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My name is Amy Street and I’ll be talking today about what I think is a very important issue, and that’s the issue of sexual harassment and sexual assault during military service. I am a researcher and an educator with the National Center for PTSD and my area of expertise is interpersonal trauma with a particular focus on sexual trauma in the military. I’m also a mental health clinician who works directly with survivors of sexual trauma in the military, so this particular issue is near and dear to my heart.

This presentation has three learning objectives. First, is to be familiar with the terms used to describe sexual harassment and sexual assault in the military. Second, is to describe estimates of the frequencies of sexual harassment and assault in the military. And third, is to describe the mental health impact of sexual harassment and assault in the military, and understand the implications of providing mental health care for service members and Veterans who have had these experiences.

The term sexual harassment is used in many different contexts. And, sexual harassment is, in fact, a legal construct with specific legal definitions that differ across different settings. However, for the purposes of this presentation, when I talk about sexual harassment I’m talking about unwanted sexual experiences that occur in the workplace. And for the purposes of today’s presentation, I’m really focusing on the military context as a workplace setting. The military is, of course, a workplace whether service members are on or off duty, or whether they’re on or off base. There are two basic types of sexual harassment.

The first is generally referred to as hostile environment sexual harassment. It includes a large range of experiences. Things like offensive comments about a person’s body or sexual activities, unwanted sexual advances, displays of pornographic materials or other sexually demeaning objects in the workplace. But essentially, it’s any unwanted sexual experience that occurs in the workplace and creates an intimidating, hostile or offensive working environment.

The second type of sexual harassment is often referred to as quid pro quo sexual harassment. And that’s any kind of coerced sexual involvement where participation in or tolerance of unwanted sexual experiences are a condition of employment or used as the basis for employment decisions, such as a promise of rewards, like a less hazardous duty assignment. Or, threats of punishment, like a decreased performance evaluation in exchange for sexual favors.
When I use the term sexual assault I’m talking about any kind of unwanted physical sexual contact that involves some type of coercion. And coercion can take many different forms. It can be physical force. It can be threats of harm. It can be abuse of authority. In the military this type of coercion is sometimes referred to as “command rape.” Or, coercion can occur when the victim does not or cannot consent, either due to intoxication or cognitive impairment, for example.

Physical contact can range from touching or fondling all the way up to attempted or completed vaginal, anal, or oral rape—coerced sexual intercourse essentially. I think it’s useful when thinking about sexual harassment and sexual assault to consider them on a continuum of severity ranging from unwanted but relatively common experiences of sexual harassment all the way up through experiences of sexual assault and rape. For simplicity’s sake, in today’s presentation I’ll use the term sexual trauma to refer to the full range of these traumatic experiences.

One term that you may have heard before is the term “Military Sexual Trauma”, which is often abbreviated as “MST.” This is a term used by the Department of Veterans Affairs and it has a specific legal definition which is set down in US Code.

The specific definition is: “Psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment [“repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character”] which occurred while a Veteran was serving on active duty or active duty for training.”

Throughout today’s presentation, I’ll use the term “MST” only when I’m specifically referring to information collected within the Department of Veterans Affairs using this definition.

Now that we’ve discussed the different relevant definitions, I’d like to move on to discussing how frequently these experiences of sexual trauma in the military occur.

But before I move into discussing specific numbers, I just want to say that it’s difficult to identify exactly how common these experiences are. Primarily, that's because frequency rates vary substantially across different studies. There’s a number of reasons for this.

Different studies focus on surveying different groups of people. So, one study may focus on all current service members. Another survey may focus on users of VA Healthcare or women seeking mental healthcare. Those different groups will give you very different frequency rates. Similarly, different surveys may ask about different time periods. Maybe one survey asks about any time in the past year, while another survey asks any time during your military service. The way the survey questions are worded, the person’s belief about their anonymity, the characteristics of the interviewer, and the characteristics of the organization who is sponsoring the survey can all impact the types of frequency numbers. Understanding those caveats about the difficulties in identifying specific frequency numbers, let me move on to give you a couple of specific sets of numbers that may help you understand how frequently these experiences occur.

