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Female Military Sexual Trauma: A Critical and Comprehensive Literature Review

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Female Military Sexual Trauma: A Critical and Comprehensive Literature Review

by

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This doctoral project was submitted by Anna Stanton under the direction of the chair of the doctoral project committee listed below. It was submitted to the Graduate School of Clinical Psychology and approved in partial fulfillment of the requirements for the degree of Doctor of Clinical Psychology at Eastern Kentucky University.

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Abstract

Military Sexual Trauma (MST) refers to a psychological trauma that resulted from any sexual assault or threatening sexual harassment that a military member experienced during his or her military service. Military sexual trauma is a significant problem within the United States military that threatens the strength, readiness, and morale of the military, and has devastating personal effects on survivors and their families. During 2006, the military began taking steps to understand the prevalence of MST and implement programs to help prevent it. Despite some of the progress these programs have shown, there are still barriers that impede an MST survivor's reporting and treatment seeking behaviors. This literature review examines the prevalence of MST and the impact it has on survivors, explores barriers service members face reporting and seeking treatment and reviews treatments for MST. This literature review also examines the history of proposed and implemented legal protection acts pertinent to MST and discusses their benefits and limitations. Finally, recommendations from the literature are discussed pertaining to future research and clinical practice. *Keywords:* military sexual trauma, prevalence, barriers, reporting, treatments, and advocacy.

Acknowledgments

I would like to acknowledge everyone who played a role in my academic accomplishments. First and foremost, my husband, who supported me with love and understanding. Without you, I could never have reached this current level of academic success. Secondly, I would like to recognize my fellow cohort members that have been like a family to me during this wonderful but challenging time of life known as graduate school. Lastly, my committee members, each of whom has provided patient advice and guidance throughout this process. Thank you all for your unwavering support.

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Section I: Introduction

Statement of the Problem and Significance of the Issue

The United States military faces a significant issue with the occurrences of military sexual trauma (MST) and the effect these have on MST survivors, their families, and ultimately the military. The Department of Defense (DoD) reports that during the 2018 fiscal year, 20,500 service members experienced sexual assault (Department of Defense, 2020). With such a high occurrence of sexual assault and harassment, one would expect equivalent rates of reporting to match. However, the contrary exists. Of those 20,500 service members, the DoD estimates only 6.2 % of females and .7% of males were accounted for in sexual misconduct reports to the DoD (Department of Defense, 2020). There are many factors to consider in understanding the discrepancy between prevalence and reporting rates of MST. Such factors include, but are not limited to, self-stigma, a military culture of hypermasculinity, fear of retaliation, etc. Moreover, survivors of MST face detrimental effects such as increased rates of Posttraumatic Stress Disorder (PTSD), suicide, homelessness, addiction, and eating disorders following their sexually traumatic event (Blais et al., 2018; Goldberg et al., 2019; Lutwak, 2013; Wilson, 2016). Additionally, sexual violence and the following psychological trauma affects survivors' relationships with their family members, friends, and co-workers (Goodcase et al., 2015; Millegan et al., 2015).

Definition of Military Sexual Trauma

According to the DoD Directive 6495.01, which is the Sexual Assault Prevention and Response (SAPR) Program, military sexual assault is defined as "intentional sexual contact, characterized by use of force, threats, intimidation, abuse of authority, or when the victim does not or cannot consent" (Department of Defense, 2012). Sexual assault can occur without regard

to gender or spousal relationship or age of victim. The SAPR Program explains in the DoD 2019 report of military sexual assault that the DoD utilizes the phrase “sexual assault” to describe a series of offenses, including rape, sexual assault, forcible sodomy, aggravated sexual contact, abusive sexual contact, and attempts to commit these offenses, as defined by the Uniform Code of Military Justice (Department of Defense, 2020). Mercardo et al. (2015) also classifies sexual intimate partner violence as a form of MST. Specifically, Mercardo and colleagues (2015) found that 15% of their female veteran participants were victims of intimate partner violence during their military service. The researchers found that these victims also had significant health issues from their sexual trauma similar to those that experienced sexual trauma from a non-intimate partner.

In addition to sexual assault, MST also includes sexual harassment (Fitzgerald et al., 1995). There are three distinct types of sexual harassment behaviors: gender harassment (also known as gender discrimination), unwanted sexual attention, and sexual coercion (Fitzgerald et al., 1995). Gender harassment consists of remarks and behaviors that discriminate based on gender. For example, making statements that women are less intelligent than men and vulgar sexual comments. Unwanted sexual attention consists of verbal and nonverbal sexual behaviors, such as unwanted touching and pressure to participate in romantic or sexual exchanges. Sexual coercion consists of promises or threats of academic or job-related consequences depending on the victim’s compliance with sexual demands, for example, sexual bribery and threats. The Veterans Affairs Healthcare System uses the Federal Law, Title 38 U.S. Code 1720D, for their definition of MST (Counseling and treatment for sexual trauma, 1992). This law states that MST refers to a psychological trauma, which a VA mental health professional believes resulted from a sexual assault, battery of a sexual nature, or sexual harassment which happened during military

service. For this review, MST refers to a psychological trauma that resulted from any sexual assault or threatening sexual harassment that any military member experienced during military service.

Purpose

The objective of this doctoral specialty project is to provide a comprehensive review of the current literature on MST. There is a vast amount of MST research that has been conducted in the past couple of decades, however, there seems to be a lack of extensive review and analysis of what has been done and what still needs to be done in relation to MST. This literature review explores the ways in which military sexual trauma has been addressed by the DoD and the VA, noting attempts on their part that range from introducing legislative acts to prevention programs. Additionally, it discusses the ways MST impacts survivors and their loved ones as well as barriers survivors face when reporting sexual misconduct and seeking treatment. Finally, this literature review provides recommendations for future research and suggestions for clinical practice.

Section II: Literature Review

Methods of Literature Search

Research was conducted by searching for online academic search engines that included: PsycINFO, EBSCO Host, Academic Search Complete, APA PsycArticles, ResearchGate, and Google Scholar. Journals searched included: Journal of Traumatic Stress; Journal of Clinical Psychology; Contemporary Family Therapy: An International Journal, Psychology of Addictive Behaviors; Cognitive Behaviour Therapy; Journal of Child & Adolescent Trauma; Professional School Counseling; Traumatology; Journal of the International Society for the Investigation of Stress, Psychological Trauma: Theory, Research, Practice, and Policy; Substance Use & Misuse; Military Medicine; Psychological Services; Trials; Psychology of Violence; Professional Psychology: Research and Practice; Perspectives in Psychiatric Care; Translational Issues in Psychological Science; Depression and Anxiety; International Journal of Sexual Health; Clinical Social Work Journal; Psychology of Men & Masculinity; Acta Psychiatrica Scandinavica; Journal of Political & Military Sociology; Health & Social Work; Professional Psychology: Research and Practice; Archives of Psychiatry and Psychotherapy; Clinical Psychology: Science & Practice; American Journal of Public Health; International Journal of Eating Disorders; Psychological Assessment; Nature Reviews Neuroscience; Journal of Community Psychology; Stress and Health: Journal of the International Society for the Investigation of Stress; Journal of Feminist Family Therapy: An International Forum; Journal of Rural Mental Health; Sexuality and Disability; Mental Health, Religion & Culture; Journal of Counseling & Development; Victims & Offenders; Best Practices in Mental Health: An International Journal; Journal of Sex & Marital Therapy; Suicide & Life-Threatening Behavior; and Journal of Psychotherapy Integration. Key words searched included: military sexual trauma, barriers, culture, advocacy,

evidence-based treatment, evidence-based assessment, diagnosis, reporting, mental health, PTSD, Suicide, substance abuse, homelessness, pre-existing sexual trauma, and epigenetics. No restriction was set for timeframe of articles during the search.

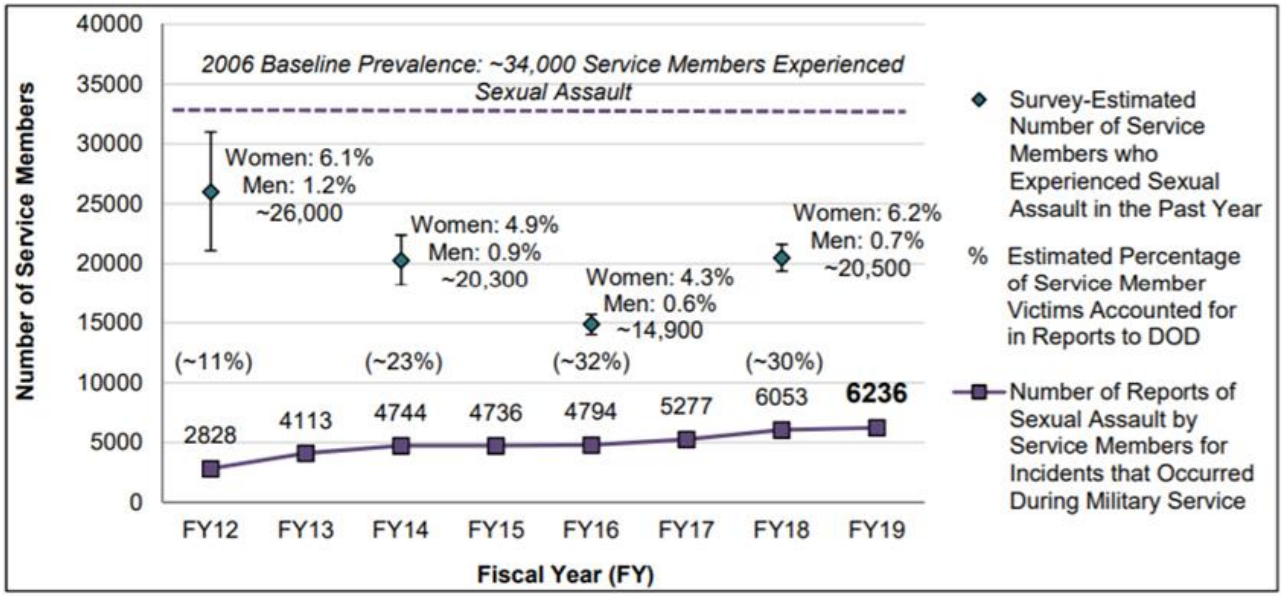
Literature Review

The Issue of Sexual Trauma within the Military

According to the DoD, 34,000 service members experienced sexual assault during the 2006 fiscal year (Department of Defense, 2020). The first year that the DoD surveyed service members to assess for prevalence of military sexual assault was 2006. This created a baseline for sexual assault prevalence in the military. More recently, the DoD reported that during the 2018 fiscal year, 20,500 service members experienced sexual assault (Department of Defense, 2020). Of those 20,500 service members, the DoD estimates only 6.2 % of females and .7% of males are accounted for in the reports to the DoD. The SAPR Program reported that the DoD received a total of 7,825 sexual assault reports during the 2019 fiscal year, a three percent increase from the 2018 fiscal year with 7,623 reports. The SAPR asserts that this might not be due to an actual rise in prevalence of sexual assaults in the military because a prevalence study was not conducted for the 2019 fiscal year to add context to the reporting rates. However, when reviewing past years of sexual assault reports and comparing them to prevalence rates, there is a steady positive correlation between the two. Please see Figure 1 for SAPR's active-duty estimate (Department of Defense, 2020).

Figure 1

Active Duty Estimated Biennial Prevalence Compared to Annual Reporting of Sexual Assault



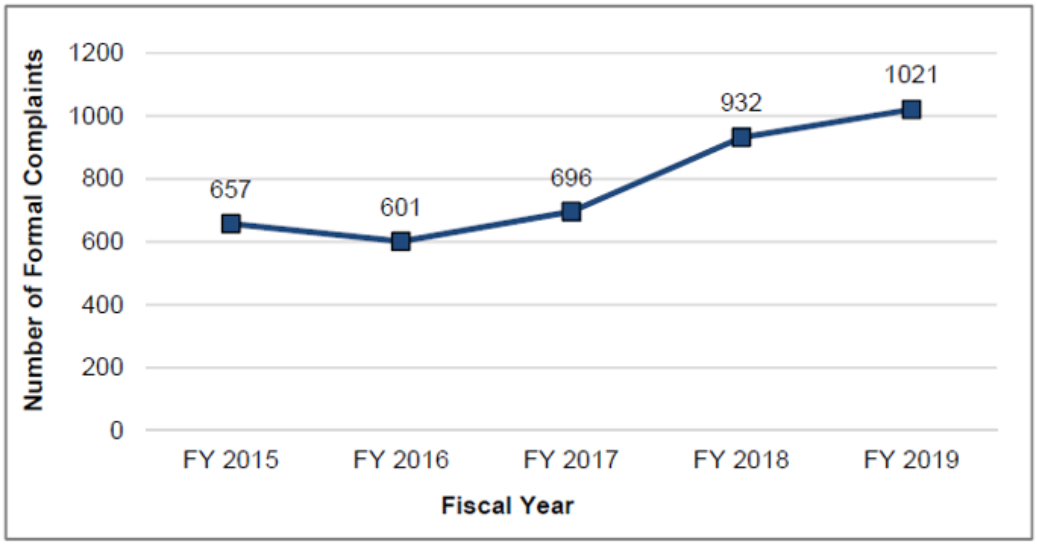
Additionally, the SAPR Program reported that during the 2019 fiscal year, the DoD received a total of 1,021 formal sexual harassment complaints, a 10 percent increase from complaints filed during the 2018 fiscal year (Department of Defense, 2020). Groves (2013) discusses the significant increase of sexual assaults reported by the DoD in 2010 after women were allowed in combat roles, with most assaults being carried out male to female (87%), but still a small fraction being male to male (7%). Unfortunately, there is limited knowledge about the frequency of military sexual assault (MSA) among LGBTQ+ service members. However, research by Beckman et al. (2018) determined that overall, 17.2% of transgender veterans experienced MSA but that the trends were in the reverse direction compared to cis gender veterans discovering that 15.2% of transgender women and 30% of transgender men experience MSA versus 20% of non-transgender women and 1% of non-transgender men. Overall, Beckman et al. (2018) concluded that transgender service members are at an increased risk for MSA and sequalae that follows, such as a heightened risk for PTSD, depression, addiction, and suicidal

ideation. Groves (2013) attempts to provide explanations for the occurrence of MST, stating that sexual assault is an assertion of control and within the military framework is perceived as an illustration of hypermasculinity. Groves (2013) declares that on occasion, sexual assault, has been supported and peer-driven within the military; this can lead to a subculture that creates barriers to reporting and treatment seeking for those who have survived such traumas. Researchers have also explored the role of other military members regarding MST. For example, Sadler et al. (2017) found that US military officer leadership behaviors significantly influence female military members' risk of and safety from MSA.

Military Sexual Trauma also involves sexual harassment. During the 2019 fiscal year, the DoD reports that they received 1,021 formal sexual harassment complaints. In 2019, the DoD formed the Sexual Assault Accountability and Investigation Task Force (SAAITF) to "identify, evaluate, and recommend immediate and significant actions to improve the accountability process specific to the investigation and disposition of cases in which members of the Armed Forces are either victims or alleged offenders of sexual assault, while ensuring due process for both." According to the 2019 SAPR report, in fiscal year 2019, the military received a total of 1,021 formal sexual harassment complaints, a 10 percent increase from complaints filed in fiscal year 2018. Please see Figure 2 for the SAAITF's DoD formal sexual harassment complaints from 2015-2019 (Department of Defense Sexual Assault Accountability and Investigation Task Force, 2019).

Figure 2

DoD Formal Sexual Harrassment Complaints (FY15-FY19)



Further exploration of the prevalence of MST, barriers to reporting and treatment seeking, and the effect of MST on survivors are discussed later in this paper.

