

PTSD & Military Sexual Trauma

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Objectives

- Articulate the kinds of experiences that constitute MST
- Describe the impact of MST and clinical needs of Veterans who have experienced MST
- Discuss possible reasons that the impact of MST may be different relative to other kinds of traumas
- Share possible enhancements to clinical practice in two key areas (interpersonal and sexual health) that commonly arise in the context of treating MST-related PTSD and other mental health difficulties



Part 1: Background

What is Military Sexual Trauma (MST)?

- VA's definition of MST comes from federal law but in general is sexual assault or repeated, threatening sexual harassment that occurred during a Veteran's military service
 - Any sexual activity in which someone is involved against his or her will
 - Can occur on or off base, while a Veteran was on or off duty
 - Perpetrator identity does not matter
- The term "MST" is not used by the Department of Defense (DoD)
 - Sexual assault and sexual harassment policies and responses are handled by separate program offices

Examples of MST

- Someone may be:
 - Overpowered or physically forced into participation
 - Unable to consent to sexual activities (e.g., asleep, intoxicated)
 - Pressured into sexual activities (e.g., with threats of consequences or promises of rewards)
- Can involve things such as:
 - Repeated comments about a person's body or sexual activities
 - Threatening and unwelcome sexual advances
 - Unwanted touching or grabbing, including during hazing experiences
 - Oral sex, vaginal sex, anal sex, sexual penetration with an object
- Compliance is different from consent

How Common is MST Among Veterans Seen in VHA?

- When screened as part of the Veterans Health Administration's (VHA) universal screening program, about 1 in 4 women and 1 in 100 men have told their VHA healthcare provider that they experienced sexual trauma in the military
 - Sexual trauma is generally underreported
 - VHA data speak only to the rate among Veterans who have chosen to seek VA healthcare
 - Data do not address what percent need or want treatment
- Although women experience MST in higher proportions than do men, because of the large number of men in the military there are significant numbers of men and women seen in VA who have experienced MST

MST-Related VHA Services

- VHA provides all MST-related care free of charge and every VA medical center provides MST-related care
- Eligibility for MST-related care is expansive
 - Veterans do not need to have reported their experiences of MST at the time or have other documentation that they occurred
 - Veterans do not have to file a claim or be service connected
 - Veterans may be able to receive free MST-related care even if they are not eligible for other VA care
 - There are no length of service or income requirements
 - Veterans with Other Than Honorable discharges may be able to receive MST-related care with Veterans Benefits Administration Regional Office approval
 - Pre-military trauma and pre-existing conditions do not impact eligibility



Part 2: Clinical Issues

Diagnoses Commonly Associated With MST and Sexual Trauma

- Among users of VA health care, data from the electronic medical records suggest that the mental health diagnoses most commonly associated with MST are:
 1. PTSD
 2. Depressive Disorders
 3. Anxiety Disorders
 4. Bipolar Disorders
 5. Drug and Alcohol Disorders
 6. Schizophrenia and Psychoses
- Rates of sexual trauma are high amongst individuals with certain personality disorders
- Other mental health diagnoses common among sexual trauma survivors include:
 - Eating Disorders
 - Dissociative Disorders
 - Somatization Disorders
- A range of common physical health conditions exist (e.g., headaches, gastrointestinal difficulties, chronic pain, chronic fatigue, and sexual health and functioning difficulties)

The Impact of MST

- MST may be more strongly associated with negative mental health consequences than sexual trauma in nonmilitary contexts (e.g., Forman-Hoffman et al., 2012; Himmelfarb et al., 2011)
 - However, findings vary depending on the specific construct studied
 - MST appears to be more strongly associated with PTSD than premilitary or postmilitary sexual trauma (Himmelfarb et al., 2006; Luterek et al., 2011; Suris et al., 2007)
 - MST is not significantly associated with suicidal thoughts and behaviors when adjusting for pre-military sexual trauma (Bryan et al., 2015)
- MST appears to be comparably or more strongly associated with negative mental health consequences than combat exposure (Kang et al., 2005; Street et al., 2013)

Factors Contributing to the Impact of MST and Other Sexual Traumas

- Nature of MST (interpersonal trauma, may be ongoing)
- Blurred boundaries between work and personal life
- Limited social support
- Barriers to disclosure
- Meaning that survivors and society attribute to sexual trauma
- Age/developmental level of survivor
- Military culture, socialization, and values
- Cumulative effects of trauma