Now that I’ve given you those caveats, in terms of understanding the frequency number of sexual trauma, let me move on to discussing a few specific studies. First, I’d like to talk about a large scale survey conducted by the Manpower Data Service of the Department of Defense. Every few years they conduct a large, well-designed survey which they refer to as the “Workplace and Gender Relations Survey of Active Duty Members.” And the most recent data was collected in 2006. It includes respondents from all branches of the military, over 23,000 respondents. And, it asks about experiences of sexual harassment and unwanted sexual contact that service members experienced during their past year.

Looking at some of the results from this most recent DOD survey of unwanted sexual experiences among active duty service members, we can see that within the past year over half of women and over a quarter of men reported experiencing offensive sexual behavior. That includes things like being told offensive
sexual stories or jokes, or experiencing unwelcome attempts to be drawn into a discussion of sexual matters. Thirty one percent of women and seven percent of men reported experiencing unwanted sexual attention, which would include things like unwanted attempts to establish a sexual relationship despite the service member’s effort to discourage it. Nine percent of women and three percent of men reported some form of sexual coercion, which would include things like feeling threatened with retaliation for not being sexually cooperative or believing better assignments or better treatment was implied if one was sexually cooperative. And, close to seven percent of women and two percent of men reported experiencing unwanted sexual contact, which would mean unwanted physical sexual contact, or what I would refer to as "sexual assault."

Another set of useful frequency numbers comes from the Department of Veterans Affairs Universal Screening Program for experiences of military sexual trauma. Every Veteran who uses VA Healthcare is screened for experiences of MST by a healthcare provider using the two questions that you see here on the slide. Of Veterans seen in VA facilities in fiscal year 2008, we have MST screening data on over four million Veterans.

A few issues to consider when interpreting these numbers: First, Veterans who respond positively to either screening item are considered to have screened positive for MST. But, a positive screen does not indicate the Veteran’s current subjective distress, any particular mental health diagnosis, or even the Veteran's interest in or need for treatment.

A positive response also does not indicate if the perpetrator was a member of the military, only that the Veteran experienced sexual trauma at some point during their military service. It's also important to consider a couple of differences between the set of numbers I'm about to show you and the set of numbers I just showed you from the DOD. The VA numbers asks about Veterans from all eras, where the DOD number asks only about active service members. The VA's numbers ask about experiences any time in the military while the DOD's numbers ask only about experiences in the past year. In addition, the VA's numbers are not anonymous, i.e. Veterans know that they're being asked these questions, and that may impact the rates or frequencies that we see.

With respect to this VA screening data, you can see that just over twenty percent of women and one percent of men reported to a VA healthcare provider that they have experienced MST. This translates to over 48,000 women and close to 44,000 men in the VA system.

I'm frequently asked if experiences of sexual harassment and assault are happening amongst service members who are deployed in support of Operation Enduring Freedom in Afghanistan or Operation Iraqi Freedom in Iraq. We can use this VA screening data to shed some light on this question. On this slide is a table that shows the comparison between fiscal year 2008 users of VA healthcare from all eras versus fiscal year 2008 users of VA healthcare who were deployed in support of Operation Enduring Freedom or Operation Iraqi Freedom.

What you can see from this comparison is that the frequency of MST experiences is slightly lower among the OEF and OIF cohort when compared to all VA users. We don't know exactly why that is. It may be that this decrease reflects actual decreases in rates of MST among more recent Veteran cohorts. Or, it may also be that these decreased numbers just reflect delays in Veterans disclosing MST to healthcare providers or delays in seeking care for MST. We'll just have to wait for more time to pass to know what the real answer is to this question.