History of Proposed and Implemented Legal Protection Acts

The United States military wants employees to report misconduct without fear of retaliation (Sharpless, 2019). As a result, in 1988, the DoD enacted the Military Whistleblower Protection Act (1988). This Act helped provide rights to and protect military members from retaliation when reporting misconduct within the military. This Act has been updated and improved in previous years by expanding the meaning of "protected communications" and broadening to whom protected communications can be made. Additionally, Executive Order No.12731(1990) required all federal employees to report waste, fraud, abuse, and corruption to appropriate authorities. Similarly, the Whistleblower Protection Enhancement Act (2012) was passed, which expanded some of the original rights and protections provided to military members from the original Whistleblower Protection Act (1989). For example, this revision required each Inspector General of a federal agency to assign a Whistleblower Protection

Ombudsman, known as the Whistleblower Protection Coordinator. This individual has the duty to inform agency employees about prohibitions on retaliation for protected disclosures and rights and remedies against such retaliation. The Military Whistleblower Protection Act (1988), as amended, states that military personnel can make a protected communication to a member of Congress or Inspector General without others impeding the process or retaliation or threats of retaliation. Under the Military Whistleblower Protection Act (1988), a protected communication includes "a violation of law or regulation, including a law or regulation prohibiting sexual harassment or unlawful discrimination", or rape, sexual assault, or other sexual misconduct in violation of the Uniform Code of Military Justice (UCMJ) (Whistleblower Protection Act, 1988, p. 522).

According to Sharpless (2019), in the case of reporting, protected communications can be made to a member of Congress, an inspector general, a member of a DoD audit, inspection, or law enforcement agency, personnel in the chain of command, a court-martial proceeding, or any other person designated allowed to receive such communications. Under the updated Whistleblower Act of 2012, the military made it clear that those reporting should be free of reprisal, also known as retaliation, as well as free of restriction or limitation to reporting. Despite these clear declarations, there is still retaliation and restriction present within the military today (O'Brien et al., 2015; Rabelo et al., 2019). The military has appeared to acknowledge the problem of reprisal and restriction and has provided ways to submit an official reprisal or restriction complaint via online and telephone hotlines (Department of Defense Inspector General).

There have also been additional proposed and implemented legal protection acts put in place since the Military Whistleblower Protection Act (1988). Moreover, the Protecting Military

Honor Act (2017) was passed with the purpose to improve protections for MSA survivors. Specifically, the Protecting Military Honor Act (2017) requires military branches to create a confidential method for MSA survivors to submit application to boards to correct military records. This Act gave MSA survivors a way to challenge the conditions or classification of their discharge or separation from the military (Protecting Military Honor Act, 2017). Additionally, during this process, discharge review boards can refer certain applications that involve a sex-related offense to the physical disability board of review (Protecting Military Honor Act, 2017).

Most recently, the Deborah Sampson Act (2021) was passed as of January 5th of 2021. This Act increases access of care and services for female veterans by minimizing barriers to services such as working to resolve issues such as homelessness, unemployment, and other barriers to health care. This Act initiates the development of the Office of Women's Health at the VA. This office will focus on female transition to civilian life via group counseling retreats for female veterans and their family members as well as increasing call center services for female veterans. This Act also decreases barriers to services for female veterans by staffing every VA healthcare facility with a women's health primary care provider, training clinicians in women's health, improving privacy, and making the healthcare environment more conducive to females. This Act also increases support services for female veterans via female focused legal services and expands access to childcare for female veterans seeking VA healthcare services. This Act also mandates that the Government Accountability Office report the VA's endeavors in helping homeless or at-risk female veterans. This Act also improves access to care and benefits for MST survivors of all genders. This is done by enlarging MST counseling services to former National Guard and Reserve members. The VA is now also permitted to treat physical health conditions related to MST. This Act has also enhanced the claims procedure for MST survivors at the

Veterans Benefits Administration by now having individuals specialized in MST reviewing veterans' service connection claims for disorders that they are claiming are MST related.

The Deborah Sampson Act (2021) also permits MST survivors without an honorable discharge to receive medical and mental health services for conditions rooted from their MST. The Deborah Sampson Act (2021) declares something to be an MST related condition if the condition is a direct result of the trauma or if the MST exacerbated the preexisting condition. Additionally, Deborah Sampson Act (2021) removes the word "repeated" when defining sexual harassment experiences. The former definition of sexual harassment deemed as MST was described as, "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character." As a result, individuals that experienced one sexual will now have access to MST services.

Overall, there has been progress in the awareness of MST and rights for MST survivors regarding reporting, discharging from the military, and seeking treatment. The ability to report without restriction or retaliation and the ability to make a formal complaint of retaliation, in the event it does occur, was set in place through the Military Whistleblower Protection Act (1988), revised in 2012. The ability for survivors to challenge their discharge or separation from the military was set in place through the Protecting Military Honor Act (2017). And most recently, the passing of the Deborah Sampson Act (2021) regarding treatment.

Despite the DoD's attempt to right a wrong concerning military misconduct through these legal acts, there still seems to be a persistent undercurrent of systemic military culture that undermines these efforts (Andresen & Blais, 2019; Blais et al., 2018). Fortunately, Janelle Marina Mendez, an MST survivor, and the president of the MST Movement, has proposed the MST Victims Bill of Rights (Mendez, 2019). There are fourteen policies proposed within the

MST Victims Bill of Rights that address a multitude of issues that are pertinent to an MST survivor. According to Mendez (2019), the MST movement is pursuing political change that will end the established system that promotes victimization of military members through MST. The following are the proposed policies through the MST Victims Bill of Rights. The first policy proposes appointing a mental health professional from the VA Healthcare System to an active-duty member once sexual misconduct is reported (Mendez, 2019). Mendez (2019) explains that this policy would guarantee all MST cases are integrated into the VA data system, and as a result, MST survivors are assured access to mental health services. Mendez (2019) also rationalizes that this potential policy could guarantee inpatient services and other support services to help prevent homelessness upon separation from the military. She cites a VA study from 2001 to 2007 that found that 14% of non-deployment related deaths of male and female veterans were suicide and a report performed by a Human Rights Watch organization in 2015 recorded that 53% of homeless female veterans reported being victims of MST. These findings are echoed in many other studies. Specifically, Wilson (2016) found that 40% of homeless female veterans have faced MST and that veterans with an MST history are over twice as likely to experience homelessness. Weinrich et al. (2016) also found that out of their population of homeless female veterans, 100% of them had experienced MST during their military service. Additionally, Blais et al. (2018) found that 71.7% of a female veteran research population identified MST as the source of their current PTSD symptoms. Additionally, when Blais et al. (2018) compared individuals who had experienced MST to those who reported the source of their PTSD symptoms as combat or deployment related, and found that those who identified MST as the source of their PTSD symptoms were at least three times as likely to report current suicidal ideation. These findings provide empirical evidence to support the policy proposal to

have an MST survivor immediately be assigned a mental health professional to help guide them through the sequalae they may be experiencing.

The second policy within the MST Victims Bill of Rights states that MST survivors should be provided the option to register for housing benefits and spending stipends for 36 months following their separation from the military. Mendez (2019) explains that this specific policy could make it easier for MST veterans to attend mental health treatment at the VA without trying to establish basic needs such as housing. She argues that the 36-month time frame would allow MST survivors to acquire the healthy coping skills to manage their PTSD symptoms which would create an easier reintegration into civilian life. This policy proposal is further supported by the evidence that was previously mentioned about the increased risk for homelessness for veterans that experience MST.

The third policy offered by the MST Victims Bill of Rights proposes legalizing medical marijuana as a form of treatment for PTSD. Mendez explains that this could be done by conducting more clinical trials for use of marijuana in treating PTSD. Mendez (2019) discusses a study from the journal of *Molecular Psychiatry* suggesting that certain plant-based cannabinoids found in marijuana could potentially help relieve PTSD symptoms such as nightmares. However, extensive research has suggested the opposite (Steenkamp et al., 2017). Specifically, Steenkamp's extensive literature review on the use of marijuana in managing PTSD symptoms found that treatment outcome research of marijuana and related cannabinoids on PTSD symptomology are not operationally rigorous and are limited due to legal restraints, impeding scientifically sound conclusions about the potential therapeutic effects of marijuana on PTSD. Steenkamp et al. (2017) also discusses how research has shown an association between marijuana use and commonly comorbid disorders with PTSD, like psychosis and substance

misuse. Steenkamp et al. (2017) also reviews how marijuana use is associated with maladaptive coping styles and worse treatment outcomes which could maintain versus reduce PTSD symptoms.

The fourth policy within the MST Victims Bill of Rights proposes overturning Section V of the Veterans Mental Health and Other Care Improvement Act which Mendez (2019) states would terminate federal financial support of using addictive medications such as Ketamine and LSD with veterans. Mendez (2019) believes there is a high risk of addiction with these substances and that they have not yet been FDA approved for the treatment of psychiatric disorder such as depression. However, on March 5th of 2019, the FDA approved a ketamine derived nasal spray medication for the treatment of resistant depression (Commissioner, 2019). According to the FDA, due to the potential of negative side effects (e.g., dissociation) and addiction, this medication is available only through certified physicians and clinics (Commissioner, 2019). The FDA assures that the use of ketamine is highly regulated using the FDA Risk Evaluation and Mitigation Strategy (REMS). The REMS was created in 2007 by the FDA to help monitor medications with a high potential for serious side effects to help ensure the benefits of a medication outweighs its risks (Commissioner, 2019).

While ketamine is now being used to treat psychiatric disorders like treatment resistant depression (Siegel et al., 2021), Mendez (2019) also believes that LSD should not be used with veterans. The use of LSD to treat psychiatric disorders began in the 1940's (Smith et al., 2014). During the mid-20th century, studies surfaced testing the use of LSD for alcoholism and other psychiatric disorders. It was determined that less than one percent of participants suffered negative side effects and showed a psychotherapeutic benefit from the substance (Smith et al., 2014). Shortly after these findings, the US government transitioned LSD to a Schedule I drug

and ceased funding for research using LSD. Recently, there has been a resurgence in the research of psychedelic-assisted psychotherapy including LSD and MDMA (Smith et al., 2014). Specifically, studies have examined MDMA in treating PTSD and after many clinical trials, results indicated a large treatment effect. Though not yet FDA approved, these studies led to the FDA granting breakthrough therapy designation for MDMA-assisted psychotherapy for PTSD.

The fifth policy within the MST Victims Bill of Rights proposes having an independent review board investigate MST cases to help minimize retaliation (Mendez, 2019). Mendez (2019) argues that retaliation easily occurs under the current system that allows chain of command to investigate these MST cases. For example, she states that the reporting MST survivor may be under the command of individuals that are implicated in their traumatic event. Duplantis (2020) states that retaliation is the norm in the military. Based in the DoD SAPR 2020 report, 64% of females who reported a sexual assault faced retaliation with 66% of retaliation reports claiming that retaliators were in the reporter's chain of command (Sexual Assault Prevention and Response, 2020). During DoD active duty focus groups administered in 2019, participants reported an unhealthy chain of command atmosphere which could lead to feelings of discomfort and concern in reporting a sexual assault or sexual harassment (Sexual Assault Prevention and Response, 2020). These focus groups also reported fear of retaliation for reporting an experience of sexual assault and worried that the report would not be remain confidential (Sexual Assault Prevention and Response, 2020). Retaliation remains present in the military despite legislation like the amended Military Whistleblower Protection Act (1988). Therefore, this proposal has merit in the hopes of protecting MST survivors during and after reporting their traumatic event.

The sixth policy within the MST Victims Bill of Rights proposes victims having the option to separate from the military once there is evidence to support their claim of MST (Mendez, 2019). Mendez (2019) explains that sometimes MST survivors will flee the military to escape further victimization and as a result will be labeled as a military member with an "unauthorized absence" which can negatively affect their reputation and career. The seventh policy proposes that military members should the option to join another military branch or separate from the military upon findings to support MST (Mendez, 2019). Mendez explain that giving MST survivors this choice will prevent a further failure of justice.

The DoD defines an unauthorized absentee as any military member who is absent from duties without permission (Department of Defense, 2012). According to DoD Directive 1325.02, absentee members will be arrested by military or civilian law enforcement agencies and then detained at a military detention center (Department of Defense, 2012). Additionally, desertion under aggravated circumstances is added to the charges if the absentee member is a commissioned officer or has had access to classified defense information that could jeopardize U.S. security interests. As a result, MST survivors that flee the military to escape revictimization are deemed criminals in the eyes of the government. If this sixth and seventh policies of the MST Bill of Rights were enacted this would allow MST survivors to separate from the military without persecution.

Like the fifth policy, the eighth policy within the MST Victims Bill of Rights proposes developing an independent review board governed by the VA in determining MST discharges (Mendez, 2019). Doing such would result in the removal of MST discharges being overseen by the Chain of Command (COC) across all military branches. Like the justification for the fifth

policy, the COC may contain members that are involved in the survivor's sexual trauma increasing the probability of retaliation and/or revictimization.

The ninth policy within the MST Bill of Rights proposes establishing a required training program across all military branches on MST (Mendez, 2019). Britt, Wright, and Moore (2012) found that military leadership behavior is a predictor of stigma and potential practical barriers trauma survivors face when considering mental health treatment. The researchers discuss how noncommissioned officers (NCO) have a large influence on treatment seeking behaviors due to their direct supervisory role over others. Their findings support the notion that military leaders who display more positive behaviors may be more likely to remove practical barriers by clarifying procedures and making accommodations for those seeking mental health treatment. While negative leadership behaviors, such as embarrassing a subordinate unit member in front of others, may be more likely to produce a work environment with higher levels of mental health stigma. As such, this type of policy would hopefully educate military leadership about MST and provide training on positive leadership behaviors that could help decrease some of the stigma and logistical barriers MST survivors face when reporting and seeking mental health treatment.

The tenth policy within the MST Bill of Rights demands that it be required that the DoD publicly report MST reports and findings (Mendez, 2019). Since 2006, the DoD has gathered statistics on the prevalence of MST and rates of reporting MST each fiscal year (Sexual Assault Prevention and Response, 2020). In these annual reports, the DoD discusses approaches they are taking to help reduce rates of MST such as implementing the Sexual Assault Prevention and Response Program. Additionally, in August of 2018, the Department of Veterans Affairs in the office of the Inspector General created a comprehensive report on denied PTSD claims related to MST to examine if VA staff correctly processed veterans' MST-related claims in accordance

with Veterans Benefits Administration policy prior to denying claims. Though this is a step in the right direction in examining disability claims for veterans with MST, this evaluation does not reveal the conclusions of active-duty service members' reports of MST.

The final policy within the MST Victims Bill of Rights proposes that all MST survivors, regardless of when they separated from the military, have their rights reestablished once the MST Victims Bill of Rights is passed. This proposed policy can help to ensure that those that have separated from the military due to MST (e.g., dishonorable discharge or being labeled as unauthorized absence) will have their rights restored.

In addition to the MST Victims Bill of Rights, other researchers are coming forward and speaking out about what further changes need to occur to further protect military service members. For example, Melin (2016) proclaims that the pentagon needs to oversee that perpetrators of MST be held accountable and that survivors of MST be protected when reporting and taking legal actions against their attackers. Melin (2016) declares that there should be a zero-tolerance policy for sexual assault and sexual harassment that would result in an immediate dishonorable discharge if a military member was found guilty of MST.

Prevalence of Military Sexual Assault and Harassment

There is a long-standing history of military sexual assault and harassment within the United States military. Sadler et al. (2004) found approximately 30% of women experienced MST during their military service. Additionally, Murdoch et al. (2004) found that a female veterans seeking disability related to PTSD reported a 71% prevalence rate of MST. Beginning in 2004, the United States military began tracking how many formal reports of sexual assault occurred during the calendar year (Lofgreen et al., 2017). As discussed in above sections of this paper, reporting numbers and prevalence numbers for military sexual assault are vastly different.

