Military Sexual Trauma

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Military sexual trauma (MST) refers to experiences of repeated, threatening sexual harassment or sexual assault during military service. MST substantially and negatively impacts male and female servicemembers, as well as the military itself. MST damages unit cohesion and mission readiness, as it disrupts the trust and bonds formed among servicemembers. The Tailhook sexual assault scandal in 1991 [1] and multiple allegations of sexual assault in the U.S. Air Force Academy that became public in 2003 [2], began to bring the long-standing issue of MST to light. The release of the Oscar nominated film, *The Invisible War*, in 2012, further raised this issue in the public consciousness and helped to motivate lawmakers to propose legislation to protect and support MST survivors [3]. More recently, the experiences of male survivors of MST have been highlighted in the popular press [4, 5]. In this chapter, we provide an overview of the impact, prevalence, prevention, and treatment of MST.

Vignettes

We will use two composite case vignettes throughout this chapter to illustrate the impact of MST on servicemembers. *Maria* is a Black, lesbian, unemployed, female Army veteran in her late 20s who sought treatment for PTSD and depression. She reported a history of a prior suicide attempt and current suicidal ideation. During

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C. H. Warner, C. A. Castro (eds.), *Veteran and Military Mental Health*,
https://doi.org/10.1007/978-3-031-18009-5_15

treatment, Maria disclosed that her father and brothers served in the Army and that she had hoped to build a lifelong career in the military when she joined at 18-years-old. She quickly proved herself during basic training and was particularly admired for her marksmanship. She served in Iraq as a prison guard and frequently did night patrols on her base. Initially, Maria spoke only about PTSD symptoms related to moral injury; she was distressed by witnessing the abuse and neglect of the prisoners she guarded. After developing a trusting relationship with her therapist, Maria disclosed that she had been raped while deployed. The day of her assault, Maria was invited to play cards with members of her unit after work. Although she did not feel like socializing, she wanted to form better working relationships with male servicemembers in her unit, who often excluded her from work-related discussions. When Maria arrived to play cards, she was surprised that only one soldier was present. She attempted to leave after a brief conversation with him, but he tackled her, dragged her to his cot, and raped her. Maria was disgusted, disoriented, and feared for her life. Afterwards, she felt incredibly ashamed and believed she should have defended herself or screamed when the assault occurred. She did not report the assault to anyone, believing that such a report would hurt her military career. She continued to see her assailant throughout her deployment. When their paths crossed, he would often wink or leer at her, causing her to feel angry and frightened about the possibility of future assaults, as well as to worry he told others about what he had done to her. Following her deployment, Maria avoided all relationships because she believed if she got close to or trusted others, that she would get hurt. She also reported significant anger, resulting in difficulties maintaining steady employment and housing, due to frequent conflict with others.

Bill is a middle-aged, heterosexual, White male Marine veteran who presented for treatment for PTSD, alcohol use disorder, and cocaine use disorder. His treatment history included numerous detox and residential substance use treatment programs. Bill waited 30+ years to disclose his MST to a medical provider. He was motivated to disclose his experience after seeing a news story about male victims of MST. He also reported that he did not think he could stop using substances until he dealt with memories of his assault. Bill reports he was assaulted after making a minor mistake in a basic training exercise that caused his unit to finish last in the exercise. That evening, Bill was taking a shower when several Marines attacked him, punched and kicked him, and raped him with a toilet plunger. During the assault they said, *"This is what we do to F*ck-ups."* The next day, Bill went to his sergeant and told him that he was "jumped" in the showers. He did not disclose the details of the sexual assault because he conceptualized the experience as "hazing" and was ashamed that he was not able to prevent it. His sergeant told him to "*do better"* during the next training exercise, so that the other Marines would be less likely to attack him in the future. Following the assault, he became hypervigilant around his fellow Marines, and during target practice he contemplated shooting the Marines who had assaulted him. He saw them daily for a full year after his assault because they were in the same unit and he began drinking heavily to cope with his anxiety, leading to a DUI (driving under the influence) off base. Upon completing his service, he began using cocaine to avoid sleeping (he had nightmares) and continued drinking, a pattern that persisted for decades. He questioned his sexual orientation, despite being attracted to women, and believed the assault made him "less of a man." Bill also reported he had refused his doctor's recommendation for a colonoscopy, despite ongoing gastrointestinal issues, because he was concerned it would trigger memories of his assault.

