences in their lives that may still bother them today."* |
| 3. Ask the question | Using behaviorally based language that avoids jargon (e.g., rape, sexual assault) and negative phrasing (e.g., *"nothing like that has ever happened to you, right?"*) | *"During your military service or at any other time in your life, did you experience any unwanted sexual attention?"* *"During your military service or at any other time in your life, were you ever forced or pressured into having sex? Did someone ever threaten you in order to have sex with you when you did not want to?"* |
| 4. Respond to disclosure | Providing support | Validation and empathy: *"I'm sorry this happened to you while you were serving our country, but I'm glad you felt you could tell me about it today."* Education and normalization: *"Many veterans have had experiences like yours and for some, it can continue to affect them even many years later. It is important to know that people can and do recover, though."* |
| 5. Ask essential follow-up questions | Assessing current impact | Assess current difficulties: *"How much does [use survivor's words about experiences] continue to affect your daily life today? In what ways?"* Assess social support: *"Have you ever been able to talk with anyone about this before? How did they respond?"* Assess coping strategies: *"How do you deal with [use survivor's words about current difficulties] when it happens? Does that help? What happens next?"* Implications for care: *"How do you think this might affect our work together?"* |

**Table 5.1** (continued)

| Steps | Key elements | Example |
|---|---|---|
| 6. As appropriate, conduct or refer for more comprehensive assessment | Gathering information about the experiences and their impact, the patient's current functioning, and implications for care | *"It sounds like this experience continues to affect you a great deal today, which is understandable. It makes me think that it would be good for me to have a better understanding of how this fits into your life. Would it be okay to spend a bit more time talking about how it has affected you?"*<br>*"We should definitely think about whether there are ways this might affect your needs during medical appointments, and what I can do to help. I'm also thinking that it might be useful for you to speak to someone with particular expertise in these issues. She or he might have thoughts about other services that might be helpful. What do you think about that?"* |

have likely been well trained in the use of guns and other weapons and may have them in their homes, so means assessment and means restriction are critical in the care of veterans who may be at risk for suicide. Monitoring survivors' level of social support and connection with others is also critical, given evidence of the importance of this in recovery from trauma. Encouraging veterans to connect with local veteran-specific or sexual trauma-specific treatment resources may be one way of ensuring access to support.

Professionals also need to remain vigilant in monitoring their own reactions to providing care to survivors. It is normal and understandable to have reactions to your work with survivors, particularly when the problems they are encountering are complicated, confusing, and emotionally difficult. It is understandable to have strong positive or negative emotional reactions to certain interactions, to make quick judgments or assumptions, to have urges to avoid or protect certain patients, or to feel more emotionally

drained at times. It is also normal to have feelings and beliefs about military service, veterans, or government institutions. The important thing is to be aware of these reactions and the impact they may be having on your verbal and nonverbal behavior, the patient–provider relationship, and your ability to provide the best care possible. Then, make necessary adjustments to mitigate that impact.

When we notice strong personal reactions or changes in our behavior, this can indicate it is an important time to engage in extra restorative or social activities, such as talking with supportive colleagues, increasing engagement in meaningful activities outside of work, and reminding ourselves of the meaningfulness and importance of our work. Thinking about how to view a patient's behavior through a trauma-sensitive, strengths-based lens as an attempt to reestablish a sense of safety, control, or predictability may also help. See the brief discussion in Principle 1 about a strengths-based mindset, review a more extensive discussion of this in Bell and Reardon [17], or consider consultation with colleagues with trauma-and military-related expertise.

## Principle 4: Anticipate Difficult Situations and Respond Effectively to Strong Patient Reactions

Adopting the strategies described earlier for how to interact with all patients in trauma-sensitive ways will serve you well in reducing the potential negative impact of MSA/H on medical encounters and survivors' healthcare experiences. As noted, however, there are aspects of the medical environment and healthcare that may be inherently triggering or distressing for survivors, and there will inevitably be difficult moments to manage. Table 5.2 reviews some general strategies to help in anticipating and planning for these situations, to help you avoid or minimize patient distress.