For this reason, a discussion of prevalence of military sexual assault will begin in 2006, which is the first year the United States military released an estimated prevalence rate versus just formal reports submitted to the DoD. The DoD reports that during 2006, an estimated 34,000 service members experienced sexual assault (Sexual Assault Prevention and Response, 2020). This number provides a baseline for the following years when looking at the prevalence of sexual assault within the military. Since the military only begun to calculate prevalence of sexual misconduct beginning in 2006, there is a significant lack of prevalence data regarding sexual misconduct prior to 2006 (Sexual Assault Prevention and Response, 2020). For example, when reviewing the earlier DoD reports on sexual misconduct, there is only information regarding formal reports and what resulted from those reports (Department of Defense, 2005). There appears to be a discussion on what the DoD learned that year regarding military sexual misconduct and what they planned on changing and implementing for the following year to prevent further victimization (Department of Defense, 2005). More recently, the DoD has been reporting estimated prevalence rates once every two years via a prevalence survey, known as the Workplace and Gender Relations Survey of Active-Duty Members (WGRA) (Breslin et al., 2019). The DoD uses the WGRA to calculate prevalence of sexual assault and sexual harassment in the active-duty force (Breslin et al., 2019).

The WGRA is conducted by the Defense Manpower Data Center (DMDC) (Breslin et al., 2019). When completing survey procedures, the DMDC uses techniques outlined by the American Association for Public Opinion Research (Breslin et al., 2019). The techniques implemented by the DMDC are regularly used by other large organizations that conduct surveys, such as the Census Bureau and the Bureau of Labor Statistics (Breslin et al., 2019). The DMDC implements random sampling from the active-duty population and the results are weighted to

represent the population of interest (e.g., female active-duty members) (Breslin et al., 2019). Additionally, the WGRA utilizes the phrase, unwanted sexual contact, to encompass sexual assault or sexual harassment (Breslin et al., 2019). The DMDC believes that using non-legal jargon when describing these crimes increases the accuracy of survey responses (Breslin et al., 2019). They argue that implementing legal terms such as forcible sodomy would not be beneficial as people that are not familiar with legal vocabulary may not be able to consider the legal components of a crime when being victimized (Breslin et al., 2019). The DMDC reports that the terminology, questions, and descriptions of unwanted sexual contact have been stable through all WGRA surveys since the onset in 2006 (Breslin et al., 2019).

A question that can be asked is whether the variability in the DoD's estimates of total active-duty members impacts the WGRA survey accuracy (Sexual Assault Prevention and Response, n.d.). The SAPR states that you can see genuine decline and increases in unwanted sexual contact for females between 2010 and 2012, but do not see this fluctuation for males (Sexual Assault Prevention and Response, n.d.). They explain that the WGRA includes a series of items that load onto a measurement of sexual harassment, which did not see a change in rates between 2010 to 2012 (Sexual Assault Prevention and Response, n.d.). As a result, the SAPR argues that if there were a procedural problem with the WGRA that resulted in an artificial inflation of estimates, then there would be a consistent fluctuation for males and females, not just females (Sexual Assault Prevention and Response, n.d.).

As a result of this WGRA survey, there are known prevalence estimations for military sexual assault for the following years: 2006, 2008, 2010, 2012, 2014, 2016, and 2018 (Sexual Assault Prevention and Response, 2020). The DoD collected prevalence data during 2020 which will be available for future SAPR reports (Sexual Assault Prevention and Response, 2020). In the

2012 fiscal year, the WGRA survey estimated that 26,000 service members experienced sexual assault with 6.1% of women and 1.2% of men making up this 26,000 in reports made to the DoD (Sexual Assault Prevention and Response, 2020). In the 2014 fiscal year, they estimated that 20,300 service members experienced sexual assault with 4.9 % of women and .9% of men making up this 20,300 in reports (Sexual Assault Prevention and Response, 2020). In the 2016 fiscal year, they estimated that 14,900 service members experienced sexual assault made up of 4.3 % of women and .6% of men making up reports (Sexual Assault Prevention and Response, 2020). Lastly, during the 2018 fiscal year, the WGRA survey estimated 20,500 service members experiencing sexual assault made up of 6.2% of women and .7% of men in reports to the DoD (Sexual Assault Prevention and Response, 2020). Further exploration into the 2018 WGRA survey results follow due to it being the most recent prevalence data available.

From August 24th to November 5th of 2018, data was collected for the WGRA survey (Sexual Assault Prevention and Response, 2020). The survey collected data from military members below officer rank 7 and had served in active duty for at least six months from the five military branches: Air Force, Army, Navy, Marines, and Coast Guard (Sexual Assault Prevention and Response, 2020). Specifically, single stage, nonproportional random sampling procedures were used when surveying the Air Force, Army, Navy, and Marines, while a census of the Coast Guard was taken for the survey due to the smaller population size (Breslin et al., 2019). The WGRA sampled 735,645 active-duty service members during 2018 and 115,884 active-duty members completed the survey (Breslin et al., 2019). Statistical weighting was then applied to create an estimation of unwanted sexual contact that represented the active-duty service members during 2018 (Breslin et al., 2019). From this survey, it was concluded that in 2018, 6.2% of active-duty women (an estimated 12,927) and 0.7% of active-duty men (an estimated 7,546)

experienced sexual assault (Breslin et al., 2019). These numbers represent a statistically significant increase from 2016 for active-duty women with 4.3% (Breslin et al., 2019). This increase of prevalence of sexual assaults for active-duty women was rooted from a significant increase in penetrative sexual assaults from 2016 with 2.2% to 3.1% in 2018 and non-penetrative sexual assaults in 2016 with 2.1% to 3.0% in 2018 (Breslin et al., 2019). Regarding female sexual assaults, the attackers were 92% male, 89% of the time were a military member, and the sexual assault occurred 62% of the time on a military base or ship while still 47% occurred off base (Breslin et al., 2019). Additionally, 16.9% of active-duty women report they have experienced a sexual assault since joining the military, resulting in a statistically significant increase compared to the 13.2% reported in 2016 (Breslin et al., 2019).

Sexual harassment is also captured by the WGRA survey (Breslin et al., 2019). In the 2018 WGRA survey, an estimated 24.2% of women experienced sexual harassment resulting in a statistically significant increase from 2016 which had an estimated rate of 21.4% (Breslin et al., 2019). Furthermore, during 2018, 79% of women reported that the worst sexual harassment experience happened more than one time with 40% of women stating that the sexual harassment occurred over a period of a few months (Breslin et al., 2019). For 58% of females, sexual harassment events that were described to be the one incident that impacted them the most involved more than one person, with 72% of the offenders being male and 95% being military members with the same or slightly higher rank (Breslin et al., 2019). Moreover, when asked to ponder the one situation that was the worst for them regarding sexual harassment/gender discrimination, 66% of females described their worst situation including gender discrimination with 84% of these experiences involving being mistreated, ignored, or insulted because of their gender (Breslin et al., 2019). Furthermore, for females, the alleged offenders were 71% male,

with 97% being military members, and 79% of offenders had a higher military rank than the target of the discrimination or harassment (Breslin et al., 2019).

Additionally, there is research examining the prevalence of sexual assault and sexual harassment among females of the LGBTQ+ community and women of color (Beckman et al., 2018; Blosnich et al., 2013; Lindsay et al., 2016). Specifically, Blosnich et al. (2013) noted that transgender individuals are overrepresented in the military with a 23 to 100,000 ratio versus a 4.3 to 100,000 ratio in the general community. Despite this overrepresentation in the military, Beckman et al. (2018) noted a gap in transgender research regarding military sexual assault and the effects of this experience for this population. As a result, Beckman et al. (2018) surveyed 221 transgender veterans to understand the prevalence of MSA, to assess its link to demographic characteristics, history of sexual victimization, and stigma-related factors. The researchers found that 17.2% of transgender veterans experienced MSA. Transgender men that served as women during their military service experienced MSA at a higher rate (30%) than transgender women who served as men during their military service (15.2%) (Beckman et al., 2018). The researchers also found that experiencing a sexual assault prior to military service was positively correlated with MSA. Similarly, a study conducted by the VA Healthcare system found that approximately one in five transgender men and one in seven transgender women screened positive for MST (Lindsay et al., 2016).

Contrastingly, the percentages of MST for non-transgender women are found to be approximately 20% and non-transgender men to be approximately 1% (Hoyt et al., 2011; Kimerling et al., 2007). When comparing the transgender to cis gender (personal identity and gender corresponds with their birth sex) prevalence rates there is clear evidence to suggest an increased frequency of MST among transgender men. Reisner et al. (2016) suggests that

discrimination in both a transphobic and homophobic nature increase rates of traumatic experiences for transgender individuals.

Women of color are also prevalent survivors of MST. A study conducted by Campbell and Raja (2005) examined the sexual assault and secondary victimization experiences of African American female veterans and reservists seeking healthcare in the VA system. During this study, the researchers screened for adulthood sexual assault. The participants in the study reported that 39% had been sexually assaulted during adulthood. Of the 39% that reported being sexually assaulted as an adult, 38% reported their sexual assault occurred during their military service (Campbell & Raja, 2005). Additionally, researchers have explored the prevalence of sexual harassment that women of color have experienced during military service (Fitzgerald et al., 1999). Research by Fitzgerald et al. (1999) found that certain racial or ethnic groups of military women experience significantly higher rates of sexual harassment compared to others. For example, the researchers found that Native American female military members reported the highest rates of every type of sexual harassment when compared to other racial and ethnic groups (Fitzgerald et al., 1999). The researchers also found that Hispanic females reported the second highest levels of sexual harassment, while Asian American females reported the lowest. In between these two extremes, lies African American and Caucasian females in the middle, except for sexual coercion which is higher for African American females among all groups except for Native American women (Fitzgerald et al., 1999).

More recently, a study completed by Buchanan et al. (2008) comparing sexual harassment subtypes among African American and Caucasian women by military rank found that Caucasian women reported overall higher rates of sexual harassment, gender harassment, and crude behavior, while African American women reported more unwanted sexual attention and

sexual coercion. The researchers also found that enlisted women reported higher rates of each sexual harassment subtype when compared to officers. Moreover, African American female enlistees reported more sexual coercion than Caucasian female enlistees. Interestingly, the researchers found no racial differences across officers regarding prevalence of military sexual harassment (Buchanan et al., 2008).

Reporting of Military Sexual Trauma

According to the DoD's SAPR 2018 WGRA survey report, there were no significant changes in reporting rates for sexual assault between 2016 and 2018 (Sexual Assault Prevention and Response, 2019). During the SAPR's 2018 examination into MSA they asked women what their top reasons were for reporting. Women explained that they chose to report because of wanting to stop the alleged attacker from hurting others (61%) or themselves again (50%) and because someone encouraged them to report (49%) (Sexual Assault Prevention and Response, 2019). Additionally, during the SAPR's 2018 examination, they found that the option to make a restricted report was highly influential in reporting rates. Specifically, only 11% of women reported that they would have pursued confidential resources and 47% reported that they would not have submitted a report without the option to make a restricted report (Sexual Assault Prevention and Response, 2020). According to DoD Directive 6495.01, restricted reporting is a form of private reporting offered in the military to report sexual assault to specific individuals such as the SAPR or healthcare personnel (Department of Defense, 2012). Having the ability to report in this way allows survivors access to healthcare, advocacy, and legal services without having to report to their command or law enforcement (Department of Defense, 2012). If a survivor of MSA decides to complete a restricted report, an SAPR victim advocate will be assigned to them. This victim advocate is supposed to notify the victim's commander that a

sexual assault has occurred for safety and command responsibility reasons (Sexual Assault Prevention and Response, n.d.). This notification to command is intended to be very limited in details to protect the identity of the victim. The SAPR victim advocate will assist the survivor throughout the process of reporting by inform the survivor about their options. For example, the SAPR victim advocate will ask the survivor if they would like a sexual assault forensic examination to be completed or would like to receive any other healthcare services, including mental healthcare. If requested by the survivor, the SAPR victim advocate will then discuss this with healthcare personnel to get this request filled (Sexual Assault Prevention and Response, n.d.). If the survivor chooses to do a restricted report, the SAPR victim advocate will contact the Collateral Duty Sexual Assault Response Coordinators (SARC) to begin the reporting process. Additionally, restricted reporters are informed by SARC about the CATCH program which gives the option to anonymously report suspect information to help the DoD catch serial sexual offenders (Sexual Assault Prevention and Response, n.d).

According to the SAPR, restricted reporting has many benefits and limitations which a sexual assault survivor must consider in a very short amount of time after their assault has occurred (Sexual Assault Prevention and Response, n.d.). Benefits of restricted reporting include gaining access to healthcare services and victim advocacy immediately following a sexual assault, maintaining control over the release of personal information, having the flexibility and time to consider options and not having to experience an intrusive and grueling investigation (Sexual Assault Prevention and Response, n.d.). Additionally, restricted reporting can allow the survivor time to meet with legal services such as the Special Victims' Counsel/Victims' Legal Counsel (SVC/VLC) about what a criminal investigation entails so they can make an informed decision (Sexual Assault Prevention and Response, n.d.). Finally, restricted reporting allows the

survivor to participate in the CATCH Program which can contact the survivor confidentially if there is evidence of a repeat sexual offender which allows the survivor to decide if they want to transfer their restricted report to an unrestricted report (Sexual Assault Prevention and Response, n.d.). While there are many benefits to restricted reporting, there are also many limitations that a survivor must consider in a short amount of time.

Limitations of restricted reporting include not being able to prosecute the attacker and they may go on to assault other (Sexual Assault Prevention and Response, n.d.). The restricted reporter cannot obtain a military protective order and cannot ask for an expedited transfer that to move to a different unit or base. Furthermore, the survivor may continue to have to interact with their attacker as well as not discuss their assault with anyone except for confidential persons such as religious leaders, healthcare personnel or a lawyer (Sexual Assault Prevention and Response, n.d.). Finally, if the survivor later decides to transfer their restricted report to an unrestricted report evidence may be completely lost and as a result, substantial difficulties in the investigation process may arise.

Sexual assault victims also have the option of unrestricted reporting (Sexual Assault Prevention and Response, n.d.). This option is for victims who wish to have an official investigation and command notification in addition to the services provided with restricted reporting (Sexual Assault Prevention and Response, n.d.). Someone that would like to make an unrestricted report can report through military law enforcement, their commander, the SARC, an SAPR victim advocate or healthcare personnel (Sexual Assault Prevention and Response, n.d.). Like restricted reporting, an SAPR victim advocate is assigned to the case and inform them of their right to legal services as well as ask if they would like to have a sexual assault forensic examination performed (Sexual Assault Prevention and Response, n.d.). The Special Victims'

Counsel provides the survivor with an attorney who assists them during the investigation process and protects their rights (Sexual Assault Prevention and Response, n.d.). The investigation process can be distressing and demanding for the survivor as it can often take several months due to time consuming factors such as collecting evidence and conducting interviews. Immediately after completing an unrestricted report, the survivor will be asked several questions about the assault to gather more information, this can be very distressing to a survivor (Sexual Assault Prevention and Response, n.d.). Additionally, the survivor's commander is supposed to update them monthly with any continual investigative, prosecution, or command actions concerning the sexual assault (Sexual Assault Prevention and Response, n.d.). These monthly updates are required until the conclusion of any judicial, non-judicial and administrative actions, including separation from the military or no action based on the reported sexual assault.