Epidemiology of MST

Unfortunately, *Maria* and *Bill* are not alone in their experiences. However, given that estimates vary dramatically across studies, the "true" prevalence of MST is difficult to determine. A recent meta-analysis noted that the prevalence of MST ranges across studies from 1 to 70% [6]. Such variation is due to methodological variability across studies, including the population surveyed, the time period assessed, the specific construct being studied (assault vs. harassment vs. both), the specific assessment used, and participants' beliefs about anonymity. Such methodological variability also makes it difficult to clearly compare the prevalence of unwanted sexual assault within and outside of military settings, although many have speculated about aspects of military culture that may contribute to an increased incidence of these experiences (e.g., hypermasculinity, strict hierarchical organizational structure, cultural acceptance of violence, heavy alcohol use, team allegiance) [7, 8].

The Department of Defense (DoD) produces some of the most robust epidemiological work, focusing on past-year prevalence of sexual assault and sexual harassment among military members. Using a widely distributed anonymous survey of active duty servicemembers, the DoD identified that 6.2% of active duty women (around 13,000 women) and 0.7% of active duty men (around 7500 men) were sexually assaulted in the year prior to the survey [9]. Although the estimated prevalence for active duty men remained stable from 2016 to 2018, the estimated prevalence for active duty women significantly increased (4.3% in 2016 to 6.2% in 2018), particularly for younger women (17–24-year-olds). In terms of sexual harassment, 24.2% of active duty women and 6.3% of active duty men indicated at least one experience of sexual harassment in the year prior to the survey [9]. These estimates represent significant increases for both women and men compared to 2016 data (21% and 5%, respectively).

Population-level prevalence data can be obtained from the Veterans Health Administration's (VHA's) universal MST Screening Program, which queries about experiences of sexual harassment or assault experienced throughout military service [10].

VHA Universal MST Screening Program Text

"I'm going to ask you about some things that may have happened to you while you were in the military. We ask all veterans and former Service members these questions because VA offers free care related to these experiences. You can simply say 'yes' or 'no' to these questions or, if you prefer, let me know that you'd rather not answer.

1. When you were in the military, did you ever receive unwanted sexual attention you found threatening (for example touching, cornering, pressure for sexual favors, sexual texts or online messages, or inappropriate verbal remarks, etc.)?
2. When you were in the military, did you ever have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?"

Recent data indicates that, among veterans seen at VHA facilities in the past year, 30.4% of women (representing 145,765 veterans) and 1.7% of men (representing 82,067 veterans) endorsed MST (sexual harassment and/or assault) on the two-question screener administered by a healthcare provider [11]. However, these data underestimate the true scope of harassment and assault, as they solely represent veterans who were VA healthcare users and who chose to disclose these experiences to a healthcare provider. In support of the hypothesis that VA screening data underestimate the true prevalence of harassment and assault, Bovin et al. [12] found that male and female veterans were more likely to endorse MST when assessed through structured interviews or anonymous surveys, as compared to VHA's Universal Screening Program. This pattern was particularly striking for male veterans, whose endorsement of harassment and assault experiences was 11 times higher on anonymous surveys than on VHA's Screening Program. For both men and women, this pattern may be explained by concerns about confidentiality or negative social reactions from others, feelings of shame or embarrassment, and stigma associated with sexual assault victimization.

Epidemiological data is a useful tool for characterizing unwanted sexual experiences of servicemembers and can be particularly helpful in understanding how prototypical experiences differ for men and women. Rigorous assessments, via large scale Department of Defense data, indicate that the majority of sexual assaults experienced by service members involve a single perpetrator (58% for men, 64% for women), although about one-third of incidents involved more than one perpetrator (37% for men, 34% for women; [9]). In regard to their "worst" sexual assault experience over the past year, 92% of women reported that their perpetrators were all men. For male victims, perpetrators were most often men (52%), although a sizable minority reported female perpetrators (30%). Women reported that their perpetrators usually included servicemembers (89%), whereas for men this was somewhat less frequent (71%). For both women (62%) and men (57%), most sexual assaults occurred at military installations. Characterizing important differences in men and women's experiences, men (38%) were more likely than women (21%) to describe their sexual assault experiences as hazing and/or bullying, which may help to explain why men were less likely than women to report these experiences to DoD authorities. In 2018, only 30% of women and 17% of men who experienced sexual assault indicated that they had formally reported those experiences.