Part 3: Treatment Considerations

Common Domains of Functioning and Well-Being

- Interpersonal difficulties or avoidance of relationships
- Occupational and vocational difficulties
- Difficulties with parenting
- Difficulties with identity and sense of self
- Spirituality issues and existential dilemmas
- Difficulties related to sexual health and functioning
- Difficulties related to emotion regulation
- Cognitive difficulties (e.g., memory, attention, dissociation)
- Issues related to self-care (e.g., eating, sleeping, physical health)

Addressing PTSD and Other Mental Health Difficulties

- Stay mindful of the factors that may make the impact of MST unique in order to guide conceptualization and treatment planning
- Consider utilizing the “non-fragilizing” stance embraced in Dialectical Behavior Therapy (DBT)
 - Stance that communicates genuine belief in survivor’s abilities (e.g., to tolerate discomfort, to engage in difficult conversations, to hear constructive feedback, to change)
 - Stance that remains mindful of vulnerabilities without making assumptions
 - Stance that communicates respect for survivor as person and equal
 - DBT concept of radical genuineness and Acceptance and Commitment Therapy frame of treating people like sunsets rather than math problems are also relevant to this approach

The Utility of a DBT or Non-Fragilizing Stance

- For MST survivors, this framework is relevant for all domains, but particularly in addressing interpersonal and sexual functioning
 - Military values/self-identity of strength and self-sufficiency can create dilemmas for MST survivors
 - A non-fragilizing stance can help counteract negative messages
 - Even well-intentioned attempts can land as fragilizing or reinforce negative self-concept
 - Examples: intervening or solving problems on survivors' behalf, using overly soothing "therapist" voice, postponing or diluting difficult conversations

A DBT or Non-Fragilizing Stance in the Therapeutic Relationship

DBT offers a useful “observing limits” framework for addressing certain challenges that can arise in the therapeutic relationship (even when DBT is not the primary treatment modality) that involves:

1. Regularly *monitoring* your reactions and ways in which they have an impact on the survivor, relationship, treatment, and you
2. Non-judgmentally and concretely *identifying* 1) when and to what you are reacting and 2) what you and the survivor need to do to alleviate the emotional impact and enhance your motivation and effectiveness

Example: engaging in supportive vs. change-oriented psychotherapy

3. *Communicating* with survivors about ways that they can facilitate this process in a non-fragilizing manner that is honest and direct AND is compassionate, empathic, and validating

The Importance of Observing Personal Limits

- Communicates explicitly our respect for survivors and the relationship and our belief in survivors' ability to handle the conversation
- Bolsters therapist engagement, effectiveness, and motivation
- Prevents burnout, premature termination of therapy, or harm to survivors
- Leads to fewer therapeutic mistakes and more effective and rewarding therapy
- Facilitates maintenance of the therapeutic relationship
- Models observing limits for survivors
- Gives survivors the opportunity to learn how to navigate their own limits in real-world settings
- Promotes longevity of career

Key DBT Principles

- Therapists are human beings who have valid and understandable limits
- Limits (and differences in limits) are normative
- Limits should be monitored continually and with each survivor separately
- Limits are “observed” rather than “set”
- Problems are conceptualized as due to poor interpersonal fit vs. due to behaviors that are inherently flawed or inappropriate
- The process of observing limits is not license to be uncaring or unresponsive to important needs, or to be inconsistent or chaotic in response to requests

Key DBT Principles

- Empathic formulations are used to describe limit-exceeding behaviors
- Limits are communicated honestly and directly to survivors
 - Limit-exceeding and desired behaviors are behaviorally defined
 - Requests are specific, clear, and concrete
 - Problems are framed in terms of therapist's ability and/or willingness to meet the survivor's needs/wishes rather than for the good of the survivor
 - Both validation and problem-solving strategies are utilized
- Limits are temporarily extended when necessary
- Therapists remain consistent and firm about limits
- Observing limits often IS the therapy

Defining Sexual Health and Functioning

- Difficulties in sexual contexts related to
 - Arousal
 - Pain and sensation
 - Desire
 - Orgasm
- Satisfaction derived from sexual encounters
- Struggles related to sexual identity and orientation
- Sexually transmitted infections
- Sexual impulses, fantasies, & addictions
- Contraception
- Other aspects of sexual history like sexual trauma, number, type, and nature of past and current sexual partners