Like restricted reporting, unrestricted reporting has many benefits and limitations which one must consider in an incredibly short amount of time after their assault has happened (Sexual Assault Prevention and Response, n.d.). According to the SAPR, benefits to unrestricted reporting include the ability to hold the attacker responsible which can give survivors a sense of closure or healing which can be helpful in the recovery process and may help prevent future assaults from the identified attacker (Sexual Assault Prevention and Response, n.d.). Additionally, unrestricted reporting allows a Military Protective Order request and an expedited transfer to a different unit or base which can help maintain the safety of the victim (Sexual Assault Prevention and Response, n.d.). Despite these benefits, there are also limitations to consider. Unrestricted reporting cannot be reversed once initiated, the unrestricted reporter no longer controls the release of their personal information and may not have the time to speak to legal counsel to assess their case prior to deciding to make an unrestricted report (Sexual Assault

Prevention and Response, n.d.). Additionally, they may experience revictimization from the investigation process through having to tell and retell specifics of their sexual assault and may face retaliation resulting from their report (Sexual Assault Prevention and Response, n.d.). For example, it was discovered in the 2018 WGRA survey that 21% of female sexual assault survivors who reported experienced retaliation (Sexual Assault Prevention and Response, 2019). Moreover, in examining the WGRA 2018 report, there seems to be a critical need for improvement in leadership actions after service members report their sexual assault. For example, it was revealed that only 48% of females who reported their sexual assault had leadership that provided them flexibility to attend an appointment related to their sexual assault, 41% said their leadership expressed concern for their wellbeing, and 38% said their leadership made them feel supported (Sexual Assault Prevention and Response, 2019).

In addition to reporting sexual assault, there is also the option to make a formal complaint of sexual harassment or gender discrimination within the military (Sexual Assault Prevention and Response, 2019). According to the WGRA 2018 report, service members can make a complaint to their chain of command, the inspector general's office, to a Military Equal Opportunity (MEO) office, or to specific personnel in their unit that can receive MEO complaints (Sexual Assault Prevention and Response, 2019). The 2018 WGRA survey concluded that 47% of women were likely to report sexual harassment violations and 51% are likely to report gender discrimination to military authorities (Sexual Assault Prevention and Response, 2019). For those who reported sexual harassment or gender discrimination, they also reported experiencing retaliation by fellow service members. For example, they were encouraged to let it go, dissuaded from reporting, were ostracized, treated badly, or blamed (Sexual Assault Prevention and Response, 2019). The WGRA survey also explored service members satisfaction with the MEO

complaint process used for sexual harassment and gender discrimination (Sexual Assault Prevention and Response, 2019). The survey found that those making sexual harassment complaints had higher levels of satisfaction than those making gender discrimination complaints. Despite this, positive statements of the MEO process did not exceed 50% for any aspect of the complaint process, indicating a significant need for change in the process of making formal complaints of sexual harassment and gender discrimination in the military (Sexual Assault Prevention and Response, 2019).

The WGRA survey also examined unit climate and workplace hostility during 2018 (Sexual Assault Prevention and Response, 2019). Overall, when examining these factors, service members reported their unit climate was positive describing it as treating each other with respect, abstaining from sexist behavior, encouraging bystander involvement, and reporting sexual assault or harassment (Sexual Assault Prevention and Response, 2019). Additionally, service members described their immediate supervisors as devoted to fostering a positive work environment. Nevertheless, females rated every facet of unit climate significantly lower and the level of workplace hostility significantly higher than males suggesting the need for further training and policy on creating a safe workplace that promotes harmony, safety, and respect for all (Sexual Assault Prevention and Response, 2019).

The SAPR discusses the significance of military members trusting the military system to help encourage reporting of sexual assault and sexual harassment (Sexual Assault Prevention and Response, 2019). Service members should have their reports respected and followed through with a process in place that is fair, transparent, and provides speedy adjudication as well as support for recovery or rehabilitation. The 2018 WGRA survey concluded that females had statistically significantly lower levels of trust in the military system compared to males (Sexual

Assault Prevention and Response, 2019). For example, 63% of women trusted that the military would safeguard their confidentiality if they were sexually assaulted versus 79% of men. Additionally, 69% of women reported trusting the military system to guarantee their safety after experiencing a sexual assault, compared to 84% of men. Furthermore, 66% of women versus 82% of men reported trusting the military system to treat them with dignity and respect if they were sexually assaulted (Sexual Assault Prevention and Response, 2019). Similarly, a study conducted by Rabelo et al. (2019) found significantly lower rates of trust in the military system in women and victims of sexual assault. The WGRA survey results and Rabelo et al. (2019) findings suggest a need for more attention from the DoD on building trust with female service members with emphasis on respect, dignity, safety, and maintaining confidentiality (Rabelo et al., 2019; Sexual Assault Prevention and Response, 2019).

When examining which women decide to report or not to report it makes sense to consider the limitations to reporting that are discussed above. Further exploration of what barriers make women less likely to report follows. Blais et al. (2018) assessed 359 female veterans opened ended responses regarding barriers they faced in disclosing MST. The researchers' results revealed that 81% of the participants reported experiencing MST. Of the 81% that identified experiencing MST, 50% reported being screened in the past with 25% not disclosing their MST status when screened. This study reveals that DoD prevalence rates of MST may be an underrepresentation of the actual frequency of MST. It was discovered that those who's assailant was a unit member (coworker) were significantly less likely to disclose their MST (Blais et al., 2018). Barriers to disclosure included discomfort with the screening setting, stigma, and trauma-oriented avoidance. Trauma oriented avoidance can include attempting to ignore or repress trauma related thoughts, feelings, and memories to prevent feeling badly.

Specifically, the most frequently cited barrier to reporting was stigma (Blais et al., 2018). Like DoD SAPR reports, women expressed concerns about others viewing or treating them with hostility or discrimination for reporting or experiencing MST or self-stigma stating things such as “I figured it would be a sign of weakness” (Blais et al., 2018, p. 472). Similarly, Anderson and Blais (2019) found that 17.7% of female veterans did not disclose MST during a previous screening and reported self-stigma as the main barrier to reporting. Furthermore, a study conducted by Burns et al. (2014) found that female service members deployed overseas between 2002 and 2011 credited low MST reporting to adverse responses and blame from peers and leadership, fears about confidentiality, and stigma.

Another barrier identified in the Blais et al. (2018) study was discomfort in reporting MST to the screener or institution. For example, some participants reported that they did not feel safe in a VA setting or had several negative experiences that impeded them in feeling comfortable to disclose their MST. However, there may be a way to increase feelings of comfortability that could increase reporting. A study conducted by Burgess et al. (2016) examined rates of disclosing MST anonymously on an online platform. Burgess et al. (2016) found that all participants had experienced a penetrative sexual assault and 36.7% of females were reporting this penetrative assault for the first time via this online platform while only 14.3% had reported their sexual assault to the military. This study suggests a serious need for reforming reporting methods to include an online platform. This may help to minimize the discomfort identified by MST survivors in settings such as VA facilities and DoD (Blais et al., 2018). Other barriers to reporting MST included that there was too much time between the traumatic event and screening and that they did not consider the incident to be assault at the time (Blais et al.,

2018). These findings indicate a need for more frequent screenings by the DoD and VA and more training and education about what constitutes MST for service members.

The SAPR annual 2018 report reviewed common factors of sexual assaults for women who reported to the DoD. According to the 2018 SAPR report, these women experienced a penetrative assault on one occasion that made them take steps to leave the military (Sexual Assault Prevention and Response, 2019). Additionally, the alleged attacker was a higher rank, a member of their chain of command, and the context around the sexual assault included bullying or hazing behaviors, stalking before or after the assault, and being sexually harassed before the assault (Sexual Assault Prevention and Response, 2019). Contrastingly, the SAPR 2018 annual report explored women's reasons for not wanting to report their sexual assault to the military. The most common reasons identified include "wanting to forget it occurred and move on (73%), did not want more people to know (61%), felt ashamed or embarrassed (57%), felt partially to blame (43%), thought it was not serious enough to report (41%), did not think anything would be done (38%), and being worried about potential negative consequences from coworkers or peers (37%)" (Sexual Assault Prevention and Response, 2019). With 43% of individuals believing they are partially to blame for their MST, survivors may hold believes such as "There was a big part of me that was like, "these things wouldn't have happened to me if I had been more guarded, if I had not trusted the wrong people, if I had not been so friendly" [Cuba 2004-2005, personal MST experience] (Burns et al., 2014, p. 347).

Another real-life example of a common barrier to reporting is when there are low numbers of females in a unit which can compromise confidentiality. One MST survivor describes this scenario by stating "If there's 1 female or 2 females in the unit and it comes down that "there's 1 female raped or sexually assaulted in this unit. Oh, there's only 2 of 'em!"

Hmmmmm, not too hard to figure out" [Afghanistan 2006---2007, personal MST experience] (Burns et al., 2014, p. 347).

Overall, there are many obstacles that an MST survivor faces both personally (e.g., self-stigma) and on a systemic level (e.g., retaliation, restrictions on type of reporting) when considering reporting MST (Groves, 2013; Wolff & Mills, 2016). These barriers significantly impact reporting rates which in turn leads to less access to resources to help MST survivors during their recovery. The ways in which an individual is impacted by MST follows.

Impact of Military Sexual Trauma on Survivors

There are many devastating effects of MST that span from physical to psychological, which can include an increased risk for suicide, PTSD, depression, substance abuse, eating disorders, cardiovascular disease, and homelessness (Blais et al., 2017; Blais et al., 2018; Blais & Monteith, 2019; Cichowski et al. 2017; Goldberg et al., 2019; Lutwak, 2013; Monteith et al., 2016). Sexual violence and the following psychological trauma also affect survivors' relationships with their loved ones and co-workers (Goodcase et al., 2015; Millegan et al., 2015).

A study completed by Blais et al. (2018) found that 71.7% of a female veteran research sample identified MST as the source of their current PTSD symptoms. The researchers found these individuals were at least three times more likely to report current suicidal ideation when compared to those who reported the source of their PTSD symptoms as combat or deployment related. Similarly, a study conducted by Newins et al. (2020) examined psychological outcomes following sexual assault. They defined psychological outcomes by the following: symptoms of PTSD and depression, substance misuse, and suicidal ideation. The researchers found that women who reported high levels of MSA also reported higher levels of all psychological distress than women who did not report experiencing adult sexual assault. They also found that women

who reported a history of MSA also endorsed higher levels of PTSD and depression symptoms than women who experienced adult sexual assault before or after military service.

Furthermore, a study conducted by Sexton et al., (2018) examined suicidal behaviors among veterans reporting for MST treatment who identified as sexual and gender minorities (SGMs). As discussed in earlier sections, SGMs have been found to be disproportionately exposed to MST which places them at an elevated risk for negative psychiatric outcomes rooted from MST. Sexton et al., (2018) found that a history of suicide attempts was higher for SGM (53.6%) compared to their heterosexual and cisgender peers.

Additionally, veterans that have experienced MST report views that the military developed a culture in which MST seemed normal, likely to happen, and lacked taking proactive stance at preventing such things from happening (Monteith et al., 2016). Over two thirds of MST veterans in a study perceived that the military had developed a culture where they no longer felt valued or staying in the military was challenging. These views of military institutional betrayal were positively correlated with PTSD and depression symptoms and an increased risk of attempting suicide after an MST experience. More specifically, Monteith et al. (2016) concluded that there was a statistically significant correlation between perceptions of military institutional betrayal and PTSD symptoms. These conclusions highlight the relevance of MST survivors' viewpoints regarding the military's efforts to prevent and respond to MST to individual recovery from military sexual trauma.

Another study conducted by Monteith et al. (2017) examined whether concepts based in Joiner's (2005) interpersonal-psychological theory of suicide were correlated with suicidal ideation among female MST survivors. Joiner's (2005) interpersonal-psychological theory is comprised of three main concepts: perceived burdensomeness, thwarted belongingness, and

fearlessness about death. The researchers found that perceived burdensomeness, thwarted belongingness, and fearlessness about death were all correlated with suicidal ideation in the past week, when adjusting for prior suicide attempts, current depressive symptoms, and current symptoms of posttraumatic stress disorder. However, when including all three interpersonal-psychological constructs in the model, only perceived burdensomeness and fearlessness about death were significantly correlated with suicidal ideation among the sample of female MST survivors (Monteith et al., 2017). These results highlight the interpersonal processes that may increase the risk of suicidal ideation among MST survivors. These results also shed light on the significance of assessing for interpersonal-psychological constructs, especially perceived burdensomeness and fearlessness about death when working with those that have experienced MST. Additionally, a study conducted by Rosellini et al. (2017) found that organization recorded sexual assault victims are three times more likely to attempt suicide compared to non-sexual assault victims.

Military sexual trauma has also been linked to an increased risk of developing PTSD (Blais et al., 2018; Monteith et al., 2016; Monteith et al., 2017; Newins et al., 2020). A study conducted by Campbell and Raja (2005) found that African American female veterans and reservists report additional victimization and distrust in others after experiencing sexual assault. Of the 39% prevalence of sexual assault reported in the African American female veteran sample, 38% described an MSA. The researchers found that these veterans and reservists report secondary victimization through things such as victim blaming, and procedures engaged in by legal and medical personnel within the military. It was discovered that this secondary victimization made these MSA survivors feel guilty, depressed, anxious, distrustful of others, and reluctant to seek further help (Campbell & Raja, 2005). The researchers concluded that this

secondary victimization was significantly positively correlated with PTSD symptoms. Another study examining the relationship among sexual abuse, ethnicity, and PTSD in female veterans found that female veterans that reported MSA had high levels of PTSD symptoms compared to female veterans with civilian sexual assault (Jones, 2003). Jones (2003) also found significant differences between African Americans and Caucasians on reported somatic symptoms. Specifically, Caucasian female veterans endorsed more somatic symptoms on the somatization subscale of the CAPS-1 than African American females. Jones (2003) theorizes that this finding could be due to African American female veterans utilizing community resources to cope with stressors that do not affect work or social functioning. There is also research that indicates female veterans with MSA history exhibit symptoms of complex PTSD, even after controlling for childhood or other adulthood trauma (Luterek et al., 2011). These complex PTSD symptoms can include things such as problems with interpersonal relationships, emotion regulation, dissociation, somatization, and self-identity (Luterek et al., 2011).

In addition to MSA, sexual harassment is another problem faced by female service members. A study conducted by Buchanan et al. (2008) found that Caucasian females reported more overall sexual harassment, gender harassment, and crude behavior, while African American females reported more unwanted sexual attention and sexual coercion. Following gender harassment, African American females reported higher levels of psychological distress than Caucasian females.

Another subcategory of veterans that experience MST at an increased rate is LGBTQ+ veterans (Beckman et al., 2018). Beckman et al. (2018) found that transgender veterans who experienced MSA positively correlated with having symptoms of PTSD within a month of taking the survey. Another study conducted by Lehavot and Simpson (2014) found that 38% of their

sample of lesbian and bisexual female veterans experienced MSA. The researchers also concluded MSA was a significant predictor of PTSD for both heterosexual, lesbian, and bisexual female veterans, as well as a significant predictor of depression for lesbian and bisexual female veterans (Lehavot & Simpson, 2014). However, the researchers concluded that lesbian and bisexual females that experienced MSA had a stronger correlation to PTSD compared to heterosexual females who also experienced MSA. The researchers propose an explanation for this finding in that MSAs directed toward lesbian and bisexual females may have been driven or perceived to be driven by the woman's sexual orientation, in essence amounting to a sexually motivated hate crime. To further complicate prognosis post MST for sexual minorities, it has been found that victimization that is perceived to be due to sexual orientation results in poorer mental health symptoms than victimization that is perceived not to be related to sexual orientation (Herek et al., 1999).

There is also evidence that suggests there is an increased risk for substance abuse among service members who experienced MST (Gobin et al., 2015; Goldberg et al., 2019; Hankin et al., 1999; Seelig et al., 2017). For example, Goldberg et al. (2019) found that a positive screen for MST is associated with an increased risk for substance use disorders in female veterans. Similarly, Hankin et al. (1999) found that female veterans who reported experiencing MSA had twice the rate of current alcohol abuse and three times the rate of current depression compared to female veterans without an MSA history. Additionally, studies conducted by Seelig et al. (2017) and Gobin et al. (2015) found patterns of unhealthy alcohol use in female military members following military sexual trauma. Gobin et al. (2015) described alcohol misuse as unsafe drinking levels, presence or beginning of an alcohol use disorder, and intrapersonal and

interpersonal alcohol-related issues. These findings suggest the need to assess for substance use disorders when working with female service members that report MST.