This same data source also provides important contextual information about men and women's experiences of sexual harassment, using a robust assessment of that construct [9]. In regards to their "worst" sexual harassment experience 79% of women and 68% of men indicated that the experience was ongoing (i.e., happened more than one time). More than half of women (58%) and men (57%) reported that the worst incident involved more than one perpetrator. Among women, perpetrators were mostly men (72%), primarily servicemembers (95%), and all of the same or slightly higher rank. Among men, perpetrators were somewhat less likely to be men (58%), were largely servicemembers (93%), and about 50% were of the same or slightly higher rank.

Etiology of MST Sequelae

Given that MST comprises experiences across a broad range of severity, and that there is variability in environmental and individual resiliency factors, there is not a single prototypical response to MST. Some individuals may recover fully from these experiences, with limited long-term impact on their health and functioning. For those who experience more significant impacts, the severity of these symptoms will vary across and within individuals over time. Like *Maria* and *Bill*, many MST survivors experience chronic mental and physical health symptoms, as well as life disruptions, that are exacerbated by internal or external barriers to seeking care.

Experiences of MST are associated with a range of mental health conditions. MST heightens risk for posttraumatic stress disorder (PTSD), depressive disorders, anxiety disorders, eating disorders, dissociative disorders, and substance use disorders (e.g., [10, 13]). Indeed, MST is as strongly or more strongly associated with PTSD symptoms, as compared to severe combat exposure [14] or civilian sexual assault [15]. Similar to *Maria*, veterans who have experienced MST have elevated rates of suicidal behavior, including suicidal ideation, non-fatal suicide attempts, and non-suicidal self-injury (e.g., [10, 16]), and are significantly more likely to die by suicide than veterans without exposure to MST [17].

The negative impact of MST also extends to physical health. Like *Bill*, men who experienced MST are four times more likely, and women are twice as likely, to report physical health symptoms, as compared to men and women without a history of exposure [18]. Additionally, a history of MST increases the likelihood that both male and female veterans will engage in risky health behaviors, including risky sex behavior [18].

Finally, MST impacts career success. Studies of career impacts of military sexual harassment or assault indicate that these experiences are associated with increased risk of military demotion among servicewomen [19]. Like *Bill* and *Maria*, active duty servicemembers with a history of these experiences are significantly more likely to end their military service and subsequently be unemployed or disabled [13]. Both *Bill* and *Maria* mourned the loss of a career in the military, noting that this was one more thing their perpetrators had taken from them. Not surprisingly, MST experiences are also associated with higher likelihood of difficulties in work due to emotional and physical health problems [19]. Related to evidence of broader struggles in health and functioning, there is evidence of a link between MST and homelessness among women veterans [20]; this issue has been understudied among male veterans.

The significant health impacts associated with MST are not surprising considering the considerable impact of sexual assault that occurs in any context. Rape is one of the traumatic events most strongly associated with PTSD [21] and gender-based violence, including sexual assault, accounts for the largest proportion of PTSD cases worldwide [22]. Sexual assault involves intentional interpersonal victimization (often by a known perpetrator), frequently occurs relatively early in an individual's development, and may represent one of multiple traumatic events across the lifespan—all factors associated with worse mental health outcomes.

In a military context, impacts may be further exacerbated because experiences of MST conflict so strongly with military cultural expectations of loyalty and teamwork. Accordingly, men and women who are victimized by fellow service members may experience a strong sense of betrayal that their "brothers and sisters in arms" intentionally harmed them in this way. Additionally, trust is disrupted in a context where needing to trust those around you is essential; *Maria* pointed out that she never felt safe in Iraq after her rape: "He treated me like I was an animal—how could I trust him or anyone else to protect me from the Iraqis after that?"