Before we move on, I'd like to comment briefly on the issue of men as victims of sexual trauma in the military. Sexual harassment or sexual assault are frequently considered to just be women's issues. And as you can see from the frequency numbers that I just showed you, it is true that the frequencies of experiences are much higher among women.

However, given that there are many more men than women in the military, there are significant absolute numbers of men who have experienced sexual trauma in the military. For example, in the VA screening
data I just showed you, while there are over 48,000 women who’ve experienced sexual trauma in the VA system, there are close to 44,000 men who've experience sexual trauma in the military within the VA system. This is certainly a relevant issue for men, as well as women. There are some unique ways in which men may be impacted from a mental health perspective and we'll talk more about this later in this presentation.

One of the reasons I believe we as mental health workers should be so concerned about this issue of sexual trauma in the military is because this experience has the potential to significantly impact Veteran and service members’ health.

There is a wide range of potential reactions that victims of sexual trauma can have. In fact, many victims of sexual trauma are quite resilient. That being said, across a wide range of studies, if you compare male and female Veterans who have histories of sexual harassment or assault in the military to those who do not have those histories, the Veterans with histories of sexual trauma have more mental health problems, more physical health symptoms and physical health conditions, and more problems in general readjusting after discharge; including problems in the occupational, financial, and housing sectors.

I don't want to hit you over the head with numbers from a hundred specific studies. But I will provide you with one example from one study here just to illustrate the point about the negative mental health effects associated with sexual trauma. Earlier, I showed you some data from the VA's mandated screening program. And this study compared those Veterans who reported experiencing MST to those who had not. And the study found that, among those who experienced MST, those Veterans were three times more likely to have a mental health diagnosis than Veterans who had not experienced MST. You can see the most frequently identified diagnoses here but, not surprisingly, anxiety disorders and depression are up at the top of the list.

It's impossible to discuss the mental health impact of sexual trauma in the military without discussing posttraumatic stress disorder (PTSD), because PTSD is the mental health diagnosis that's most closely associated with experiences of sexual trauma. Data that comes from both civilian and military samples indicate that sexual assault is one of the potentially traumatic events that has the highest conditional risk of PTSD. That means that sexual assault is more likely to occur in PTSD diagnosis than most other traumatic events. I have a table here that illustrates this point from one study among Gulf War Veterans. And this study demonstrated that PTSD was more strongly associated with sexual assault than it was associated with heavy combat exposure. As you can see, women who experience military sexual assault had a five times greater risk of developing PTSD, and men who experienced sexual assault had a six times higher rate of developing PTSD. You can compare that to numbers for heavy combat exposure which also increased risk of developing PTSD, but only by a factor of four.

Why is it that experiences of sexual trauma are so strongly associated with mental health symptoms? I think there are a few different reasons. First, like other types of traumatic events, sexual trauma may shatter previously held beliefs. So, perhaps service members have some generally prevalent beliefs that, for example, the world is a safe place or that bad things don't happen to good people. And, when they experience some kind of sexual trauma, then they're in a bind because the world no longer seems safe or it seems that bad things do happen to good people.

Alternatively, the service member might have had some experiences previously that already led them to believe that the world is not a safe place or that bad things frequently happen to them and the experience of sexual trauma just confirms that belief system. There are also some things specific to sexual trauma in the military that can challenge some additional beliefs. The military is a setting that promotes a self identity of being very strong, very tough, and very physically powerful. And it almost sets up an expectation that military units are cohesive and loyal groups with an important shared mission. The experience of being sexually victimized while being in the military can shatter these previously held beliefs in a way that really detrimentally impacts a Veteran’s mental health.
There are several other issues to consider when thinking about why sexual trauma in the military can be so damaging for mental health. One is that in the field of traumatic stress, we often think about traumatic events as relatively more simple versus relatively more complex. Sexual trauma can often be considered a more complex traumatic event. It involves interpersonal victimization possibly by a known perpetrator which means that someone else had to do something to the victim, which can be very difficult to make sense of. The sexual victimization may be ongoing over a period of time as opposed to a single event. The sexual trauma may occur relatively early in development. The victim may be relatively young: seventeen, eighteen, nineteen or twenty years old. And, the sexual trauma may potentially represent only one of multiple traumatic events across the lifespan.