There are also strong associations between trauma and eating disorders. A study conducted by Blais et al. (2017) concluded that MST is associated with post-deployment eating disorders among Afghanistan and Iraq female veterans. Specifically, veterans with a positive screen for MST had a nearly twice the probability of having an eating disorder diagnosis. Similarly, a study conducted by Breland et al. (2018) examined whether MST and combat exposure were independent predictors of eating disorders among female veterans. The participants of the study were made up of female veterans aged 18-70 with a mean age of 49 and 40% of the participants were women of color. The researchers found that MST is correlated with eating disorders in female service members, while combat exposure is not. Specifically, females reporting MST were twice as likely of having an eating disorder to women who did not (Breland et al., 2018). Interestingly, the only demographic factors associated with eating disorders were Asian race and age. The researchers found that Asian women had significantly higher probability of meeting eating disorder diagnostic criteria compared to Caucasian women. Additionally, the researchers found that every added year of age was correlated with a slightly increased chance of meeting eating disorder diagnostic criteria. In addition to the increased risk for an eating disorder, there are adverse physical health effects that MST survivors face from eating disorders. These adverse effects can include a strain on the cardiovascular, gastrointestinal, and endocrine systems as well as neurological functioning (Kaye et al., 1998; Takimoto et al., 2006). Additionally, eating disorders have been linked with high mortality and poor obesity related outcomes (Arcelus et al., 2011; Masheb et al., 2015). These findings reveal the importance of assessing for eating disorders when working with female military members that report MST.

Military sexual violence and the following psychological trauma also affect survivor's relationships with their family members and co-workers. For example, Millegan et al. (2015) found that female military members reporting recent sexual harassment or assault were more likely to report poor mental and physical health, and difficulties in work or regular activities. Millegan et al. (2015) also found that recent sexual harassment was associated with the survivor receiving a work demotion evident through drop in pay grade. Additionally, those who report recent sexual trauma may be removed from their units during an investigation, leading to the loss of potentially vital team member for the unit and the loss of social support for the MST survivor (Millegan et al., 2015). When the perpetrator is a service member and the survivor decides not to report the MST, the survivor may have the additional stress of continuing to work with the perpetrator. This can threaten the feeling of unit cohesion which is vital for successful military functions (Millegan et al., 2015). Similarly, Rosellini et al. (2017) found that sexual assault victims are at a significantly higher risk of demotion when compared to non-sexual assault victims. The researchers suggest that this finding may be due to MST causing emotional reactions that lead to impaired occupational functioning and potential insubordination that eventually results in a demotion. These findings reveal that MST is a potential danger to military operational readiness and reiterates the importance of prevention efforts to reduce the varying sequelae of MST. Moreover, Goodcase (2015) found that survivors of MST and their romantic partners suffer physical, emotional, psychological, and interpersonal difficulties, which can add to the preexisting impacts of traumas experienced in their lives.

In addition, to these physical, psychological, and interpersonal effects of MST, military separation can also lead to challenges in transitioning to civilian life. Katz et al. (2007) found that female MST survivors have more difficulty with adjusting to civilian life. Homelessness is

one example of another negative impact that is faced by female MST survivors due to struggles with transitioning back into a civilian role. MST survivors can have trouble keeping a job, staying in communication with family, and maintaining housing stability due to the high comorbidity of disorders experienced by females with MST (e.g., depression, PTSD, and SUD) (Gabrielian et al., 2019). Though many homeless veterans use the VA to receive a variety of psychological and medical services, Gabrielian et al. (2019) suggests that the challenges of transitioning from military to civilian life may supersede the benefits offered by VA care. This claim is supported by Maslow's hierarchy of needs, as the veteran is not meeting the basic and first level of physiological needs that consists of food, shelter, clothing, sleep, etc. (Maslow, 1943). The next level of the hierarchy of needs is safety needs, which is made up of personal security, employment, resources, health, and property. As a result of a veteran not having shelter, they will have an increased level of difficulty making progress in recovering from mental and medical health conditions. Therefore, it is vital for more programs to be implemented to target prevention of homelessness in veteran populations.

Epigenetic Effects of Military Sexual Trauma

There are also epigenetic modifications that are present among those that have experienced sexual trauma (De Neve et al., 2012; Epel & Prather, 2018; Meier et al., 2019; Ridout et al., 2018; Smith et al., 2011; Walsh et al., 2012). Unlike genetic changes, epigenetic changes are reversible and do not change the DNA sequence, but they can change how the brain reads a DNA sequence (Walsh et al., 2012). Epigenetic changes may be one way in which sexual trauma leads to negative outcomes in survivors (Smith et al., 2011). Studies have shown that there are correlations between sexual trauma and changes in brain structure and function (Smith et al., 2011). More specifically, there is empirical evidence that suggests that

epigenetic markers associated with exposure to sexual violence may influence the development of psychological disorders such as PTSD and MDD (De Neve et al., 2012).

More specifically, research has revealed that DNA methylation has been linked to trauma exposure and the development of PTSD and MDD (Felitti et al., 2019; Malan et al., 2011; Smith et al., 2011). The DNA methylation that occurs in the brain is essentially an epigenetic system that ensues when a methyl group is added to DNA. This addition of a methyl group modifies the function of genes and affects gene expression. Sexual trauma has been associated with methylation in specific genes, including the promotor region of the serotonin transporter (Smith et al., 2011). The serotonin transporter performs a crucial role in regulating serotonin concentration in the synaptic cleft and extra synaptic sites. Serotonin is a vital hormone that stabilizes mood, feelings of well-being, and happiness (Smith et al., 2011).

A study by De Neve et al. (2012), found that changes in the serotonin transporter gene-linked polymorphic region can impact subjective well-being or happiness. The researchers found that individuals with long polymorphisms (serotonin transporter gene) have increased serotonin reuptake activity which correlated with significantly higher levels of life satisfaction compared to individuals with short polymorphisms. These results help to explain the biological underpinnings of an increased rate of mental illness in those that have experienced sexual trauma.

Furthermore, there appears to be a connection between adverse childhood experiences, environmental stressors (e.g., sexual trauma), and the length of telomeres (Epel & Prather, 2018; Ridout et al., 2018). Telomeres are compound structures at the end of our chromosomes that protect them from premature degradation. The length of a telomere provides a biomarker of biological aging and essentially the shorter the telomere the older the biological age. Shortened telomeres have been directly linked to stress and trauma (Epel & Prather, 2018; Ridout et al.,

2018). More specifically, telomere shortening has been associated with experiencing adversity at varying stages of development and after multiple types of adverse exposures. For example, there is an inverted relationship between persistent psychosocial stressors and telomere length suggesting that those who encounter recurring psychosocial stressors face telomere attrition (Meier et al., 2019). As a result, individuals who have undergone this extensive early adversity have increased odds of developing poor physical and mental health outcomes. According to Felitti et al., 2019, these include suicidality, anxiety, diabetes, depression, asthma, post-traumatic stress disorders, among many others. An example of this conclusion is evident in a research study conducted by Malan et al. (2011) in which they investigated telomere length and psychological stress in rape survivors. The researchers found a significant correlation between telomere length and PTSD in women who had experienced rape. These findings reveal that shorter telomeres might have been a predisposing factor in the development of PTSD after a severely traumatic event like rape. Overall, Military sexual trauma survivors face many sequalae including physical and psychological diseases, interpersonal difficulties at work and home, premature biological aging, and homelessness, among others. Treatment barriers that MST survivors face are discussed below.

Barriers to Treatment

When someone is experiencing the devastating effects of MST they are often met with cultural and systemic barriers to seeking treatment. Some of these barriers include high levels of self and group stigma, military leadership, warrior culture and hypermasculinity (Anderson & Blais, 2019; Britt et al., 2011; Bryan & Morrow, 2011; Burns et al., 2014; Campbell & Raja, 2005; McFarling et al., 2011; Tanielian & Jaycox, 2008; Wright et al., 2009).

In the DoD WGRA 2018 report, females who experienced and reported sexual assault were provided information and resources (Sexual Assault Prevention Response, 2019). The most shared resources included “information about behavioral healthcare and treatment (61%), the right to consult with legal counsel (60%) and the right to an expedited transfer and/or on medical healthcare and treatment (both 56%)” (Sexual Assault Prevention Response, 2019). Despite this information being shared with MST survivors, systemic and cultural barriers persist which can make it challenging and distressing for MST survivors to seek treatment.

A study conducted by Campbell and Raja (2005) found that African American MSA survivors experienced secondary victimization through things such as victim blaming behaviors and procedures employed by legal and medical personnel within the military. This secondary victimization made these MSA survivors feel guilty, depressed, anxious, distrustful of others, and reluctant to seek further help. Campbell and Raja (2005) concluded that this secondary victimization was significantly positively associated with PTSD symptoms. This finding is important in understanding the learned helplessness that MST survivors may experience because of continuously facing negative and uncontrollable situations at the hands of military personnel, including healthcare professionals. Eventually these interactions could lead to MST survivors terminating their attempts to seek help including psychological treatment.

Stigma plays a significant role in treatment seeking behavior for military personnel that have experienced MST. Zinzow et al. (2015) found that stigma was the largest barrier to treatment seeking in U.S. active-duty service members with sexual assault histories. Anderson and Blais (2019) found that higher self-stigma was related to decreased probability of disclosing MST during screening in female veterans that experienced MST. Another study conducted by Burns et al. (2014), determined that barriers to treatment seeking for MST survivors included

confidentiality concerns, lack of information, and stigma. Similarly, Murray-Swank et al. (2018) found that scheduling difficulties, distance from facilities, and internalized stigma were the most frequently reported barriers to seeking treatment in rural female veterans. Similarly, McFarling et al. (2011) concluded that stigma was a barrier to substance abuse treatment and mental health treatment for service members. Furthermore, Valenstein et al. (2014) discovered that 48.3% of service members reported not receiving mental health services in the previous year despite experiencing significant mental health symptoms. Valenstein et al. (2014) examined the reported treatment barriers for U.S. Army National Guard Soldiers at three time points (2007-2008, 2009-2010, 2011-2012) for three main categories of barriers including stigma, logistics, or negative beliefs about treatment. Interestingly, the researchers found that negative beliefs about treatment decreased significantly among the three time periods. They also found reductions in stigma barriers as time passed. More specifically, the researchers concluded that endorsement of individual barriers regarding negative reactions to a soldier seeking treatment declined over time, but barriers related to concerns about career advancement did not. They also concluded that service members with negative beliefs about treatment were less likely to seek treatment (Valenstein et al., 2014). Additionally, not meeting veteran status is another barrier to treatment that National Guard members face within the United States. Specifically, a former National Guard member must have served on federal active duty or be service connected to be eligible to seek VA care (E. Rudisell, personal communication, February 22, 2021). This is a big problem as we know that MST does not just occur when serving active duty and can happen during other military duties such as trainings.

Organizational culture also plays a role in barriers military personnel face when seeking mental health treatment. Wright et al. (2009) found that ratings of more positive officer

behaviors and higher levels of unit cohesion were correlated with decreased stigma and practical barriers. However, it is important to note that the strength of these relationships was relatively modest. Additionally, a study conducted by Britt et al. (2012) explored positive and negative leadership behaviors as predictors of stigma and practical barriers to mental health treatment in military members. Stigma and practical barriers were assessed using self-report Likert scales used previously in research involving military populations. Items for stigma included statements such as “I would be seen as weak” and “My visit would not remain confidential” (Britt et al., 2012, p. 29). An MST survivor notes confidentiality concerns and the cultural stigma of mental health in the military stating, “Some things in the military records are career enders... It doesn’t matter what it’s for, they see that you’ve been in there for mental health and they’ll re-evaluate you—are you really stable enough to be a soldier? [Djibouti 2003---2004, personal MST experience] (Burns et al., 2014, p. 347). Items for practical barriers included statements like “I don’t know where to get help” and “It is difficult to schedule an appointment” (Britt et al., 2012, p. 29). One MST survivor explained a lack of psychological services while on deployment stating, “You’re lucky if you can refer yourself to psychiatry and get yourself in to see a psychiatrist. Other than that, when I was there, there was no Sexual Assault Response person, there was no Victim Advocate, there was nothing” [Afghanistan 2006---2007, personal MST experience] (Burns et al., 2014, p. 347). Leadership behaviors were operationalized using a leadership Likert scale that has been used in prior research involving noncommissioned and commissioned officers. Positive behaviors included statements like “NCOs/Officers treat all members of the unit fairly” while negative behaviors included statements like “NCOs/ Officers show favoritism to certain members in the unit” (Britt et al., 2012, p. 29). The researchers found that both positive and negative noncommissioned and commissioned officer behaviors were

related to stigma and practical barriers to seeking mental health treatment, however noncommissioned officers had a stronger association (Britt et al., 2012). Therefore, the researchers concluded that noncommissioned officer behaviors were especially important in influencing perceptions of stigma and practical barriers to mental health treatment (Britt et al., 2012). The researchers found that negative leadership behavior was strongly associated to stigma, whereas positive leadership behavior was strongly associated to practical barriers. These results suggest that positive leadership behaviors may be successful in mitigating practical barriers such as explaining procedures and adjusting as necessary for those seeking treatment. While negative leadership behaviors, like embarrassing unit members in front of others, may produce a work environment favorable to elevated levels of stigma oriented around mental health care (Britt et al., 2012).

Another aspect of the organizational culture within the U.S. military is known as warrior culture. This culture is one that values strength, resilience, bravery, and personal sacrifice (Tanielian & Jaycox, 2008). This is evident in some of the branch's mottos and core values. For example, one of the three core values of the United States Air Force is *Service Before Self* or the Army motto, *Army Strong*. Psychological strength is a very common norm within the warrior culture, expecting military members to cope with stress at a mastery level without issue, establishing a standard of inner strength and reliance to "shake off" injury and illness (Tanielian & Jaycox, 2008, p. 276). It is not shocking that individuals within this culture may grapple with mental health stigma. Military members struggling with their mental health may perceive themselves as weak, going against core military values that they are trained to embody (Tanielian & Jaycox, 2008). Therefore, it is argued that clinical language, such as disorder,

illness, symptoms, etc. is directly clashing with the warrior mentality and bolsters the divide among military members and mental health services (Bryan & Morrow, 2011).

Interestingly, there is a subgroup of military personnel who seek mental health services outside of the military health care system (Waitzkin et al., 2018). One theme for this treatment seeking behavior was fear of retaliation within the military system for mental health issues. Waitzkin et al. (2018) explored the reasons service members seek mental health services outside the military and noted that "Clients reported feeling afraid of peers and superiors. For instance, one young female client was raped on base. She was subsequently diagnosed with PTSD and was transferred to another base. At this new location, her command appeared to be seeking her discharge without benefits for minor disciplinary infractions. Afraid of losing access to treatment for her PTSD after discharge, she sought civilian services" (Waitzkin et al., 2018, p. 235). Other reasons service members reported wanting to seek civilian mental health services over military services included not trusting command, unsatisfactory and unresponsive services, cost (e.g., absence without leave-with no health benefits), deception, enlistment remorse, guilt, preexisting mental health disorders, family and household issues, and MST. The researchers found that many clients in these settings reported MST. They provide an example of a female MST survivor and her reason for seeking services outside of the military, stating "A woman in the Army had been sexually assaulted. She believed that the reason involved her expressing an interest in applying for conscientious objector status. Despite severe anxiety and panic attacks that she linked to the sexual assault, she was not approved for disability benefits" (Waitzkin et al., 2018, p. 237). Dr. Liz Rudisell, the MST coordinator at the Lexington KY VA, discusses how some veterans do not meet veteran status which allows service members to receive treatment through the VA (E. Rudisell, personal communication, February 22, 2021). For example, National Guard members

do not meet veteran status unless they have been activated federally for a certain period. Dr. Rudisell explains that in the past, some National Guard members had been federally activated but fell below the threshold of time served by just a couple of days and were then not considered to meet veteran status resulting in them not being eligible for VA services.