**Table 5.2** Strategies to plan for difficult situations and minimize distress

| |
|---|
| *Anticipate and prepare* |
| Explain that it is normal for survivors to have strong reactions to certain kinds of appointments, exams, and procedures |
| Describe the reasons for and steps involved in the exam or procedure and ask what the patient anticipates will be the most difficult part |
| Brainstorm with the patient potential coping strategies or ways to make the situation as comfortable as possible. For example, seeing the procedure suite and tools in advance; having a chaperone or family member present; considering sedation or pain medication if clinically appropriate; using distraction (e.g., headphones, music, focused breathing, imagining a pleasant event); using other strategies the patient has found helpful in the past |
| *Give control and choice when possible* |
| Ask permission before touching |
| Let the patient know you will stop or pause if asked |
| Describe what you will do before you do it and then keep a running commentary of what you are doing as you do it. For example: "*Okay, I am picking up an instrument now. This is for looking in your ears; it shouldn't hurt. I am going to move close to you and briefly touch your ears while I am looking at your inner ear, is that okay?*" |
| Check in periodically and ask how he/she is doing |

Despite your best efforts and planning, survivors still can have strong reactions during medical appointments. When this happens, even well-intentioned professionals may be unsure how to respond and sometimes hurry through or try to skip over those moments to "protect" patients. However, it typically will be more helpful to stop what you are doing, if possible, or slow down and explain why, if not. It is important to respect the patient's subjective experience, even if it seems extreme to you given the objective circumstances. Never ignore or dismiss a patient's request or expression of distress. This may feel distressing to survivors who were previously ignored, dismissed, or blamed, particularly in relation to their experiences of MSA/H. Table 5.3 reviews additional strategies that will help in these situations.

**Table 5.3** Strategies for managing strong patient reactions

| Goal | Strategies |
|---|---|
| Minimize additional triggering or distress | • Stop what you are doing, if possible<br>• Avoid further touching without asking first<br>• Avoid moving closer or "invading" the patient's personal space<br>• Avoid making sudden loud noises (e.g., hand clap, finger snap) |
| As needed, help the patient return to the present moment ("grounding") | • Call the patient's name in your regular speaking voice: "*Are you still here with me?*"<br>• Ask the patient to focus on sensations and/or the external environment: "*Can you feel your feet on the floor? Good. Now how about focusing your attention on the sensation of sitting in your chair. What sounds do you hear in the room right now?*"<br>• Ask the patient to focus on the present: "*Can you tell me what day of the week it is? And where are we? How did you travel here today?*" |
| Demonstrate concern and restore control | • Ask the patient how he/she is doing and what he/she needs from you in that moment<br>• Listen empathically, acknowledging his/her distress<br>• Apologize for distress you may have caused, even if unintentionally<br>• Explain the reasoning behind your behavior<br>• Explore with the patient what you can do to restore a feeling of being in control |

## Principle 5: Refer for Specialized Care When Needed

You can make significant contributions to an MSA/H survivor's recovery, not only by addressing any medical impacts of MSA/H but also by offering a reparative, caring experience that counteracts a survivor's previous experiences. Your own knowledge paired with consultation with knowledgeable colleagues when needed may be sufficient to address a survivor's needs. However,

there will be times when a MSA/H survivor's treatment needs may be beyond the scope of your practice or expertise and a referral for specialty or other services may be warranted. For example, patients with complex medical or psychosocial presentations, or with multiple comorbidities, may benefit from specialist attention and/or a coordinated team approach. Likewise, survivors who are interested in mental health treatment or who are struggling with significant mental health difficulties would benefit from a referral for mental health services. Treatment from professionals or systems with particular expertise in treating residuals of MSA/H in veterans also may be helpful and appealing to some survivors.