Military cultural taboos against reporting fellow servicemembers' inappropriate or illegal behavior may limit disclosure and help-seeking. In addition, realistic concerns about retaliation from perpetrators or others also limits disclosure and help-seeking. As was the case with *Bill*, survivors who do disclose their experience may experience exacerbations in negative mental health sequelae if they perceive responses from leadership to be insufficiently supportive, victim-blaming, or ineffective at stopping the sexual trauma or holding the perpetrator accountable. Sadly, in one sample of female MST survivors, all who disclosed their MST to someone in the military reported experiencing at least one negative reaction their disclosure, with half of the women experiencing some form of retaliation [23, 24].

Another exacerbating factor of the military context is that, as compared to sexual trauma experienced among civilians, for servicemembers escape may be limited. Because of the nature of military service, servicemembers cannot easily quit their jobs and may not be allowed to change their duty stations or work assignments, resulting in ongoing contact with perpetrators. As noted by *Bill*, "I had to see, live, and work with my rapists every day for the next year, and it killed me. Of course I started drinking every chance I got."

Male MST survivors may struggle with an additional unique set of issues, in part explaining why many mental health impacts are worse among male, as compared to female, MST survivors [21, 25]. Because experiencing sexual trauma is not consistent with a traditional masculine identity, many men are not prepared to cope with this experience and feel intense shame in the wake of an assault [26]. Given the preponderance of male perpetrators, many men, like *Bill*, struggle with questions around their sexual orientation following an assault. Further, given that men are less likely than women to disclose these experiences to others, men are less likely to be connected with important informal or formal sources of support that could aid in their recovery.

Prevention

Given the alarmingly high prevalence of sexual harassment and assault in military settings, and the significant negative impact of these experiences on the health and wellbeing of those who have been victimized, primary prevention of sexual trauma

is a critical goal. The establishment of the DoD Sexual Assault Prevention and Response Office (SAPRO) in 2005 was a key initial step in establishing DoD-wide policies of effectively preventing and responding to sexual assault. A detailed discussion of DoD prevention strategies is beyond the scope of this chapter, but, in brief, SAPRO has focused on strategies with some evidence base, including bystander intervention training, responsible alcohol consumption promotion, and the creation of violence prevention specialists [27]. Following reports that the incidence of military sexual assault increased from 2016 to 2018, the acting Secretary of Defense, Patrick Shanahan identified additional key actions to prevent and respond to sexual assault in the military, including launching a program to catch serial offenders, improving assessments of the character of military applicants, and enhancing training for junior officers and junior enlisted leaders [28]. It will be important to continue to track the implementation and effectiveness of these initiatives over time to determine their impact on servicemembers.

The DoD has also developed secondary prevention programs aimed at preventing long-term negative health sequalae. A cornerstone of this effort is providing high-quality assistance to sexual assault survivors, through the efforts of Sexual Assault Response Coordinators (SARCs) and Sexual Assault Prevention and Response (SAPR) Victim Advocates, positions that were developed and filled by 2006 and standardized in 2012 [27]. Regarding legal support, the Special Victims' Counsel program ("the Victims' Legal Counsel" in the Navy) provides personalized legal advice and representation to survivors, helping them navigate the military justice system. Survey data demonstrates high levels of satisfaction among survivors using these programs [29].

A cornerstone of DoD's secondary prevention programs is the victim-centered reporting policy, which allows for restricted, or confidential, reporting to specific individuals like victim advocates or healthcare personnel. This policy allows individuals to benefit from victim advocacy, medical and mental healthcare services, and legal advice, without notifying command or law enforcement officials, thereby triggering a criminal investigation [30]. This approach also allows the victim to maintain control over their personal information and provides space and support to carefully consider the decision to participate in a criminal investigation, an approach that is likely to lead to increased unrestricted report rates. In an ongoing debate, many policymakers and survivors have argued that the prosecution of these crimes should occur outside of the chain of command, instead being handled by military prosecutors [31]. Advocates suggest this approach would encourage survivors to engage with the criminal justice system, improve their experiences, and reduce future assaults. Opponents suggest that commanders are critical to enforcing order and discipline in the military and that removing them from the process would result in fewer sexual assault prosecutions. A recently approved pilot program of independent sexual assault prosecutors at military service academies may provide new information on the effectiveness of this approach [32].