Moreover, active-duty members that have experienced MST and are seeking treatment outside of the DoD and instead with the VA face a lot of barriers. Specifically, Dr. Rudisell explains that they must receive pre-approval with the DoD insurance (tri-care), the DoD could also potentially have access to the active-duty member's records which goes back to the concerns surrounding confidentiality (E. Rudisell, personal communication, February 22, 2021). When asked if she has noticed any themes in why active-duty members seek VA healthcare versus active-duty services, Dr. Rudisell stated, "that they feel unheard, they have tried to address it in other ways prior to seeking care at the VA, and they have felt unsatisfied about how those attempts have gone and also the other options they have been given so feeling not heard or misunderstood and feeling pressured to be okay." (E. Rudisell, personal communication, February 22, 2021). Dr. Rudisell describes how she noticed while working with active-duty members in the VA that there is "that expectation to hold it together and you've got to be okay" which she believes contributes to feeling misunderstood.

It is important to also identify factors that mitigate these barriers and help to facilitate treatment seeking in MST survivors. Zinzow et al. (2015) identified numerous influences of treatment-seeking among sexual assault survivors including social network encouragement, having positive perceptions about mental health treatment, knowledge about treatment resources, leadership that permitted time off, and having schedule flexibility. Furthermore, the researchers found that black race was positively and individually associated with treatment seeking. As a

result of this finding, it appears that some races may have a higher probability of treatment seeking behaviors compared to others. Surprisingly, Zinzow et al. (2015) found that psychological symptoms were not correlated with treatment seeking behavior in MST survivors. Comparably, Dardis et al. (2018) found that females that labeled what they experienced as sexual harassment were more likely to perceive a need for and use of mental health services compared to those that did not label their experience as sexual harassment. Research by McManus et al. (2018) examined MMPI-2-RF scores of veterans seeking treatment for MST and found that those who presented for treatment endorsed several somatic complaints as well as symptoms of depression and anxiety. Similarly, Rowe et al. (2009) found that female MST survivors seeking treatment reported higher psychological distress compared to those without MST. These various findings reveal the significance of helping service members recognize what constitutes MST, the psychological symptoms that can follow, as well as the benefits of mental health treatment; this can help bridge the gap of treatment seeking in service members experiencing psychological distress or impairment due to MST.

In Addition, Bryan et al. (2019) involved veterans in creating consumer marketing for MST treatment. Based on veteran feedback, two pamphlets were designed. The first pamphlet targeted females while the second was gender neutral and provided the exact same information but displayed varying ages, genders, and ethnicities to display relatable individuals seeking mental health care for MST. The researchers state that including input from stakeholders can help to increase the treatment seeking by increasing awareness, destigmatizing treatment, and incorporating elements of military culture into the marketing.

It is a positive sign that despite the various barriers faced by MST survivors, Holder et al. (2020) found that MST was correlated with the highest probability of beginning psychological

treatment such as CPT or PE compared to other disorders such as mood, psychotic, pain, or SUD disorders. This finding is extremely important because, as mentioned in the impact section above, MST is linked with poor mental and physical health. The earlier an MST survivor seeks treatment the better the outcome. Holder et al. (2020) proposes that MST survivors seek out treatment at a higher rate than other disorders due to success in programs targeting outreach, screening, and psychological referrals for MST survivors with PTSD. Treatments for MST are discussed in the following section.

Treatments of Military Sexual Trauma

Military sexual trauma is often treated with evidence-based treatments for PTSD such as cognitive processing therapy (CPT) and prolonged exposure (PE) (Holder et al., 2018; Holliday et al.,2014; Holliday et al., 2015; Holliday et al., 2017; Rauch et al., 2020; Resick et al., 2017; Suris et al., 2013). These standard treatment options will be discussed below. Additionally, newly emerging programs that have been developed to help with some of the more specific problems' MST survivors face will be discussed.

Cognitive processing therapy has been an established as an evidence-based therapy for PTSD, which is a common diagnosis for a lot of MST survivors (Resick et al., 2017). In recent years, the VA system has spent a lot of time focusing on treating PTSD related to MST (Holliday et al.,2014; Holliday et al., 2015; Holliday et al., 2017). Holliday et al. (2014) discuss the effects of cognitive processing therapy on PTSD related negative cognitions with MST. A key feature of PTSD are negative cognitions about self, others, and the world. Holliday et al. (2014) examined how PTSD and related negative cognitions can be modified in MST survivors using CPT compared to a present centered therapy (PCT). Present centered therapy is a manualized treatment for PTSD; however, it does not contain cognitive-behavioral or trauma-focused

elements of CPT (Holliday et al., 2014). Present centered therapy does not focus on traumatic events but instead offers broad support and psychoeducation concentrating on present issues in the patient's life. During PCT, the attention is on problem solving and interpersonal skills while determining links between the patient's current problems and PTSD symptoms (Holliday et al., 2014). Present centered therapy has a written component which includes daily journaling as opposed to written trauma narratives like CPT. In this study, the researchers found that the MST survivors who received CPT had significantly decreased negative cognition scores after treatment and at follow up sessions compared to those in PCT (Holliday et al., 2014). The researchers also concluded that negative cognition levels were positively correlated with PTSD severity. However, it is important to note that the researchers removed results of patients from psychotherapists that were determined to have poor fidelity in providing the manualized treatments (Holliday et al., 2014). This is crucial to mention as these successful clinical results may not be present when the therapist does not have strong fidelity of the manualized treatment.

Historically, research has noted higher rates of early treatment termination from evidence-based treatments such as CBT among black females when compared to white females (Lester et al., 2010). As a result, Holliday et al. (2017) evaluated the effectiveness of CPT for black females compared to white females with MST related PTSD. The researchers concluded that both black and white females experienced significant decreases in PTSD symptoms during treatment and this clinical progress was preserved up to six months after treatment. The researchers found that number of sessions attended, rates of early treatment termination and change in clinical symptom severity did not significantly differ based on race. Ultimately, the researchers concluded that CPT is an effective evidence-based treatment for black and white female MST survivors (Holliday et al., 2017). Holliday et al. (2015) also explored the role of

CPT in improving psychosocial functioning, health, and quality of life in MST survivors. The researchers found that those treated using CPT reported significantly higher physical functioning over time than those treated with PCT. A study conducted by Voelkel et al. (2015) evaluated the effectiveness of CPT for male and female MST survivors in a residential treatment program. The researchers found that PTSD and depression symptoms significantly decreased over time and that females displayed a higher reduction in PTSD symptoms over time than men. It is important to note that this study did not have a control group or random assignment, as all treatment groups were in a residential treatment program and were given CPT. As a result, this study can only be generalized to residential treatment program patients being provided treatment in the form of CPT. Similarly, Suris et al. (2013) completed a randomized clinical trial of CPT for veterans with MST related PTSD. The researchers assessed the effectiveness of CPT using self-report and clinician assessment of symptom severity during pretreatment, posttreatment and a 2, 4, and 6-month follow up. The researchers measured symptom severity through the CAPS for clinician assessed PTSD symptom severity, PCL for self-report PTSD symptom severity, and the QIDS for self-report depression symptom severity. The researchers found that at posttreatment, participants who received CPT had a significantly greater decline in self report symptom severity, but not clinician assessed, compared to the PCT treatment group. Suris et al. (2013) concluded that the three outcome measures improved significantly, both clinically and statistically, across time in both treatment groups. However, larger effect sizes were a trend in the CPT group, suggesting CPT having a higher level of effectiveness in treating PTSD related to MST when compared to PCT. Like the studies mentioned above, this study had a significant limitation due to fidelity issues. These issues and the impact on clinical progress will be discussed later in this section.

A study conducted by Holder et al. (2018) examined the effectiveness of CPT on sleep disturbance in MST related PTSD patients. The researchers discuss the devastating effects of sleep disturbance such as an increased risk for suicidal behavior, substance misuse, and poor physical health. Sleep disturbance was evaluated pre and posttreatment. The researchers found no significant relationship between clinically significant change in PTSD symptoms and resolution of sleep disturbance. Despite the significant reductions in PSTD symptoms post CPT treatment, sleep disturbance remained persistent for patients. As a result of these findings, clinicians should be aware of these limitations with CPT and provide effective strategies to specifically address sleep disturbance in this population.

As mentioned in early sections of this paper, individuals with previous sexual trauma have a higher risk of experiencing MST. Holder et al. (2018) examined the effect of childhood sexual assault history on outpatient CPT for MST related PTSD. During the study, PTSD symptom severity was assessed during pretreatment, posttreatment, and up to six months follow up. The researchers also evaluated the number of sessions attended and completion of treatment. Holder et al. (2018) discovered that participants with and without historical childhood sexual trauma were found to make clinical progress from CPT. The researchers also found that historical childhood sexual trauma did not significantly impact the number of sessions attended, treatment completion, or the overall treatment response. These results indicate the efficacy and acceptability of outpatient CPT for veterans with MST related PTSD irrespective of historical childhood sexual trauma (Holder et al., 2018).

Another evidence-based treatment for MST related PTSD is prolonged exposure (PE). Prolonged exposure facilitates emotional processing of a trauma through methodical exposure of trauma related stimuli (Foa et al., 2019). Prolonged exposure is made up of three main elements

including psychoeducation, repeated imaginal exposure, and in vivo (real life) exposure (Foa et al., 2019). Research conducted by Rauch et al. (2020) found that self-reported PTSD, depression, and neurological symptoms significantly decreased while social functioning significantly increased with PE treatment. Interestingly, the researchers found that black veterans and veterans with MST reported higher levels of severity at baseline compared to white or combat trauma veterans. However, this higher severity at baseline did not differ their clinical outcomes from PE treatment. The researchers also found that a more exaggerated cortisol response at baseline predicted smaller reductions in PTSD symptoms during PE treatment while larger reductions in this cortisol response from baseline to posttreatment were correlated with improved results (Rauch et al., 2020). Finally, the researchers found that intensive PE in conjunction with corresponding interventions such as case and medication management, relapse prevention, interpersonal skills training, recreational activities, vocational/financial support, and promotion of physical health and wellness activities revealed exceptional retention and clinically reduction in PTSD and related symptoms in just two weeks. This research provides support in the use of PE in the treatment of PTSD even with complex presentations that include differing demographics and symptom presentations (Rauch et al., 2020). Another study completed by Rauch et al. (2009) also found that PE was an empirically supported treatment for veterans with MST. Specifically, the researchers found that MST veterans had significant reductions in PTSD and depression symptoms from pre to posttreatment. However, it is important to note that this research has many limitations including the sample size being small, the sample only being Caucasian, and the sample was not randomly assigned. The researchers also did not assess for therapist fidelity or patient attrition rates. As discussed above, fidelity issues have created issues

in treatment outcomes and attrition rates. As such, therapist fidelity is vital to ensure ethical and competent care provided to patients.

Cognitive processing therapy and prolonged exposure are used often due to their evidence-based background for treating PTSD related to MST. However, there are other therapies that are also available to MST survivors. Below is a discussion of various therapies that have been used in treating PTSD related to MST.

Eye movement desensitization and reprocessing (EMDR) therapy has also been used in the treatment of PTSD related to MST (Hurley, 2015). EMDR has eight main components to the treatment consisting of: history taking, preparation, assessment, desensitization, installation, body scan, closing, and reevaluation (Shapiro, 2001). History taking includes getting a broad psychosocial history, preparation includes informed consent and the patient displaying self-regulation skills such as relaxation techniques (Shapiro, 2001). The assessment stage activates the traumatic memory and desensitization is when the therapist provides around 20 to 35 repetitions of rapid bilateral stimulation and then stops and asks the patient for brief feedback on what the patient is experiencing with the memory (Shapiro, 2001). Installation includes implementing a positive self-referencing belief and body scan has the patient scan the body and note any negative sensations which are then processed with any needed additional eye movements (Shapiro, 2001). During the closing phase the therapist ensures the patient is calm and stable before ending the session and reevaluation is the recurring assessment the therapist conducts each session to direct treatment (Shapiro, 2001).

Hurley (2015) states that MST survivors may like EMDR as a treatment because it is a nonverbal approach and would not require them to discuss details of their MST. Additionally, EMDR is a client centered approach which promotes collaboration between therapist and patient

(Hurley, 2015). This collaboration can help to address obstacles during treatment and can build the patient's trust and confidence in the treatment process and outcome. Hurley (2015) discusses how subjective units of distress are tracked by the therapist and patient during sessions so there is proper intensity regulation of activation and distress during treatment. This can help to ensure that the therapist and patient stay within the therapeutic window so that the distressing memories are manageable for the patient which has been shown to limit the amount of early treatment termination (Briere & Scott, 2006).

Interpersonal therapy (IPT) is another treatment option available for PTSD due to MST (Cloitre et al., 2016; Peskin et al., 2018). Interpersonal therapy was guided by CBT and psychodynamic theory and is a short term affect focused treatment (Cloitre et al., 2016; Peskin et al., 2018). Peskin et al. (2018) reports a case study describing the use of IPT in treating PTSD symptoms in a female MST survivor. The researchers found that after a brief course of IPT, the female MST survivor reported significant reductions in PTSD and depression symptoms as well interpersonal progress. Similarly, research conducted by Cloitre et al. (2016) discuss case reports for a treatment that focuses on strengthening social support and relationships among survivors of MST, known as Skills Training in Affective and Interpersonal Regulation (STAIR). The authors discuss the limitations of standard PTSD treatments such as CPT and PE, stating that they lack approaches to facilitate development in social and interpersonal functioning. STAIR has four main components that consist of psychoeducation, demonstration of skills, practice of skills, and practice assignments using skills between sessions (Cloitre et al., 2016). The first part of the treatment works on emotion regulation skills. The second part of the treatment focuses on identifying interpersonal schemas rooted in trauma. During this phase of treatment, the patient will learn to replace maladaptive schemas with adaptive schemas and will role play to practice

applying behaviors that align with these more adaptive interpersonal schemas (Cloitre et al., 2016). When reviewing the three case studies, it appears that the patients had significant reductions in PTSD symptoms and growth in interpersonal skills following the STAIR treatment. There even appears to be an example of post traumatic growth in one of the case reports (Cloitre et al., 2016). Specifically, after the completion of the STAIR treatment, one of the patients became engaged with an MST advocacy group where she helped other MST survivors.

These studies provide early support in the use of IPT based treatments for MST survivors in dealing with PTSD symptoms as well as other sequalae such as depression and interpersonal difficulties. However, these studies are case reports and are limited in generalizability to the greater MST survivor population. As a result, further research must be done to determine the appropriateness of IPT based treatments for the treatment of MST.

Mindfulness-Based Stress Reduction (MBSR) is another treatment that has been used in recent years for veterans with MST (Gallegos et al., 2015). Mindfulness-Based Stress Reduction is an evidence-based therapy used in treating depression, anxiety, and PTSD by combining mind and body with mindfulness and working on emotional regulation (Stephenson et al., 2017; Zhu et al., 2019).

Gallegos et al. (2015) argues that MBSR for MST is beneficial because traumatic stress negatively impacts emotion regulation, which is a common difficulty faced by those with PTSD, depression, and suicidal behaviors. Mindfulness can influence can help with attention and emotion regulation, connecting the body and mind, and self-perception. Mindfulness consists of a present minded nonjudgmental framework which teaches patients live in the present moment in a nonjudgmental way (Kabat-Zinn, 2003). This present focus helps patients be more aware of bodily sensations, feelings, and automatic thoughts while implementing mindfulness practice that

focuses on reduction of thought suppression, rumination, overgeneralization, and avoidance, which are common difficulties faced by those with PTSD (Kabat-Zinn, 2003). Gallegos et al. (2015) argue that MBSR can also provide training on reassessing thoughts and physiological perceptions with mindfulness which could improve emotional regulation and reduction of PTSD symptoms. Research by Vujanovic et al. (2009) provided support for Gallegoes et al. (2015) idea to use MBSR for treating PTSD symptoms. Vujanovic et al. (2009) found that mindfulness was associated with a reduction in PTSD symptoms. However, the researchers did not use a sample of MST survivors, as a result, this support is limited to adults with PTSD symptoms and cannot be applied to those that have faced MST. Further research must be conducted before MBSR can be considered an evidence-based treatment for MST.