All of these things can add up to an event that's associated with a lot of mental health difficulties. There's also the issue to consider that among Veterans, particularly those who are deployed to a combat zone, there is a risk that sexual trauma may be only one type of multiple types of trauma exposure. So perhaps the Veteran is exposed to both sexual trauma and combat trauma which is likely to increase the risk of negative mental health outcomes. Or alternatively, maybe sexual trauma is experienced as even more threatening by the victim because it occurs in the context of a combat zone in which there is a generalized decreased sense of safety.

Veterans who experience sexual trauma during a combat deployment may struggle with some unique readjustment issues following their homecoming. It may be that these Veterans may feel that their experiences are not as legitimate as the experiences of those Veterans experiencing combat trauma. These Veterans may be reluctant to disclose their experiences to loved ones or to disclose them to health care providers, limiting their opportunity to healthcare support. These Veterans may also believe that treatment programs that are targeted at returning Veterans will not welcome them. They may inaccurately believe that these treatments are focused only on Veterans who experienced combat trauma and are not appropriate for Veterans who experience sexual trauma.

I'd like to move on to discussing some specifics in providing mental health care for Veterans who’ve experienced sexual harassment or sexual assault during their military service.

I think the most important issue to remember is just not to be afraid to ask Veterans about their experiences of sexual trauma because sexual trauma is associated with a variety of physical and mental health problems. Because there's a high frequency of these events and because Veterans won’t disclose these experiences unless they are asked about them, it’s important to ask all Veterans about these experiences.

Sometimes health care providers are reluctant to ask Veterans about their sexual trauma experiences because of fears they may have of offending Veterans. But, it is really a pretty simple process. First, you just want to normalize the fact that you are asking the questions. You can include it as a broader discussion of taking a social history or you can provide a rationale for asking. For example, you can say something like, “Unfortunately, these experiences are so common that I ask all Veterans who I see about these experiences.” That helps the Veteran feel like you’ve not spotted something about them that makes them crazy or weird and that's why you are asking.

You just want to very simply ask the question. You want to avoid more jargony words like rape or sexual assault and instead ask questions like, “Did you ever have a sexual experience that made you feel uncomfortable or that you did not want?” And you want to avoid negative questions. You want to avoid saying things like, “Nothing like that ever happened to you, right?” Because a Veteran will be unlikely then to tell you about these experiences.

And then, finally, you just want to be sensitive that there are some very real barriers to disclosure. First, many Veterans have shame about these experiences that may keep them from telling others. And they also may have fears of how others will view them if they disclose these experiences, particularly if they have had previous negative experiences in disclosing or reporting these events.
When considering the issue of treatment, I think it is important to realize that treatment of sexual trauma survivors is in many ways similar to treatment of survivors of other types of traumatic events. So all of the skills and all of the things you already know about working with survivors of traumatic events in general can probably be applied to this population.

However, there are certain issues that sexual trauma survivors struggle with more so than other trauma survivors. And, among survivors who are young at the time of the trauma or who were multiply traumatized across their life spans, those folks may have particularly complex clinical presentations to be attended to.

I am not going to talk a whole lot today about specific treatment approaches; instead I am going to focus more on general treatment themes. But I do want to talk about a couple of specific types of therapies that can be useful among this population.

The first is skills training therapies. These are the types of therapies that are designed to promote initial stabilization and to provide skills to the Veteran to help them either manage a course of trauma processing therapy or just to manage their lives more effectively. These types of therapies can promote stress management or distress tolerance or interpersonal skills. And a couple of examples of these types of therapies include Stress Inoculation Therapy, Seeking Safety, or the skills component of Dialectical Behavior Therapy.