Screening and Assessment

Servicemembers and veterans may feel more comfortable disclosing MST when it is discussed within the context of broader assessments of mental health functioning and within a trusting supportive relationship that destigmatizes their experiences [29, 33].

Best Practice Guidelines for Screening and Assessment

- Assess MST within the context of a broader assessment process that gathers background and military history
- Note that you ask ALL clients/patients these questions because these experiences are common
- Provide *clear, concise* descriptors of *specific* behaviors in question (e.g., "were you forced to have sex against your will?"), rather than asking about more technical or emotionally charged terms, like sexual assault or harassment (see VHA Universal MST Screening Program text for example questions)
- If individuals endorse these experiences, thank them for their honesty and validate them:
  - "I really appreciate that you were willing to be honest with me about these experiences."
  - "By telling me about this, you have taken an important step on your path towards recovery."
  - "I am happy to connect you with treatment resources that have been helpful for other veterans who have had similar experiences."
- Know that anyone can be an MST survivor, regardless of demographic characteristics
- Offer respect, information, and support

Given that many survivors have had negative experiences with disclosure in the past, or have waited decades prior to disclosing MST, it is key to respond in a validating, empathic, and nonjudgmental manner when disclosure occurs [34]. When inquiring about and discussing MST, use clear, concise, specific language that fully defines the behaviors in question [23, 24]. For initial screenings, empower survivors to decide whether they want to disclose specific details of their MST. Although it may be necessary to gather additional information about the MST over time (e.g., to assess for Criterion A in PTSD), giving survivors control over what and how much they want to discuss following initial disclosures is key in developing trust. Finally, when survivors disclose these experiences, it can be helpful to normalize their reactions and to provide resources to support them on their path of recovery. Although no survivor should be pushed to report their MST experiences through formal channels, some survivors may wish to talk through the complicated issues involved in a decision to file a formal report with law enforcement officials, thereby triggering a criminal investigation. This issue is best discussed with a victim advocate who is

knowledgeable of local civilian and military regulations (either facility-based, from a local rape crisis center, or at DoD's anonymous Self Helpline).

Treatment

Given the range of psychiatric diagnoses associated with experiences of MST, recommended treatment modalities will depend, to a large degree, on the specific symptom patterns reported, underscoring the importance of a comprehensive diagnostic assessment. However, given that PTSD is the diagnosis most closely associated with experiences of MST, a solid knowledge of evidence-based treatments for PTSD is often key to delivering successful care to MST survivors. Clear guidance regarding PTSD treatment can be derived from two recent, rigorous reviews of the PTSD treatment outcome literature, the VA/DoD Clinical Practice Guideline for the Management of PTSD [35] and the International Society for Traumatic Stress Studies PTSD Prevention and Treatment Guidelines [36].

PTSD Treatment Guidelines

VA/DoD Clinical Practice Guidelines for the Management of PTSD

Psychotherapy: Individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include prolonged exposure, cognitive processing therapy, eye movement desensitization and reprocessing, specific cognitive behavioral therapies for PTSD, brief eclectic psychotherapy, narrative exposure therapy, and written narrative exposure.

Pharmacotherapy: Sertraline, paroxetine, fluoxetine, or venlafaxine as monotherapy for patients diagnosed with PTSD who choose not to engage in or are unable to access trauma-focused psychotherapy.

ISTSS PTSD prevention and treatment guidelines:

Psychotherapy: Cognitive processing therapy, cognitive therapy, eye movement desensitization and reprocessing, individual CBT with a trauma focus (undifferentiated), and prolonged exposure are strongly recommended for the treatment of adults with PTSD.

Pharmacotherapy: Fluoxetine, paroxetine, sertraline and venlafaxine are identified as interventions with low treatment effects for adults with PTSD.