Evidence-Based Treatment

- No existing integrated treatments specific to simultaneously addressing sexual trauma (or trauma in general) and sexual functioning
 - One study on adjunctive sex therapy (Cohen & Ben-Gurion, 2008)
- Addressing sexual functioning difficulties in sexual trauma survivors can and does occur within the context of current evidence-based protocols
 - Non-PTSD focused (e.g., standard DBT, IPT for Depression)
 - PTSD-focused (e.g., CPT and PE)
- However, research is limited
 - Some evidence that using standard EBPs for PTSD can result in improvements in sexual functioning (Schnurr et al 2009; Resick et al 2003)
 - Some evidence that improvements in sexual functioning observed following PTSD treatment are equivalent to those observed in active treatment controls (Schnurr et al., 2009) and no-treatment controls (Cohen and Hien, 2006)

Applicable Principles from PTSD Treatment

- Psychoeducation and normalization are powerful interventions
 - Example: sexual response/arousal/orgasm experienced during MST
- Comprehensive and direct assessment guides effective intervention
- Seeking adjunctive treatments and utilizing interdisciplinary treatments teams when indicated improves treatment response

Comprehensive & Direct Assessment: What to Cover

- Ask about a range of sexual functioning difficulties, not just the presenting concern or the most salient one(s)
- Assess both problem itself and its interconnectedness with trauma and trauma symptoms
 - Chain analysis
 - Structured/semi-structured assessment tools
 - Coordination with other services (e.g., primary care, sexual health, urology, andrology)
- Examples:
 - Intrusive memories and discomfort during sexual activity
 - Difficulty maintaining an erection or achieving orgasm

Comprehensive & Direct Assessment: How to Do It

- The “ABCs” of conducting your assessment in a non-fragilizing way
 - Acknowledge potential discomfort
 - Be direct and precise
 - Clarify your rationale for asking
- This approach models effective communication and demonstrates your openness and comfort level
 - Use specific words and terms for body parts and difficulties
 - Some parallels to Prolonged Exposure Therapy in terms of therapist habituation and clinical rationale for eliciting specific details
 - Clarify vague language and make sure your understanding is accurate
 - “It just doesn’t work. When I am about to have sex, it just doesn’t work.”
 - Attend to subtle cues and signs
 - “My relationship isn’t what is used to be.”
 - Consider and ask about contributions of gender identity and prescribed societal/cultural gender roles and socialization, religious and cultural beliefs, other values

Factors to Consider in Treatment Planning

- Organic risk factors
- Non-organic or psychogenic contributors
- Complexity of presentation
- Fit of traditional protocols
- History of PTSD treatment
- Availability of local resources
- Personal expertise and comfort
- Referring vs. consulting



Free one-on-one consultation to assist you in your work with Veterans who experienced sexual assault or sexual harassment during military service

Speak directly to experts about:

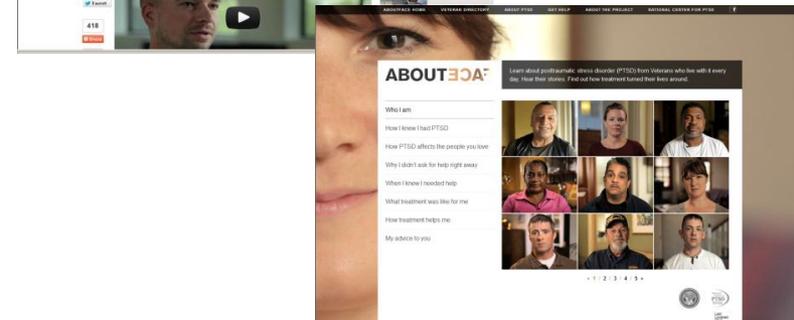
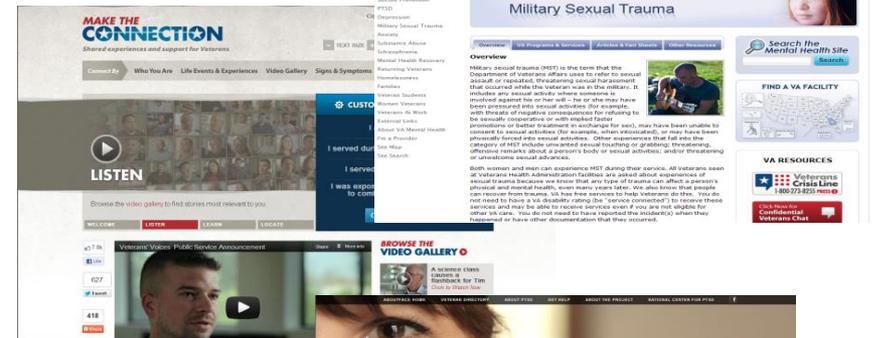
**IMPACT ♦ UNIQUE NEEDS ♦ RECOVERY
TREATMENT ♦ SCREENING ♦ ASSESSMENT
DIAGNOSIS ♦ PROGRAM DEVELOPMENT**