A second type of therapy is referred to as trauma processing therapies. These are exposure therapies that help the Veteran work to process the traumatic experience and the memories associated with that experience. This includes types of therapies like cognitive processing therapy and prolonged exposure. Because these trauma processing therapies have a very strong evidence base that suggests they are very effective, these are a good choice of therapy to use for survivors of sexual trauma.

Because sexual trauma is by its nature an interpersonal event, it’s very likely that sexual trauma survivors will struggle with issues in interpersonal relationships. You may see this generally in the interpersonal relationships of the sexual trauma survivor or you may even see it play out in the therapeutic relationship. The types of things you may encounter are that the survivor will struggle with issues like trust, with safety and interpersonal relationships, or with intimacy (having difficulty getting close to interpersonal others). The sexual trauma survivor may also have difficulty identifying and setting appropriate boundaries; either having boundaries that are too strict and rigid or perhaps too loose. And, the sexual trauma survivor may also have strong reactions to any kind of hierarchical relationships: any kind of relationship in which they feel that someone else has some power over them, whether it be their employer or perhaps their therapist. This may be a particular issue for those sexual trauma survivors who were assaulted by higher ranking officers in the military.

In addition to difficulties trusting others, or having generally negative views of other people, sexual trauma survivors may also struggle with having a negative view of themselves. You may see this play out in therapy as the sexual trauma survivor blaming themselves for their sexual trauma experience. And the experience may be associated with very strong feelings of guilt and shame.

If the sexual trauma survivor blames themselves, you may also see this play out in therapy as a strong mistrust of the self and the survivor may generally distrust their own ability to make good decisions and have difficulty with any kind of important decision-making process.

Another theme that you may see come up more frequently among survivors of sexual trauma are struggles around sexuality and sexual functioning. This may take the place of sexual dysfunction or even beyond a diagnosable sexual dysfunction to more general difficulties with sexual behavior. You may see extreme sexual behavior including either avoidance of all sexual behavior, engaging in sex only when under the influence of alcohol or other drugs, or a hyper-sexuality, including sexuality with many casual sexual partners.
Problems with sexuality and sexual functioning may be particularly prevalent among those male and female survivors who experienced some form of involuntary sexual arousal during their sexual assault. This can be a very confusing situation for a survivor to deal with.

Another common theme that comes up when working with sexual trauma survivors is around issues of safety and revictimization. Often therapists will struggle by what they see as extremes in the behavior of the sexual trauma survivors. Either the sexual trauma survivor experiences global distrust of others—hyper-attention to safety and an inability to engage in any kind of trusting, close interpersonal relationship. Or alternatively, the sexual trauma survivor may seem to trust too easily and to be seemingly completely inattentive to any kind of safety behaviors. Both of these situations can be pretty challenging for mental health providers.

There are in fact very high rates of revictimization among this population. Certainly, some sexual trauma survivors will continue to be in the same environment with their perpetrator so may continue to be exposed to the sexual trauma. But in addition to this, you may also see things like new relationships with new abusive partners, unsafe sex, perhaps prostitution, generally poor boundaries with others and trusting too easily particularly in casual sexual situations, or just generally putting themselves in dangerous situations.

Survivors may have also developed some strategies that help protect them from the mental health symptoms but put them at increased risk for being re-victimized. Things like disassociating under stress, or using substances to manage their symptoms or just generally being inattentive to their internal reactions and symptoms, all of which can increase risk of re-victimization.

While male survivors and female survivors tend to respond more similarly than they do differently, there are some unique issues that come up for male and female survivors. Among male survivors, there is an increasing evidence that men are at even more risk for negative mental health outcomes than are their female counterparts.

This is not really surprising when you think about the fact that men have no context for understanding their victimization. They never expected to be sexually victimized and so the experience of sexual victimization is often quite a shock for male survivors. We see that male survivors are even more reluctant than their female counterparts to disclose experiences of sexual trauma or engage in treatment. And this is often because these survivors have particularly strong feelings of shame or self-blame so it is extremely difficult for them to share these experiences with other people.