When considering a referral, keep in mind that the Department of Veterans Affairs (VA) provides free care for any mental or physical health condition related to a veteran's experiences of MSA/H. VA refers to these experiences as military sexual trauma, or MST. Veterans do not need to have reported the MST or have any evidence or documentation of it to receive this free care. They also do not need to have a VA disability rating or have applied for disability compensation or to have sought treatment within a certain timeframe, and they may be able to receive MST-related care even if they are not eligible for other VA care. Services are available at every VA medical center. To connect with care, veterans (or you, on their behalf) can contact the nearest VA healthcare facility and ask to speak with the MST Coordinator.

## Principle 6: Consult Resources and Continue Expanding Your Knowledge

We encourage you to continue expanding your knowledge of MSA/H, its impact on veterans and their healthcare needs, and things you can do to address those needs. Table 5.4 lists additional resources and ways to learn more.

**Table 5.4** Resources and ways to learn more

| Topic | Key resources |
|---|---|
| Military sexual assault/ harassment | *Web-based resources*<br>• VA military sexual trauma website: http://www.mentalhealth.va.gov/msthome.asp<br>• National Center for PTSD continuing education course, "PTSD and Experiences of Sexual Assault During Military Service": https://www.ptsd.va.gov/professional/continuing_ed/sexual_assault_military.asp<br>• PsychArmor Institute continuing education course, "Military Sexual Trauma": https://psycharmor.org/courses/military-sexual-trauma-2<br>• Make the Connection website, military sexual trauma section: http://maketheconnection.net/conditions/military-sexual-trauma<br>• Department of Defense Safe Helpline for active duty Service Members: https://www.safehelpline.org/<br>*Articles and book chapters:*<br>• Bell ME, Dardis CM, Vento SA, Street AE. Victims of sexual harassment and assault in the military: understanding risks and promoting recovery [6].<br>• Bell ME, Reardon A. Experiences of sexual harassment and sexual assault in the military among OEF/OIF veterans: implications for health-care providers [41].<br>• Bell ME, Turchik JA, Karpenko JA. Impact of gender on reactions to military sexual assault and harassment. Health & social work [31].<br>• Castro CA, Kintzle S, Schuyler AC, Lucas CL, Warner CH. Sexual assault in the military [11].<br>• Skidmore WC, Roy M. Male Veterans' recovery from sexual assault and harassment during military service [37].<br>• Turchik JA, Wilson SM. Sexual assault in the US military: a review of the literature and recommendations for the future [12]. |
| Suicide prevention | • Veterans Crisis Line and suicide prevention resources: https://www.veteranscrisisline.net/ and https://www.veteranscrisisline.net/education/veteran-programs |
| Trauma-informed care | • Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse http://www.integration.samhsa.gov/clinical-practice/handbook-sensitivve-practices4healthcare.pdf<br>• Substance Abuse and Mental Health Services Administration TIP 57: Trauma-Informed Care in Behavioral Health Services [42]<br>• Survivors of Childhood Sexual Abuse: A guide for primary care providers: http://www.csacliniciansguide.net/index.html |
| Military culture | • National Center for PTSD continuing education course, "Understanding the Context of Military Culture When Treating the Veteran with PTSD": https://www.ptsd.va.gov/professional/continuing_ed/military_culture.asp<br>• Center for Deployment Psychology military cultural competence course: http://deploymentpsych.org/online-courses/military-culture |

## Conclusion

This chapter reviewed key information to consider when providing care to survivors of military sexual assault and harassment, including the impact of those experiences on survivors' health and healthcare needs. Although the experience and effects of MSA/H mirror those of other forms of gender-based violence in some ways, there are also unique aspects to consider. In addition, every veteran's experience and recovery is different; some survivors may be doing quite well without significant subsequent problems, while others struggle with acute or chronic health and/or psychosocial concerns. Identity and cultural variables also intersect with and influence both the experience of and recovery from experiences of MAS/H.

Adapting your practice in simple but powerful ways to be sensitive to how MSA/H can impact health and healthcare will help you address the full range of each survivor's healthcare needs and facilitate more effective and efficient medical care. In doing so, you also have the opportunity to play a pivotal and reparative role in their healing process and help them move forward in their lives. This can be an incredibly rewarding experience. We hope you find this chapter a helpful and enduring resource to assist you in this work.

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