Of note, both sets of guidelines provide the strongest recommendation for individual, manualized, trauma-focused psychotherapies as first-line treatments for PTSD. Both sets of guidelines also acknowledge that, given more limited evidence for its effectiveness, medication monotherapy is not indicated as a first line treatment for PTSD. VHA/DoD guidelines note that there is moderate evidence for Selective Serotonin Reuptake Inhibitors (SSRIs; Sertraline, Paroxetine, Fluoxetine, Venlafaxine), while also acknowledging that psychopharmacology is only recommended for

patients who do not want to engage in psychotherapy. The ISTSS guidelines state that SSRIs can be a recommended treatment when indicated, while acknowledging a low treatment effect for these medications. In terms of other medications, the VHA/DoD guidelines recommend against or strongly against many additional medications including specific antidepressants, antipsychotics and antiepileptics. The ISTSS guidelines indicate that there is insufficient evidence to recommend a similar list of medications, although notes that the antipsychotic medication Quetiapine is a treatment with emerging evidence of efficacy. As new medication-based interventions are developed and tested for their efficacy in PTSD, the recommendations for psychopharmacology-related treatment of PTSD are likely to change. Given the current evidence base, however, for treatment of PTSD, including PTSD due to MST, trauma-focused psychotherapies should be considered first-line treatments. Two of the most strongly supported psychotherapies, Cognitive Processing Therapy [37] and Prolonged Exposure Therapy [38] were originally developed for and tested among sexual assault survivors. CPT includes psychoeducation about PTSD and focuses on challenging maladaptive thoughts and beliefs about safety, trust, power/control, esteem, and intimacy that develop following trauma exposure, in order to impact emotional and behavioral responses [39]. Recent meta-analytic work indicates that 89% of individuals participating in CPT fared better posttreatment than those in inactive control conditions [40], and CPT has shown modest benefits compared to active control treatments among veterans with MST-related PTSD [41]. PE includes psychoeducation about PTSD, breathing retraining to decrease autonomic arousal, repeated recounting of the trauma to teach individuals that their trauma memories are not dangerous and do not need to be avoided, and in vivo exposure to feared real-world situations to decrease fear responses to trauma reminders in the environment. PE intervenes at the level of trauma-related behavior to change thoughts and emotions. A substantial body of research supports the use of PE among survivors of sexual assault [42], with large reductions in symptoms observed following PE among veterans, regardless of trauma type and gender [43], and demonstrated effectiveness among women veterans, most of whom were treated for MST-related PTSD [44].

In our clinical experience, there are several treatment themes that are particularly likely to emerge when treating MST-related PTSD. Given the interpersonal nature of MST, many survivors report difficulties in interpersonal relationships, including struggles with trust and intimacy, problems identifying and setting appropriate boundaries, or unusually strong reactions to hierarchical relationships. Sexual trauma, in general, is strongly associated with self-blame, guilt and shame, and these thoughts and emotions frequently arise among MST survivors. Safety and revictimization may be an area in need of particular focus. Some patients may experience extremes in safety behavior, including global distrust of others, accompanied by hyperattention to personal safety, or a seeming inattention to safety, or vacillation between both extremes. Finally, given the sexual nature of MST, many survivors struggle with questions around their sexuality, extremes in sexual behavior (e.g., only able to engage in sexual behavior while intoxicated or high), or sexual dysfunction.

Of note, the VHA offers *free* care (therapy, medication, outpatient, residential, etc.) for all MST-related mental and physical health conditions, allowing survivors to get

much-needed care, regardless of their eligibility for other VHA services. Returning to our case examples, both of whom received care at a VHA facility, *Maria* engaged in a course of CPT. She declined a referral to be evaluated for medications to help with symptom management. Due to employment and economic stressors, she often had difficulties with homework completion in CPT. Nonetheless, as we challenged particular beliefs around trust (e.g., "I cannot trust anyone"), she began to increase her connection with others. PTSD symptoms improved and she began to feel safer in her environment. By emotionally engaging with her trauma memory, she allowed herself to feel the grief she had suppressed and work through her sadness and anger. Cognitive restructuring (i.e., examining the evidence for and against the idea that it was her fault she was raped) allowed her to let go of self-blame and shame. *Bill* engaged in a course of Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE), a treatment modality that integrates PE with cognitive behavior therapy (CBT). Throughout the course of treatment, he worked on CBT skills for sobriety, while repeatedly exposing himself to his trauma memory and to trauma reminders/avoided situations (e.g., gym locker room with men, sitting with his back to the door in a restaurant, building trust in familial relationships by telling his mother he was an MST survivor). Initial imaginal exposures to his trauma memory caused rapid reductions in anxiety. As he repeatedly recalled details of his rape, his perspective on the experience shifted and he stopped blaming himself for his rape, which led to reductions in shame. Later imaginal exposures focused on processing his grief regarding what he described as "a loss of innocence," as well as a loss of a lifelong career in the military. Upon completing COPE, he evidenced clinically significant improvements in PTSD symptoms, was abstinent from substances, and sought a colonoscopy for his gastrointestinal problems.