Frequently among male survivors, you will see them struggle with issues of gender identity or concerns about their sexual orientation. Because most sexual trauma of men is perpetrated by other men, many male survivors, whether they are heterosexual or homosexual, worry that they may have been targeted for some reason perhaps because they are gay. In addition, a frequent issue that you see among male survivors is the use of alcohol or other drugs to cope with symptoms because this is a gender-acceptable way to cope with stress.

Among female survivors, specifically those in the military setting, these women may have really focused on being tough because they wanted to exhibit that as a woman in the military. And, being a survivor of sexual trauma really conflicts with that idea of being tough and strong. They may also struggle with the effects of sexual trauma on their thoughts about military service. Perhaps they thought that they were accepted, they were just one of the guys and the sexual trauma really shattered that belief for them. And, in general you frequently see that female survivors of sexual trauma struggle more generally in relationships with men.

Another important issue to consider when focusing on gender issues in working with sexual trauma survivors is that of the sex of the provider. This is an important issue for both male and female survivors of sexual trauma. Sexual trauma survivors have concerns about safety, about their ability to disclose to providers or they may feel inhibited due to gender roles. And, if a survivor is forced to work with a mental
health provider who is the same sex as their perpetrator, it may even affect their willingness to engage in treatment at all.

That being said, it may be useful to encourage survivors to work with a provider who is the same sex as their perpetrator. This can be very therapeutically powerful when it is handled correctly. It can help the survivor challenge their assumptions about men or women, it can help them confront their fears, it can help them foster the appropriate boundaries in relationships and it can be an emotionally corrective experience if the survivor feels able to step outside of their comfort zone in this area.

However, it is widely considered best practice to allow survivors some control over the choice of sex of their therapy provider. So, if a sexual trauma survivor says, I just don’t feel comfortable working with, for example, a male provider, it is important to respect that decision.

In addition to individual therapy with sexual trauma survivors, there are some real benefits to group therapy with this population. First, a group of sexual trauma survivors together can really help validate and normalize their experiences and as a really important means of reducing the sexual trauma survivor’s sense of being alone.

There are two issues that need to be considered when forming therapy groups with sexual trauma survivors. The first is the issue of including mixed gender groups, i.e., of including both male and female survivors of sexual trauma within one group. The issues that come up with this are very similar to the issues that are raised when considering the sex of the provider, i.e., it may be uncomfortable and difficult for some sexual trauma survivors to be in a group that has men or women depending on the sex of their perpetrator. But if they are able to do that, it can really help confront and work through some of those gender specific issues.

The second issue that often comes up is the question of including mixed trauma types within a single group, i.e., including sexual trauma survivors in a group with, for example, combat trauma survivors. There are some real benefits but also some costs to this type of issue. One of the main benefits is that in having mixed trauma type groups allows for survivors to have their experiences normalized and validated.

On the other hand, there is the risk that these groups may not adequately address issues specific to sexual trauma and it may be the case that sexual trauma survivors are just not willing to participate unless they are in a group only with other sexual trauma survivors. If resources permit, I think there are real benefits to having both mixed trauma and sexual trauma specific groups available depending on the needs of the specific sexual trauma survivor.

In conclusion, I hope I have conveyed to you that there are effective treatments available for sexual trauma survivors. This work can be very challenging for mental health providers, but it can also be extremely rewarding.

I would like to leave you with a few additional resources appropriate for survivors of sexual trauma that may be useful in working with service members and Veterans. Every VA facility has providers knowledgeable about treatment for the after-effects of military sexual trauma and Vet Centers also have specifically trained sexual trauma counselors.

You can find a list of VA and Vet Center facilities online or from the VA general information hotline. And you can also find information specifically relevant to current service members with the Department of Defense Sexual Assault Prevention and Response Program.

Thank you for your time and attention today.