Available to *anyone* working in VA

Contact us at MSTConsult@va.gov or (866) 948-7880

MST-Related Website Resources

- MST SharePoint for VA Staff
 - <http://vaww.mst.va.gov>
- VA Internet website on MST
 - www.mentalhealth.va.gov/msthome.asp
- Make the Connection
 - www.maketheconnection.net
- NCPTSD's AboutFace website
 - www.ptsd.va.gov/aboutface



Additional Resources

- **MST-related resources:**
 - Bell, M.E. & Reardon, A.F. (2012). Working with survivors of sexual harassment and sexual assault in the military. In J. Beder (Ed.), *Advances in social work practice with the military* (pp. 72-91). New York, NY: Routledge.
 - Street, A.E., Kimerling, R., Bell, M.E., & Pavao, J. (2011). Sexual harassment and sexual assault during military service. In J. Ruzek, P. Schnurr, J. Vasterling, & M. Friedman (Eds.) *Caring for Veterans with deployment-related stress disorders: Iraq, Afghanistan, and beyond* (pp.131-150). Washington, D.C.: American Psychological Association Press.
 - Street, A.E., Bell, M., & Ready, C.E. (2011). Sexual assault. In D. Benedek & G. Wynn (Eds.) *Clinical manual for the management of PTSD* (pp. 325-348). Arlington, VA: American Psychiatric Press, Inc.
- **DBT-related resources:**
 - Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
 - Koerner, K. (2011). *Doing Dialectical Behavior Therapy*. New York, NY: The Guilford Press
- **Sexual health and functioning resources:**
 - Maltz, W. (2001). *Sexual Healing Journey: A Guide for Survivors of Sexual Abuse*. New York, NY: HarperCollins.
 - Binik, Y. M. & Hall, K. S. (2014). *Principles and Practice of Sex Therapy: Fifth Edition*. New York, NY: The Guilford Press.

The MST Support Team's Teleconference Training Series

- Webinars available to all VA providers
- Take place every other month on the first Thursday of the month at 12:00 ET, 11:00 CT, 10:00 MT, 9:00 PT
- Our next webinar will be on Thursday, April 7th (during Sexual Assault Awareness Month): *Gender Differences in Recovery from Sexual Trauma: Implications for Clinical Care* presented by Tara Galovski, Ph.D.
- For more information, email James.Leathem@va.gov to subscribe to our email list or visit the MST Resource Homepage at <http://vaww.mst.va.gov>.



Thank you!

For any questions, please feel free to contact me at
melissa.foynes2@va.gov.

VA providers can also reach out to the MST Consultation Program
(MSTconsult@va.gov or (866) 948-7880).

We'd love to hear from you!



PTSD Consultation Program FOR PROVIDERS WHO TREAT VETERANS

(866) 948-7880 or
PTSDconsult@va.gov



There is no charge for these services.

Who can contact us?

Any provider treating Veterans with PTSD.

Who are the consultants?

Experts at the National Center for PTSD including psychologists, social workers, physicians, and pharmacists.

Ask us about

- Evidence-Based Treatment
- Medications
- Clinical Management
- Resources
- Assessment
- Referrals
- Educational Opportunities
- Improving Care
- Transitioning Veterans to VA Care

WWW.PTSD.VA.GOV



What can you expect?

- It's easy to make a request
- Responses are quick
- Questions are answered by email or phone
- Calls are scheduled at your convenience