Additional Resources:
VA MST information and VHA services and services:
https://www.va.gov/find-locations/
www.mentalhealth.va.gov/mst
https://www.mentalhealth.va.gov/msthome/resources.asp
https://www.va.gov/health-care/health-needs-conditions/military-sexual-trauma/
Factsheet for MST survivors:
https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf
Self-help mobile app for MST survivors:
Beyond MST—PTSD: National Center for PTSD (va.gov)
Helplines:
Veterans Crisis Line—"Dial 988 and Press 1" www.veteranscrisisline.net
DoD Safe Helpline—(855) 344-5137 www.safehelpline.org
VHA Women Veterans Call Center—1-855-829-6636
National Sexual Assault Hotline (RAINN)—1-800-656-4653
Community resource for male survivors:
www.1in6.org
PTSD treatment overview and free expert consultation for anyone treating veterans with PTSD:
https://www.ptsd.va.gov/understand_tx/tx_basics.asp
PTSDconsult@va.gov or (866) 948-7880

Videos of veterans discussing their experiences recovering from MST:
Military Sexual Trauma	AboutFace (va.gov)
https://maketheconnection.net/conditions/military-sexual-trauma
Finding healthcare and therapists:
https://www.ptsd.va.gov/gethelp/find_therapist.asp
http://www.vetcenter.va.gov
http://www.findcbt.org/FAT/
https://istss.org/public-resources/find-a-clinician.aspx

Conclusions

Military sexual trauma substantially and negatively impacts individual servicemembers and the U.S. military as an institution. It is a costly problem that disrupts the bonds between servicemembers and threatens unit morale. As per DoD reports, *38 men and 33 women are sexually assaulted daily* in the military [45]. MST survivors often suffer in silence for years following these experiences, waiting for decades to seek treatment. As providers, it is our responsibility to create an empathetic and caring environment that can empower those who have experienced MST to face their traumatic memories and move forward on a path of recovery. Further, connecting servicemembers and veterans with evidence-based treatments is essential. They paid a terrible price while serving their country and it is incumbent upon us to provide them with the support and care necessary to heal.

Clinical Pearls

- In 2018, the DoD identified that 6.2% of active duty women (around 13,000 women) and 0.7% of active duty men (around 7500 men) were sexually assaulted, while 24.2% of active duty women and 6.3% of active duty men indicated at least one experience of sexual harassment.
- Most recent data indicates that, among veterans seen at VHA facilities in the past year, 30.4% of women (representing 145,765 veterans) and 1.7% of men (representing 82,067 veterans) endorsed MST (sexual harassment and/or assault) on the two-question screener administered by a healthcare provider. However, these data likely underestimate the true prevalence of harassment and assault, as they solely represent veterans who were VA healthcare users.
- Given that many survivors have had negative experiences with disclosure in the past, or have waited decades prior to disclosing MST, it is key to respond in a validating, empathic, and nonjudgmental manner when disclosure occurs.
- For initial screenings, empower survivors to decide whether they want to disclose specific details of their MST.
- Given the range of psychiatric diagnoses associated with experiences of MST, recommended treatment modalities will depend, to a large degree, on the specific symptom patterns reported, underscoring the importance of a

comprehensive diagnostic assessment. However, given that PTSD is the diagnosis most closely associated with experiences of MST, a solid knowledge of evidence-based treatments for PTSD is often key to delivering successful care to MST survivors.

- Clear guidance regarding PTSD treatment can be derived from two recent, rigorous reviews of the PTSD treatment outcome literature, the VA/DoD Clinical Practice Guideline for the Management of PTSD [35] and the International Society for Traumatic Stress Studies PTSD Prevention and Treatment Guidelines [36].

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