Research has also explored other treatments that have been used with female MST survivors such as the Warrior Renew Group (Katz, 2016). Katz (2016) examined the effectiveness of the Warrior Renew group therapy in an outpatient setting for female MST survivors. This group therapy focused on building coping skills for emotion regulation and specific MST struggles such as anger and resentment due to their experienced injustices, lack of closure, betrayal, and self-blame. This treatment also focuses on interpersonal factors such as relationship patterns and teaching healthy interpersonal skills (Katz, 2016). Katz (2016) found significant reductions in PTSD, anxiety, and depression symptoms which provide initial support for the use of the Warrior Renew Group for female MST survivors. However, this research has many limitations such as not being a randomized controlled trial, having a small sample size, and no having a follow up assessment as well as the researchers neglecting to prescreen if the patients met criteria for a PTSD diagnosis prior to treatment. Further research is needed to assess if this treatment can address the unique issues faced by MST survivors and can clinically hold up

to other evidence-based treatments such as CPT and PE. Further research should examine the longevity of clinical change from this treatment and the effectiveness of treatment with a larger sample size made up of more diverse populations including individuals from the LGBTQ+ community.

Accelerated resolution therapy (ART) is another treatment that has been explored in recent years for treating MST (Kip et al., 2019). Accelerated resolution therapy is a brief psychotherapy with four key parts that consist of a narrative component, in vivo or imaginal exposure, cognitive restructuring, and relaxation training (Hernandez et al., 2016; Kip et al., 2014). Kip et al. (2015) compared ART for the treatment of PTSD and sexual trauma between civilian and military adults. In the military segment of the study, the researchers conducted a two-group randomized controlled trial with half the participants assigned to ART and half assigned to the control condition. Not surprisingly, when compared to the civilian sample, the military sample had a high rates of head trauma, poor sleep quality, and higher levels of arousal displayed on the PCL (Kip et al., 2015). The researchers found that both civilians and military members had reductions in PCL scores, however, civilians had a greater reduction during posttreatment and follow up. More specific for the focus of this paper, the researchers discovered that civilians and military females with sexual trauma had substantial mean reductions on the PCL. However, the researchers found that the subgroup of females with MST, had a reduced clinical response compared to the civilian and other military participants posttreatment. The researchers explained that these MST survivors tended to have a more severe clinical profile at baseline and argued that due to a smaller female MST sample, the estimates of treatment response may be inaccurate for this population. As a result, further research must be done to determine efficacy and tolerability of ART with this population.

Processing MST within the couple relationship has also been another treatment strategy explored in recent years. As discussed in the impact section of this paper, MST not only negatively impacts the survivor of MST but also impacts their relationships with others. Goodcase et al. (2015) explored treating MST within a couple framework. Goodcase et al. (2015) explain that their therapy model includes components of transgenerational theory, attachment theory, emotionally focused therapy, and incest treatment models to help the MST survivor and romantic partner process the trauma. During this treatment, the therapist is expected to identify projections in the relationship as well as help the couple become more sensitive to each other's emotional needs to help facilitate a secure attachment within the relationship (Goodcase et al., 2015). The researchers argue that forming a secure attachment can help the couple maintain trauma processing even posttreatment. This potential treatment could be beneficial in addressing physical, emotional, psychological, and interpersonal struggles that are faced by MST survivors and their romantic partners. However, this treatment has not been put into practice yet. Further research is needed to determine effectiveness and tolerability of MST treatment using this approach.

Acceptance and commitment therapy (ACT) has also been used to treat individuals with MST (Prins et al., 2015). Acceptance and commitment therapy promotes accepting one's thoughts and feelings instead of fighting, suppressing, or feeling guilty for them (Hayes et al., 2012). Hiraoka (2016) discusses how ACT has been used to treatment depression in civilians and veterans but that there was a lack of research to support using ACT with individuals exposed to trauma. To address this research gap, Hiraoka (2016) completed a clinical case study of a 21-year-old female MST survivor being treated for depression rooted from MST using ACT. The researchers concluded that the patient's depression symptoms decreased significantly throughout

the ACT treatment. The researchers also discovered that the patient had an increased capacity to be in the present moment, accept thoughts and emotions of uncertainty, and align decisions with her identified values. This case study, though limited in nature, provides initial support in the use of ACT in treating depressive symptomology in MST survivors.

These treatments provide a lot of potential benefit for MST survivors, however, the clinician conducting the treatment plays a significant role in the level of clinical progress achieved (Holder et al., 2018). Research conducted by Holder et al. (2018) examined the role of psychotherapist fidelity on outcomes of CPT for MST related PTSD. Patients' trauma related negative cognitions, depression symptoms, and PTSD symptoms were assessed pretreatment, 1-week, two-month, four-month, and six-month posttreatment. The CPT psychotherapists were evaluated on fidelity to the CPT manualized treatment, and it was determined that of the four psychotherapists, two of them were below average in treatment fidelity. Holder et al. (2018) discovered that patients treated by psychotherapists with average to above average fidelity, had significantly greater reductions in negative cognitions and depression and PTSD symptoms than those treated by a psychotherapist with below average treatment fidelity. These research findings reveal the importance of ensuring and sustaining clinician treatment fidelity so not to negatively impact the potential clinical progress of the patient.

Interestingly, Borah et al. (2017) found that clinicians treating active-duty service members for PTSD underuse the three-leading evidence-based treatments for PTSD (CPT, PE, EMDR), and instead are using CBT. Clinicians reported lack of training as the main barrier to using these preferred PTSD treatments. Additionally, clinicians reported that hindered effective application of these treatments was due to a lack of clinical support and insufficient clinic layout after training. These research findings suggest the importance of proper and effective trainings in

EBTs as well as proper clinical support via clinical supervision provided by a proficient clinician in the EBT that was being trained, follow up to ensure proper application, and to provide time to resolve issues that could hinder correctly implementing the EBTs. Borah et al. (2017) warn that the military's ability to ensure treatment fidelity and related improvements in patient outcomes may be diminished without formal assessment of both the method of training and supervision. Moreover, it is vital for future research examine implementation models that can address concerns and obstacles in an active-duty military health care system (Borah et al., 2017).

Treatment outcomes can also be impacted by other factors. Tiet et al. (2015) explored if gender and MSA were correlated with psychiatric symptom severity differences at baseline of treatment for PTSD. Tiet et al. (2015) discovered that PTSD symptom severity did not differ at baseline by gender or MSA status. However, they did find that females had significantly higher depressive symptom severity at baseline while males had more aggressive or violent symptoms. The researchers also found that gender, MSA status, and the interactions between gender and MSA did not influence treatment outcomes. Ultimately, the researchers concluded that male and female veterans with and without MSA status had equally positive treatment outcomes from PTSD treatment provided in a VA setting. However, despite these positive treatment findings, it is important to acknowledge individual differences presented with each case and adapt the treatment to best fit the individual while at the same time ensuring maintenance of treatment fidelity. The following section of this paper will discuss the vital role of advocacy within the mental health field.

Advocacy

Clinicians hold the crucial role of being advocates for those that experience mental illness (Marshall-Lee et al., 2020). Historically, advocacy has not been a major focus within the

responsibilities of psychologists, but in 2003 the American Psychological Association added guidelines which called psychologists to take on leadership roles that facilitate social change and justice via advocacy (APA, 2003). As a result, times have changed, and advocacy has become a vital role within the field. Mental health advocacy is crucial because it increases awareness of mental health issues and the impact it has on individuals and their families. Advocacy can influence policy makers who can bring about positive change and progress on a local and national level.

According to Marshall-Lee et al. (2020), social justice advocacy are purposeful and consistent measures aimed to influence public policy with or for a vulnerable individual, group, community, or the public at large. There are three different levels of advocacy: individual, community, and the larger public, such as at a national level (Marshall-Lee et al., 2020). The individual level of advocacy is where psychologists can directly interact with MST survivors. Sometimes the survivor may hold beliefs or face situations that may make it difficult for them to advocate for themselves (E. Rudisell, personal communication, February 22, 2021; Marshall-Lee et al., 2020). For instance, a therapist should act as a resource for an MST survivor and step in to assist in the process of having an MST survivor's needs met in other forms of treatment besides mental health by setting up services that are conducive to the survivor (E. Rudisell, personal communication, February 22, 2021).

Dr. Rudisell provides an example of individual advocacy describing a situation during which a female MST survivor needed an MRI but was assigned a male MRI technician and was experiencing distress around the potential situation of being in a medical gown in a small space with a male technician. In this situation, Dr. Rudisell advocated for the MST survivor's needs by contacting the MRI office and explaining that the patient would need to have a female MRI

technician for her upcoming appointment. Dr. Rudisell also explains that if applicable, the clinician can work with an MST survivor through role plays in a therapeutic framework to help the MST survivor learn self-advocacy skills (E. Rudisell, personal communication, February 22, 2021).

There are also positions a mental health provider can take such as becoming a victim advocate for MST survivors or taking a professional position like an MST coordinator, like Dr. Rudisell. Within the VA system, Dr. Rudisell explains that an MST coordinator is usually the first point of contact for an MST survivor and will speak with a survivor to provide support and educate them on their options by providing information about resources available to them. If the survivor wants to tell their story, the MST coordinator is there to listen, and sometimes this may be the first time that the MST survivor may be telling their story or have the sense that they are truly being heard (E. Rudisell, personal communication, February 22, 2021). Additionally, As stated in earlier sections of this paper, the SAPR victim advocate within the DoD is present to support the MST survivor by aiding with decision making, escorting to appointments, having frank discussions, and encouraging steps towards healing (Sexual Assault Prevention and Response, n.d.). The victim advocate will promote healing by helping the MST survivor find mental and medical health care and legal services if they so choose.

The community level of advocacy reaches beyond a single MST survivor. This level of advocacy can include acts such as hosting events with community organizations to bring about awareness (E. Rudisell, personal communication, February 22, 2021). These awareness campaigns not only help bring recognition to the issue of MST but can help connect MST survivors with services (E. Rudisell, personal communication, February 22, 2021). Psychologists can also advocate at this level by reaching out to their local and state representatives to speak to

them about MST and how it impacts their constituents. Psychologists can additionally develop fundraisers to help support MST survivors and the sequalae they face.

On a larger scale, psychologists can take their advocacy to the national level (Marshall-Lee et al., 2020). At this level, psychologists can conduct research on various topics within MST and disseminate their findings throughout the country. They can also become members of advocacy groups for MST and act by reaching out to federal level politicians to educate them about MST and the damage it brings to so many within the country. Psychologists can also take on an advocacy role by using their platform as a psychologist to publicly support proposed MST legislation to increase rights for MST survivors.

Section III: Original Contributions to Practice

Recommendations for future research and clinical practice

In the past few years, there has been improvement in addressing the issues of MST and the sequalae that follows. However, there is still a lot of progress that is necessary to tackle the problem of MST. Below is a discussion about the recommendations for future research and clinical practice provided in the literature.

Efforts to increase awareness of MST are crucial. Burns et al. (2014) discusses suggestions for increasing awareness of MST. In their research, participants felt the military should raise awareness about MST through improved pre-deployment informational meetings about MST which could include where and how to access care while on deployment. The participants during Burns et al. (2014) research also noted the need for improved ongoing outreach for soldiers after deployment. One MST survivor explained that the DoD cannot just explain information and resources once and expect people to remember. Another MST survivor discusses this issue by stating, "You don't know who the SARCs [Sexual Assault Response Coordinators] are, you don't know who the Victim Advocates are, you really don't have an understanding a lot of times of what your options are if you're a victim of assault" (Burns et al., 2014, p. 348). Zinzow et al. (2015) suggests that treatment-supporting interventions should focus on improving recognition of mental health symptoms. Moreover, Dr. Rudisell, an MST coordinator for the VA, explains the importance of increasing awareness about the way the "body manifests dealing with and experiencing military sexual trauma" to survivors (E. Rudisell, personal communication, February 22, 2021). Additionally, Dr. Rudisell believes it is important for clinicians to inform patients about their options for treatment beyond just mental health care and she considers this is an area of growth for clinicians. Moreover, Dr. Rudisell discusses how

some clinicians are not aware of what constitutes MST. Fortunately, implementing trainings and tools like the MST screener through the VA can help clinicians to better understand what constitutes MST so they can provide the appropriate information and resources to survivors (E. Rudisell, personal communication, February 22, 2021). Furthermore, outreach can help survivors recognize symptoms of mental illness and understand what MST is, which can facilitate connection to services. For example, research has shown that female military members labeling their MST influenced their perception of needing and using mental health services (Dardis et al., 2018). Dardis et al. (2018) suggest that future research replicate their study with larger longitudinal studies to determine if labeling changes over time, if confidentiality worries limit treatment seeking during deployment, if labeling differs between active duty and veterans, and the psychological and occupational outcomes of labeling. Clinically, Dardis et al. (2018) suggest challenging schemas and rape myths that diminish and invalidate MST experiences, place blame on survivors, and thwart labeling.

It appears from the research that there is progress to be made in understanding the prevalence of MST. The first step in improving the understanding of MST prevalence is by enhancing the reporting system and procedures within the DoD (Burgess et al., 2016; Wolff & Mills, 2016). Specifically, Wolff and Mills (2016) suggest reforming the MST reporting process by varying options for reporting for all types of sexual misconduct through a third-party organization instead of chain of command. Moreover, Burgess et al. (2016) proposes implementing an online reporting system for MST. It would be very beneficial to reform the reporting process in the hope of mitigating the various limitations of the DoD reporting system (Sexual Assault Prevention and Response, n.d.). During restricted reporting, the survivor cannot obtain a military protective order or an expedited transfer to a different unit or base and as a

result may have to endure continuous contact with their assailant. Furthermore, survivors are recommended to not discuss their assault with anyone except for confidential persons which can be very isolating for survivors. Finally, if the survivor later decides to transfer their restricted report to an unrestricted report, evidence from the crime scene may be completely lost and significant issues in the investigation process may occur (Sexual Assault Prevention and Response, n.d.). Unrestricted reporting also carries limitations that are detrimental to survivors. Unrestricted reporting cannot be reversed once commenced, the survivor can no longer control the release of their personal information and may not have opportunities to speak to legal counsel prior to deciding to make an unrestricted report (Sexual Assault Prevention and Response, n.d.). Lastly, survivors may experience revictimization during the investigation process through having to tell and retell specifics of their sexual assault and may ultimately face retaliation resulting from their report.

Reforming the reporting system by permitting more options such as reporting to the same gender, reporting online, and reporting to an independent party outside the chain of command could help to reduce some of these reporting limitations which could help to increase reporting rates allowing a more accurate understanding of MST prevalence. Future research should examine how MST is psychologically impacting military members via non-disclosing, especially looking at males as they have lower rates of disclosing and seeking medical and psychological services compared to females (Burgess et al., 2016). Burgess et al. (2016) suggests clinicians routinely ask about sexual abuse history and the nature of any disturbing intrusive thoughts to assess earlier if the patient has experienced sexual trauma. Additionally, Burgess et al. (2016) recommends clinicians increase their understanding of common comorbidities of MST as well as interprofessional collaboration to ensure best care for MST survivors. For example, the

researchers propose working with nurse practitioners to identify MST survivors in a primary care setting. This could help to ensure an MST survivor gets connected with mental health services.

Like the DoD reporting system, the VA has a comprehensive screening procedure, however, additional revisions in this procedure could help to increase its effectiveness (E. Rudisell, personal communication, February 22, 2021). The VA has created and implemented the MST clinical reminder which is an MST screener that needs to be asked at least one time, ideally at the very beginning of treatment (E. Rudisell, personal communication, February 22, 2021). The screener will not become due again, unlike the depression, alcohol use, or interpersonal violence screening which is once per year. However, if a provider has been working with a veteran and they are now reporting MST, that provider can then go in and edit that MST screener so the veteran can gain MST benefits (E. Rudisell, personal communication, February 22, 2021). Additionally, if a veteran declines to answer an MST screening, the screener will be due again in one year. The MST screener will also become due again if someone is still serving active duty (E. Rudisell, personal communication, February 22, 2021). Fortunately, The VA has created an MST screener manual which has helped to standardize the screening process throughout the VA system. The MST screener has many benefits such as the option to make a referral for mental health care which goes directly to the MST coordinator within that specific VA. The MST screener also has an MST fact sheet imbedded into the screener for male and female MST survivors so they can be given something during their visit (E. Rudisell, personal communication, February 22, 2021).

Dr. Rudisell, explains that there is a tracking system in place that enables her to see which veterans have not yet been screened for MST so she can follow up with providers to get this completed. Regarding clinical suggestions, mandating initial visit MST screening could be

beneficial so that veterans that have experienced MST do not fall through the cracks regarding MST treatment because they were not screened earlier. Additionally, Dr. Rudisell describes another issue that has surfaced since the COVID-19 pandemic. She explains that there has been a large influx of new virtual VA clinics making it more difficult to ensure that all veterans are being screened for MST. Essentially, the screening software populates certain VA clinics that are target clinics such as primary care and mental health clinics and provides clinical reminders to ensure MST screening is being completed. However, these new virtual clinics have not been marked as MST target clinics and as a result MST screening has been more difficult. Updating the MST screener software to recognize virtual clinics as target clinics will be important in the COVID-19 era to help ensure all veterans are being screened for MST. Moreover, within the VA MST screening system, demographics are not tracked other than by gender (E. Rudisell, personal communication, February 22, 2021). No background is collected regarding race, ethnicity, sexual orientation, or branch of service (E. Rudisell, personal communication, February 22, 2021). Updates in the tracking system could help to increase understanding of who is being impacted and at what rate. With improved tracking systems, this can allow mental health professionals to better understand their target audience for outreach purposes which could help survivors receive services earlier.

There has been a lot of research that has provided insight into how MST impacts survivors and how to best help survivors. Despite these advances, there is still a lot of progress to be made in this realm. Research has shown ethnic, racial, sexual orientation, gender, and rank differences in MST experiences (Blais et al., 2017; Buchanan et al., 2008; Dardis et al., 2018; Hankin et al., 1999; Herek et al., 1999; Rauch et al., 2020; Sadler et al., 2017). As a result, more research is needed to examine the experiences of these groups so that MST survivors can be

better understood (Blosnich et al., 2013; Beckman et al., 2018; Blais et al. 2019; Woods et al., 2009). Additionally, researchers suggest examining the link between MST and other comorbid disorders such as SUD, eating disorders as well as suicidal ideation (Blais et al., 2017; Blais et al., 2019; Blosnich et al., 2013; Gobin et al., 2015; Goldberg et al., 2019; Monteith et al., 2016; Monteith et al., 2017) to help ensure thorough targeted assessment and treatment for MST survivors. For example, Lutwak (2013) suggests that the VA assess the most effective treatments to decrease comorbidities such as suicidal ideation and depression caused by MST. Clinically, Lutwak (2013) recommends continuous evaluations to determine effectiveness of treatments. To address suicidal ideation in MST survivors, researchers recommend examining how to effectively decrease perceptions of burdensomeness, belongingness, and fearlessness about death (Monteith et al., 2017). Researchers also suggests further examination and training in social, emotional, and medical problems that are linked to sexual abuse (Felitti et al., 2019; Monteith et al., 2017) as well as increasing research on the prevalence and impact of interpersonal violence related MST (Mercado et al., 2015). Though not the focus of this paper, male MST appears to be understudied (Burns et al., 2014; Dardis et al., 2018; Katz et al., 2007). As a result, future research should also examine the specifics of male MST experiences and the effects that ensue.

Advocacy is a very important role of mental health professionals (Marshall-Lee et al., 2020). It is vital psychologists continue research, increase clinical knowledge, and respond to policy (Herek et al., 1999). Mental health professionals should act as advocates for MST survivors and speak up about the issues of MST to bring about change within the DoD system and beyond. For example, advocacy is needed to increase support for *all* service members, including those without active-duty experience and may not be eligible for VA services (E. Rudisell, personal communication, February 22, 2021). Additionally, Groves (2013) suggests the

DoD update their infrastructure and provide proper advocacy services for female service members as they report that some bases do not have basic female specific services despite having large female populations. Having inadequate female services on bases makes it difficult for female members to get victim advocates and other resources after experiencing MST (Groves, 2013) Overall, mental health professionals must take action to bring about change and stand with and for MST survivors so that progress can be made at an individual as well as systemic level (Holland et al., 2016; Kimerling et al., 2007; Millegan et al., 2015; Sadler et al., 2017)

There are several barriers to treatment that MST survivors face. Some of these barriers include self and group stigma, confidentiality concerns, warrior culture, leadership behaviors, and logistical hurdles (Anderson & Blais, 2019; Britt et al., 2012; Bryan & Morrow, 2011; Burns et al., 2014; Groves, 2013; Rosellini, et al., 2017). Burns et al. (2014) recommends making MST services available from independent providers outside the military and the military to work on increasing confidentiality and reducing judgment and stigma. Increasing confidentiality could help to reduce fears of retaliation around MST reporting and treatment seeking. Interestingly, Burns et al. (2014) found that military service providers were seen by MST survivors as more prone to view sexual assault survivors as "weak" for seeking treatment or to have prejudiced sentiments, which discouraged some females from seeking treatment (Burns et al., 2014, p. 348). One participant in their study that was deployed to Afghanistan during 2006 and 2007 stated that her unit's Victim Advocate was "not friendly to women" (Burns et al., 2014, p. 348). Similarly, Blais et al. (2018) found that there are barriers that female MST survivors face when disclosing MST such as being sexually assaulted by someone in their unit, stigma, avoidance, and discomfort with the provider or screening setting. Blais et al. (2018) recommend an increased

effort and focus on perceived safety and benefits of disclosing MST to increase screening disclosing behavior.

To help facilitate feelings of safety at treatment settings and decrease perceptions of stigma, Dr. Rudisell, recommends training front desk staff so they can communicate a culture of acceptance, awareness, and knowledge. She explains the importance of front desk staff as these individuals are the very first people that survivors are interacting with when seeking treatment (E. Rudisell, personal communication, February 22, 2021). Dr. Rudisell also discusses overcoming obstacles to mental health treatment like when an MST survivor reports to primary care instead of mental health care. She explains that mental health care integration with primary care can improve connection to MST services when someone is reporting MST within primary care units.

Burns et al. (2014) recommends mandating mental health treatment after an assault to reduce care-seeking stigma, improving the availability and confidentiality of medical services, having a reporting system that permits women to report assault to women, and producing an anonymous hotline for soldiers deployed overseas. Furthermore, Zinzow et al. (2015) suggests that interventions should enlist support for treatment seeking from unit members, leadership, and significant others to help decrease stigma. When screening for MST, examiners should also assess for self-stigma (Valenstein et al., 2014). Screening for self-stigma can help identify individuals that may be reluctant to endorse their MST and seek services. In identifying these individuals, clinicians can work with them to reduce their self-stigma and increase their chances of receiving help. Overall, future research should continue to explore stigma among MST survivors and influences it has on seeking services (Valenstein et al., 2014).

There are also logistical obstacles that MST survivors face when treatment seeking. Murray-Swank et al. (2018) found that scheduling difficulties and distance from facilities were the most regularly reported barriers to treatment seeking in rural female veterans. Murray-Swank et al. (2018) suggest that mental health services adopt HIPAA compliant telehealth platforms and train clinicians in providing telehealth services ethically and competently. They argue that these changes could be beneficial in removing some of these logistical barriers that some MST survivors face. Additionally, Dr. Rudisell, explains that under the Veterans Community Care Program (2019), veterans can seek services in their community which can be reimbursed by the VA (E. Rudisell, personal communication, February 22, 2021). Dr. Rudisell discusses some of the reasons that veterans may be seeking care outside of the VA such as specialized treatments, long drive time, and being waitlisted over 30 days for treatment at the VA. Burgess et al. (2016) recommends interprofessional collaboration between military nurse practitioners and behavioral health clinicians as well as innovative strategies using telecommunication and online counseling. Ultimately, increased interdisciplinary communication and flexibility from the VA and DoD regarding treatment will be essential going forward to mitigate logistical barriers.

Furthermore, Britt et al. (2012) recommends future research continue to explore organizational influences on perceived stigma and practical barriers for accessing mental health treatment as well as the causal role of leadership behaviors in influencing military service members seeking mental health care. Similarly, researchers recommend future research explore the services offered to MST survivors who postpone or never initiate evidence-based treatment and how clinical, military, and demographic factors influence what services are presented and taken (Holder et al., 2020).

After experiencing MST and the negative effects of it, some MST survivors seek mental health services to help address the sequalae. There has been a lot of developments regarding mental health treatment for MST, nevertheless, more progress is needed to help ensure adequate treatment for MST survivors. Research recommends further exploration into existing EBTs and their suitability for minority MST survivors such as those within the LGBTQ+ community and individuals of color (Campbell & Raja, 2005; Holder et al., 2018). For example, Lindsay et al. (2014) proposes future research examine the suitability and effectiveness of current treatments among transgender veterans due to their increased rates of PTSD and depression. Additionally, there are high rates of MSA among transgender military members but despite an increasing trend toward VA use, many transgender veterans do not use VA services (Lindsay et al., 2014; Sadler et al., 2017). As a result, non-VA clinics treating transgender individuals should screen for veteran status and MST. additionally, Holder et al. (2018) suggests that future research continue to investigate factors that can consistently predict which MST survivors would benefit from an EBT like CPT. We know that EBTs are clinically successful treatments, but it is important to determine which EBT would be most successful for each individual patient versus generalizing the use of one EBT for all MST survivors. Additionally, researchers recommend exploring if 12 sessions of CPT are optimal for clinical progress with MST survivors or if additional sessions would provide further reduction in PTSD symptoms (Holliday et al., 2014). Likewise, researchers recommend exploring how EBTs can address *all* components of psychosocial and health functioning as well as quality of life in MST survivors (Holliday et al., 2015). Additionally, Romaniuk and Loue (2017) and O'Brien et al. (2015) recommend additional consideration in research and treatment for male MST survivors. The MST prevalence rates are

lower for males compared to females but that does, but this does not justify not addressing their concerns.

Future research also needs to replicate and further explore proposed treatments for MST as well as investigate treatment approaches that address symptoms that are not being addressed in preexisting treatments. For example, Gallegos et al. (2015) stated that MBSR could be an important component of a comprehensive approach to care for veterans with trauma. However, research is still needed to thoroughly examine mindfulness-based treatments for MST survivors. Similarly, the Warrior Renew, ART, and IPT programs reveal potential value for MST survivors, but further research is needed to determine if valid and reliable among MST survivors (Katz, 2016; Kip et al., 2015; Peskin et al., 2018). Additionally, Holder et al. (2019) reports high remaining levels of sleep disturbance in veterans with PTSD, despite reductions in overall PTSD symptoms following CPT treatment. As a result, they recommend future research on identifying successful strategies to specifically address sleep disturbance in this population. Furthermore, Cloitre et al. (2016) found STAIR to be a possible treatment for veterans with MST via case reports but recommends future research implement a randomized controlled trial to determine the effectiveness of STAIR compared to PTSD EBTs.

Furthermore, Bryan and Morrow (2011) discuss the need to improve the marketing of mental health services in a more culturally competent manner. In their study, Bryan and Morrow (2011) implemented language and pictures in their treatment program that aligned with their target audience's culture. For example, the treatment program was presented as a performance enhancement program, not a mental health program. The researchers explain that the implementation of the specific unit language was deliberately integrated into the program to increase acceptability and reduce stigma, expedite learning, and raise the probability for

application. As a result, future research should examine if implementing military cultural language and pictures in treatment programs create additional clinical progress compared to programs without this implementation. Similarly, Bryan et al. (2019) recommends future research examine the impact of direct consumer marketing on treatment seeking and commitment especially for stigmatized groups. They also recommend examining which methods of marketing are most successful in decreasing stigma while increasing intent to treat for MST survivors especially including those from diverse backgrounds and various geographic areas to gain more insight in this area.

Furthermore, the proper implementation of treatment approaches is crucial for treatment success but there appears to be factors resulting in poor implementation of treatments. For example, clinician fidelity problems appear to be a theme among treatment studies (Holder et al., 2018). Fidelity issues in manualized treatments have created problems in treatment outcomes and attrition rates (Suris et al., 2013). As such, therapist fidelity is vital to ensure ethical and competent care provided to patients. Future research should explore fidelity issues in clinicians and potential means of mitigating these issues that threaten the effectiveness of clinical treatments. Research has found that despite prior training and practice guidelines, clinicians use CBT over stronger evidence-based treatments such as CPT, PE, and EMDR for PTSD (Borah et al., 2017). The researchers discovered that the amount of training received influenced clinician's level of using the EBTs for PTSD. Furthermore, the researchers found that clinicians were not receiving adequate training and were not supported by regular consultation and clinical supervision when implementing treatments that were new to them. Clinical supervision is essential as it allows clinicians space to discuss their questions and concerns about treatments which can improve acceptance of these treatments compared to treatments they are more

comfortable providing to patients (Borah et al., 2017). Due to military clinicians facing unique challenges, the researchers recommend future research explore what post training supervision models work best within the military setting while developing military implementation models that can address the unique issues that arise in active-duty healthcare settings. The researchers propose that providing these military specific models could facilitate more prompt acceptance and implementation of treatment approaches.

Likewise, meeting a patient where they are at is very important for the treatment process. Goodcase et al. (2015) proposes a model for practice with MST survivors. Their model is founded in the understanding of family systems, human sexuality, sexual assault research, personal military connections, and therapeutic work with service members and their families. The researchers suggest that if an MST survivor presents with comorbid symptomology such as severe substance abuse, or severe depression or dissociation then the clinician should stabilize these presenting components before progressing with trauma work. The researchers also relay that the clinician should use their clinical judgment regarding the frequency of risk assessments for MST survivors considering this populations access to firearms, exposure to stress, and additional service time remaining.

Researchers also discuss how trainings of EBTs should be evaluated to ensure effectiveness of the training (Borah et al., 2017). Implementing post training evaluations can improve quality of trainings. The researchers also propose improving training procedures through group interventions before and during training that directly focus on concerns that may support after training implementation goals. The researchers also recommend creating a system for civilian clinicians that can track clinician treatment use like the Army's Behavioral Health Data Platform. This data can be beneficial to track clinical progress across different treatment

modalities in the civilian realm. Additionally, the researchers suggest that civilian clinicians treating military members have similar accountability procedures to ensure that services provided by civilians meet DoD clinical standards of care (Borah et al., 2017). As a result, future research should focus on improving data collection techniques for military members who seek treatment from civilian clinicians (Waitzkin et al., 2018).

Overall, there has been a lot of progress made in addressing MST and the havoc it causes but it is imperative that researchers, clinicians, and the DoD/VA do not decelerate in their efforts to bring about change and stand for those that matter…the survivors. After gaining experience working with MST survivors in clinical practice, future application of this literature review will take the form of an informational brochure or handbook. This brochure or handbook will provide data about MST and recommendations on how to treat ethically and competently those that have experienced MST.

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